

South Africa
Country Operational Plan
(COP) 2019
Strategic Direction Summary
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List of Acronyms

Acronym	Definition
3HP	Isoniazid-rifapentine regimen
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
APR	Annual Program Results
ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
BAS	Basic Accounting System
CCM	Country Coordination Mechanism (Global Fund)
CCMDD	Central Chronic Medicine Dispensing and Distribution Programme
CDC	U.S. Centers for Disease Control and Prevention
CHW	Community Health Worker
CLHIV	Children Living with HIV
CODB	Cost of Doing Business
COP	Country Operational Plan (PEPFAR)
COP18	2018 Country Operational Plan
COP19	2019 Country Operational Plan
CSE	Comprehensive Sexuality Education
DBE	Department of Basic Education
DoH	Department of Health
EID	Early Infant Diagnosis
FBO	Faith-Based Organizations
FSW	Female Sex Workers
FTE	Full-Time Equivalent
FY	Fiscal Year
GBV	Gender-Based Violence
GFATM	Global Fund for AIDS, TB and Malaria
GoSA	Government of South Africa
HAST	HIV/AIDS, STIs, and TB (Directorate)
HIV	Human Immunodeficiency Virus
HPRS	Health Patient Registration System
HRH	Human Resources for Health
HSRC	Human Sciences Research Council (South Africa)
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IM	Implementing Mechanism
IPT	Isoniazid Preventive Therapy
LAM	mycobacterial lipoarabinomannan
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex people
MSM	Men who have sex with men
NDoH	National Department of Health
NGO	Non-Governmental Organization
NHLS	National Health Laboratory Service
NIMART	Nurse-Initiated Management of ART
NSP	South Africa National Strategic Plan for HIV, TB, and STIs, 2017-2022
OVC	Orphans and Vulnerable Children
PCO	PEPFAR Coordination Office
PEPFAR	President's Emergency Plan for AIDS Relief
PFIP	Partnership Framework Implementation Plan

Acronym	Definition
PICT	Provider-Initiated Counseling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
POC	Point-of-Care
PrEP	HIV pre-exposure prophylaxis
PUP	Pick-up-Point
PWID	People Who Inject Drugs
SA	South Africa
SAHPRA	South African Health Products Regulatory Authority
SANAC	South African National AIDS Council
SI	Strategic Information
SID	Sustainability Index Dashboard
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
StatsSA	Statistics South Africa
STI	Sexually Transmitted Infections
SyNCH	Synchronized National Communication in Health
TB	Tuberculosis
TLD	Tenofovir/Lamivudine/Dolutegravir fixed-dose combination (ARV)
TPT	TB Preventive Therapy
U=U	Undetectable=Untransmissible
U.S.	United States
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
USD	U.S. Dollars
USG	United States Government
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZAR	South African Rand

1.0 Goal Statement

Through the President's Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan 2019 (COP19), the United States (U.S.) government (USG) will support the South Africa (SA) government (GoSA) toward the goal of HIV epidemic control.

While PEPFAR SA and the GoSA are fully committed to this goal, during 2018 the SA HIV treatment program failed to meet its targets and fell short on retaining people living with HIV (PLHIV) on antiretroviral treatment (ART). As a result the GoSA with the support of PEPFAR SA has instituted a "reboot" of interventions. These interventions have the following priority objectives: (1) expand quality ART, with a focus on high-burden districts and high-volume facilities; (2) retain PLHIV on ART; and (3) expand combination HIV prevention programs, including services for orphans and vulnerable children (OVC), programs to reduce HIV risk for adolescent girls and young women (AGYW), and saturation of voluntary medical male circumcision (VMMC) for men (15-34 years).

PEPFAR SA will work with the GoSA to implement program fundamentals well and consistently at all levels and to rapidly adopt and implement critical national policies at the facility level to ensure the U.S. government HIV resources are maximized and additive to the GoSA HIV investments, and that HIV-specific investments focus and achieve the HIV programmatic goals. Program and policy implementation will address facility-level operational challenges, such as scale-up of and effective use of human resources, same-day ART initiation, extended clinic hours, and the promotion of a U=U campaign (Undetectable=Untransmissible).

PEPFAR SA has focused for impact both geographically and programmatically. During COP19, PEPFAR SA will continue to invest in South Africa's 27 highest HIV burden districts—accounting for 79% of PLHIV. Among these districts, COP19 will further focus on the high burden districts, with the four largest metropolitan districts (accounting for 29% of PLHIV) and populations with largest treatment gaps receiving the majority of the PEPFAR programmatic support. An additional 1,058,455 million PLHIV will be enrolled on treatment in these districts in FY2020, building on the additional 1,003,833 million enrolled during FY2019, totaling 4,878,720 million on treatment and 4,428,310 million virally suppressed in the public sector by the end of FY2020. Overall, 6,710,000 million PLHIV across the country will be enrolled on life-saving treatment by the end of FY 2020 (6,100,915 million in the public sector).

Within PEPFAR supported districts overall viral load (VL) suppression was reported at 91% by the end of Fiscal Year 2018 (FY18), and we fully expect the program to achieve at least 80% VL suppression across all populations/genders by the end of COP19. The upcoming roll-out of Tenofovir/Lamivudine/Dolutegravir fixed-dose combination (TLD) beginning August 2019 and continuing into COP19 is expected to provide an additional boost to both ART coverage and VL suppression rates.

PEPFAR SA will use HIV rapid recency testing (confirmed by VL test) in the four highest burden districts. Data will be used to identify transmission hot-spots, and results will be used to prioritize tracing of partners of persons with recent infection.

PEPFAR SA will support improved data systems and data use at all levels, as well as health facility-based accountability through daily performance monitoring against core indicators and weekly trend analysis. PEPFAR SA will align programs to identified needs and will specifically focus programs to reach men and young women. Prevention shifts will include expanded self-screening strategies and index testing and increased pre-exposure prophylaxis (PrEP) services. All interventions will be aligned to the 2017-2022 South Africa National Strategic Plan for HIV, TB and STIs (NSP), the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 goals, World Health Organization (WHO) guidelines and global best practices, and with the PEPFAR Strategy for Accelerating HIV/AIDS Epidemic Control (2017-2020).

PEPFAR SA continues to be fully committed to active partner management and accountability, engagement at all spheres of government, and mobilizing faith-based organizations, civil society, private sector and all stakeholders to maximize program impact. PEPFAR SA is particularly committed to working closely with the PLHIV sector to ensure they receive quality HIV services and have the opportunity to make meaningful contributions to the HIV response.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

SA is an upper-middle income country, with many cultures, languages, races, and religions shaping its health profile. The population was estimated at 57.7 million in 2018, of whom approximately 51% (29.5 million) were female. Life expectancy at birth was estimated to be 67.3 years for females (71.5 without HIV/AIDS) and 61.1 years for males (64.5 without HIV/AIDS), and the infant mortality rate was 36.4 per 1,000 live births.¹

In 2019, SA's HIV disease burden is an estimated 7.6 million PLHIV based on the updated Thembisa Model 4.1 estimates for 2019,² of which more than half (55%) are women aged 25 and older. The estimated number of new infections among adults declined by 56% from 1999 to 2019, but incidence remains high, with an estimated 227,995 new infections in 2019.³ Among children, the estimated number of mother-to-child transmissions declined by 86% from 2004 to 2019, and 76% of those transmissions are now estimated to occur during breastfeeding.⁴ This decline in

¹ Statistics South Africa [StatsSA], Mid-year population estimates, 2018. Statistical Release P0302, StatsSA: Pretoria.

² Johnson LF, May MT, Dorrington RE, Cornell M, Boulle A, Egger M and Davies MA. (2017) Estimating the impact of antiretroviral treatment on adult mortality trends in South Africa: a mathematical modelling study. *PLoS Medicine*. 14(12): e1002468. (Thembisa Estimate)

³ Ibid.

⁴ Ibid.

incidence and shift of transmission from perinatal to postnatal has led to a shift in the age distribution of HIV-infected children, over half (52%) of whom are now 10-14 years of age.⁵

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 national and regional population mobility and migration; economic and educational status; lack of knowledge of HIV status; alcohol and drug use; early sexual debut; sexual and gender-based violence (GBV); incomplete coverage of male circumcision; intergenerational sex; multiple and concurrent sexual partners; inconsistent condom use, especially in longer-term relationships and during pregnancy/post-partum; discrimination and stigmatization; and gender dynamics, including unequal power relations between men and women.

The SA National Department of Health (NDoH) and the Departments of Health (DoH) at provincial, district and municipal levels lead the public-sector HIV treatment and biomedical prevention efforts to achieve epidemic control. As of February 2019, there are 4.57 million people on ART in the public sector, including 157,749 children (<15 years) and 4,411,868 adults.⁶ In addition, there are an estimated 380,000 PLHIV on ART in the private sector.⁷ SA manages the largest national treatment program in the world. With universal ART eligibility, overall treatment coverage in 2019 is an estimated 62% (Thembisa model).^{8,9} ART coverage is higher among adult females (15+, 65%) than among adult males (15+, 58%) but is low among adolescent girls and young women (15-24, 49%¹⁰). ART coverage among children is estimated to be 55% (Table 2.1.2).

In 2018, South Africa's Human Sciences Research Council (HSRC) issued initial results of the Fifth South Africa National HIV Prevalence, Incidence, Behavior and Communications Survey.¹¹ Overall the survey demonstrated a marked decrease in new infections from 2012 to 2017, with a 56% decline among women. Incidence was higher for women than men, and in the important age group of 15-24 incidence was three times higher among young women than young men. An estimated 38% of new HIV infections were among those aged 15-24 years of age.

According to the HSRC, South Africa has reached 85-71-88 toward the UNAIDS 90-90-90 targets. South Africa made considerable progress toward testing and identifying PLHIV, with 85% of HIV-

⁵ Johnson, L. Personal communication. Age-specific output for Thembisa 4.1.

⁶ NDoH Program data (DHIS), February 2019.

⁷ Evans D, Miot J, Girdwood S and Long L. Private sector data related to the HIV care and treatment burden by geographic area. HE²RO Policy Brief Number 30, Health Economics and Epidemiology Research Office, 2018.

⁸ Johnson et al., *op. cit.*

⁹ Using the numbers in the two previous sentences (4.57 million people on ART in the public sector and 380,000 people on treatment in the private sector) and the 2019 mid-year PLHIV estimate from Thembisa (7.63 million), current coverage is estimated at 65%.

¹⁰ Eaton, J & Johnson, L. Personal communication – District-level modeling of South Africa Prevalence by Age and Sex. (Datapack).

¹¹ <https://www.hsrepress.ac.za/books/south-african-national-hiv-prevalence-incidence-behaviour-and-communication-survey-2017>

positive South Africans aware of their status. However, South Africa had a significant gap to reach these PLHIV with HIV treatment and keep them virally suppressed.

The HSRC survey measured a variety of behavioral factors contributing to HIV risk. The survey indicated that condom use increased from 2012 but was less than the peak measured in the 2008 survey. Condom use at last sex for individuals age 15-64 with two or more sexual partners was 55.6%. The survey also confirmed an increase in sexual debut before the age of 15 and an increase in the number of adolescents in sexual relationships with older partners. Multiple sexual partnerships decreased slightly. The survey indicated a significant increase in adult male circumcision over the past five years, primarily with medical circumcision.

SA continues to expand and strengthen policies to improve access to treatment and to enhance quality of treatment services. Universal test and treat was adopted in 2016, and both same-day initiation and linkage rates have improved significantly. A total of 1.47 million patients receive two months of medications through adherence clubs and centralized chronic medicines dispensing and distribution (CCMDD) models; beginning in COP19, patients will be able to receive three months of medications and will have access to additional medical collection options such as lockers. The TLD transition (including access for women of childbearing potential based on informed choice) is anticipated to begin in August 2019, and the majority of patients are expected to transition by January 2020. Treatment literacy will be needed to inform PLHIV of the risks and benefits of switching to TLD versus TLE400. PEPFAR SA will support PLHIV and community led treatment literacy interventions which will include trainings and health promotional campaigns. The NDoH has prioritized and is supporting full implementation of index testing for sexual partners and children of PLHIV, and both index testing and self-screening are included in the new National HIV Testing Services (HTS) register which is currently being rolled out. In May 2018, NDoH released a circular to address some of the barriers impacting negatively on TB preventive therapy (TPT) scale-up (including dropping the requirement for a Tuberculin Skin Test allowing TPT to be initiated at ART initiation); scale-up has been significant (from 84,327 in FY17 to 126,119 in FY18 and still increasing in FY19) but has been hampered by Isoniazid (INH) stock-outs due to inaccurate quantification and inability of the supplier to meet the demand. Proxy linkage to ART rates were 95% in January-March 2019, and the majority of districts had linkage rates over 95%; PEPFAR partners are adding case managers and linkage officers to ensure that all diagnosed patients (especially adolescents and youth 10-24) are linked to ART. South Africa prohibits informal and formal user fees for HIV, TB, antenatal care and routine clinical services in the public sector, and instances of non-compliance are quickly reported by PEPFAR SA and others to national-level counterparts for remediation. South Africa's viral load testing capacity exceeds demand, and estimated VL testing coverage is 80-95% according to the National Health Laboratory Service (NHLS); due to incomplete data capture only about 64% of patients have a VL test result recorded in TIER.Net; of those, about 90% of males and 94% of females are virologically suppressed. South Africa's national morbidity and mortality reporting system includes the District Health Information System, Birth and Death Registries, Census and cause-specific data reporting systems. The OVC program is closely aligned with the care and treatment and prevention

programs; children living with HIV (CLHIV) enrolled in the program increased from 9,079 (2%) in Annual Progress Report FY17 (APR17) to 28,376 (11%) in the Semi-Annual Progress Report FY19 (SAPR19) due to intense partner management, improved case finding strategies, new interventions targeting CLHIV, and increased collaboration between clinical and community Implementing Partners. PEPFAR South Africa awarded 73% of COP18 funding to local indigenous partners; this is projected to increase to 83% in COP19 (pending finalization of remaining TBD mechanisms). South Africa's Health Patient Registration System (HPRS) was developed in answer to the need for a unique identifier for national health insurance, and the country is on track to enroll 35 million patients by the end of fiscal year 2018-2019. Additional information on these policies is provided in Appendix D.

South Africa's plan to put an additional two million PLHIV on ART, announced by President Ramaphosa in the State of the Nation Address in February 2018, was the start of an increasingly targeted effort designed to accelerate epidemic control in SA by putting a total of 6.1 million individuals on ART in the public health system by December 2020. The GoSA and PEPFAR SA developed a Treatment Surge plan, and the roll-out began in COP18 with substantial PEPFAR investments in direct service delivery in the 27 priority districts and in high-impact technical assistance and above-site interventions that support the national ART program. The goal of the USG-supported Surge is to support the GoSA to achieve epidemic control by 2020, after which the GoSA will take on an increasing role for maintaining epidemic control. Year 1 of the Treatment Surge focused on six targeted investments to expand effective and quality service delivery, described below. Treatment Surge investments for Year 2 are described in Section 4 of this document.

1. Provision of supplemental health workers from clinical and support cadres to provide targeted facility-based direct service delivery in existing high-volume public health facilities, to identify PLHIV, initiate and retain them on ART. The NDoH issued supplemental staff guidance to all provinces that PEPFAR-supported staff should be "additive" and not replace DoH staff. In COP18, PEPFAR SA investments also supported physical improvement of high-volume facilities with chronic space limitations. PEPFAR South Africa will conduct a time and motion study at the beginning of July to map the service delivery time of HIV services provided by various cadres. Results will inform HRH recommendations by facility in August. Staffing numbers will be shared with OGAC and DSPs in September and DSPs will begin hiring staff so that they can be in place by October 1, 2019.
2. Optimization of the national Ward Based Primary Health Care Outreach Team program that assigns community health workers to ensure a bridge between public health facilities and the communities in their catchment area, including demand creation and service delivery to achieve GoSA targets. PEPFAR SA investments supported NDoH to establish strong training, performance expectations, management structures, standard remuneration, and monitoring systems to ensure impact from community workers.
3. ARV drugs and community ARV delivery. Funding for ARVs is being provided to ensure uninterrupted drug supply for new and continuing ART patients, including community-based ARV distribution implemented as part of differentiated service delivery.
4. Activation of faith-based organizations (FBOs) and traditional structures through targeted investments in these crucial structures to influence social norms, mobilize demand for

services, conduct targeted HIV testing especially among youth and men, actively link PLHIV to ART, and support ART adherence and retention strategies.

5. Mobilization of the private sector, through general practitioners who can reach and provide services to people (particularly men) who do not access public health facilities and through an Innovations Accelerator that leverages private sector expertise to generate innovative solutions from non-traditional stakeholders.
6. Acceleration of health information, through targeted support to the health information systems needed to strengthen data and information use, including through provincial Information Hubs.

Major programmatic and system gaps or barriers to achieving epidemic control remain. Patients continue to start treatment too late and too sick; there are approximately 40,000 untreated HIV+ children with advanced disease, and an estimated 16% of HIV-infected adults have a CD4 count less than 200.¹² Linkage and retention must be improved; overall ART coverage is only about 62%, and approximately 1.3 million people are estimated to have discontinued ART.¹³ 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.

During February 2019, PEPFAR staff, officials from the NDoH and provincial DoHs and PEPFAR-supported Implementing Partners implemented an extraordinary effort at healthcare facilities with high HIV burdens. The “February Frenzy/Blitz” targeted HIV treatment at 220 high burden facilities, representing 27% of the PLHIV on ART in South Africa. PEPFAR and DoH officials made repeated site visits to target facilities and addressed staffing, management and data quality issues. As a result of this initiative, target facilities achieved a 36% increase in the number of new PLHIV started on treatment compared to the same period in the previous year.

Bolstered by the February success, in March 2019 the PEPFAR team and the NDoH expanded the intensive facility-based support to cover 343 facilities providing HIV treatment through a program known as “Siyenza!” (“We are doing it!” in Nguni). The Siyenza approach is based on repeated site visits by PEPFAR SA staff, accompanied by DoH or NDoH officials wherever possible, with the goal of ensuring full implementation of HIV treatment policies and fundamentals with a focus on improving retention. Siyenza works with facility staff and managers to ensure that PLHIV are linked to care, PLHIV who miss appointments are traced immediately and returned to care, and PLHIV who have dropped out of care are identified and welcomed back. The NDoH has established performance standards for health care workers including nurses, community health workers, lay counsellors, and data clerks, initially implemented through Siyenza, but to be scaled to additional facilities during COP19. Siyenza also focuses on strengthening data systems and data use. The intended objectives at a patient level include an improved experience through better health worker engagement and reduced waiting times – all with the goal of improving retention. At the facility level, the Siyenza goals are increased numbers of PLHIV on treatment and reduced

¹² Johnson et al., *op cit.*

¹³ Johnson et al., *op cit.*

loss to follow-up. In addition to a full schedule of site visits, PEPFAR SA staff have daily calls and meetings with NDoH officials, and have created customized reporting tools to monitor facility performance on a daily basis. Siyenza is nested within the overall NDoH response (Operation Phuthuma, or “Hurry”). Operation Phuthuma is a robust project management structure tasked with driving implementation of key interventions to rapidly accelerate towards the 90-90-90 targets thus improving HIV performance across the entire health system.

SA Gross National Income per capita was estimated at U.S. Dollar (USD) 5,430 in 2017.¹⁴ Total health expenditure was estimated to be about 8% of the Gross Domestic Product in 2016 (\$428 per capita), with health spending expected to reach SA Rand (ZAR) 223 billion (approximately USD15.6 billion¹⁵) in 2019/20.¹⁶ Domestic private expenditures (voluntary health insurance, out of pocket expenses) accounted for 44% of health expenditures in 2016.¹⁷ GoSA is committed to continuously increase budgetary support for the HIV response. The recent GoSA budget allocation for HIV indicates a continued increase from \$1.7 billion in 2018/19, to \$2.1 billion in 2020/21, accounting for over 70% of the country’s HIV expenditure.

HIV prevalence and incidence vary significantly across geographic areas; over half (52%) of PLHIV are concentrated in the Gauteng and KwaZulu-Natal provinces,¹⁸ which together have 45% of the total population. 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.

¹⁴ Gross National Income per capita, Atlas method (current USD). World Bank: World Development Indicators. Online: <http://data.worldbank.org/indicator/>

¹⁵ Using the current Exchange Rate (May 2019) of ZAR14.35:USD1.

¹⁶ Budget Review (2019). National Treasury, Republic of South Africa, February 20, 2019.

¹⁷ World Health Organization (2019). Global Health Expenditure Database. <http://apps.who.int/nha/database/ViewData/Indicators/en> Accessed May 5, 2019.

¹⁸ Johnson LF, Dorrington RE, Moolla H (2017). Progress towards the 2020 targets for HIV diagnosis and antiretroviral treatment in South Africa. *South African Journal of HIV Medicine*. 18(1):a694.

Table 2.1.1 Government of South Africa Results

Table 2.1.1 Host Country Government Results															
			<15				15-24				25+				
	Total		Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	Source, Year
Total Population	57,725,606	100%	8,508,575	14.7%	8,534,942	14.8%	4,901,409	8.5%	4,851,541	8.4%	16,135,520	28.0%	14,793,618	25.6%	Statistics South Africa (StatsSA), Mid-year population estimates, 2018 [1]
HIV Prevalence (%)		13.1%		1.7%		1.7%		10.8%		3.8%		24.7%		16.4%	Thembisa 4.1, 2019 [2]
AIDS Deaths (per year)	79,547		AIDS deaths in male & female children <15= 5,954				N/A		N/A		AIDS deaths in female adults ≥15= 33,669		AIDS deaths in male adults ≥15= 39,924		Thembisa 4.1, 2019 [2]
# PLHIV	7,633,309		138,820		139,615		511,247		180,302		4,177,635		2,485,690		Thembisa 4.1, 2019 [2]
Incidence Rate (Yr)		0.45%		0.06% (10-14)		<0.01% (10-14)		1.60%		0.44%		0.55%		0.49%	Thembisa 4.1, 2019 [2]
New Infections (Yr)	227,995		6,702 (1,615 ages 10-14)		5,141 (54 ages 10-14)		75,562		21,305		92,383		73,805		Thembisa 4.1, 2019 [2]
Annual births	1,200,436	100%													StatsSA, 2018 [1]
% of Pregnant Women with at least one ANC visit	N/A	94%	DHS has age disaggregations <20 (94.7%), 20-34(93.5%) and 35-49 (93.4%).												DHS, 2016 [3]
Pregnant women needing ARVs	250,350	21.7%													Thembisa 4.1, 2019 [2]
Orphans (maternal, paternal, double)	2,763,000 (530,000 maternal; 1,728,000 paternal; 505,000 double)		N/A		N/A		N/A		N/A		N/A		N/A		General Household Survey, 2017 [4]
Notified TB cases (Yr)	227,224		N/A		N/A		N/A		N/A		N/A		N/A		WHO, 2017 [5]
% of TB cases that are HIV infected	123,148	60%	NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	WHO, 2017 [5]
% of Males Circumcised	4,330,000 (medical; 15+)	61.65% (all)			1,064,835	13.4% (all)			1,773,689	70.2% (all)			6,948,082	59.9% (all)	SABSSM V, 2017 [6]

Table 2.1.1 Host Country Government Results (continued)															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Estimated Population Size of MSM	312,397	~2%												UCSF, 2018 [7]	
MSM HIV Prevalence	96,646	30%												UCSF, 2018 [7]	
Estimated Population Size of FSW	113,325	~0.5-1%												UCSF, 2018 [7]	
FSW HIV Prevalence	60,866	54%					N/A	N/A			N/A	N/A		UCSF, 2018 [7]	
Estimated Population Size of PWID	75,700	NA												SANAC, 2015 [8]	
PWID HIV Prevalence	NA	14%*												Scheibe [9]	
Estimated Size of Priority Populations: Military	75,051	100%												South African Department of Defense, 2018 [10]	
Estimated Size of Priority Populations: Black African Females 15-34 years	8,694,635	100%												StatsSA, 2018 [1]	
Estimated Size of Priority Populations: Black African Males 25-49 years	8,860,537	100%												StatsSA, 2018 [1]	

Table 2.1.1 References-

*Number calculated using prevalence rate of Scheibe et al applied to SANAC estimated population size of PWID.

[1] Statistics South Africa [StatsSA], Mid-year population estimates, 2018. Statistical Release P0302, Statistics South Africa: Pretoria

[2] Johnson LF, May MT, Dorrington RE, Cornell M, Boule A, Egger M and Davies MA. (2017) Estimating the impact of antiretroviral treatment on adult mortality trends in South Africa: a mathematical modelling study. PLoS Medicine. 14(12): e1002468. Thembisa 2019 estimates reflect mid-year 2019 for point estimates (like prevalence) and mid-year 2019 to mid-year 2020 for flow estimates (like number of new infections).

[3] National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC), and ICF. 2019. South Africa Demographic and Health Survey 2016. Pretoria, South Africa, and Rockville, Maryland, USA: NDoH, Stats SA, SAMRC, and ICF.

[4] Statistics South Africa [StatsSA], General Household Survey, 2017. Statistical Release P0318, Statistics South Africa: Pretoria. Analysis by Katherine Hall and Winnie Sambu, Children's Institute, UCT.

[5] World Health Organization (2017). *Tuberculosis Country Profiles (South Africa 2017)*. Accessed April 29, 2019 at https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=ZA&LAN=EN&outtype=html

[6] Simbayi LC, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, Mabaso M, Ramlagan S, North A, van Zyl J, Mhlabane N, Dietrich C, Naidoo I and the SABSSMV Team (2019) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. Cape Town: HSRC Press

[7] University of California, San Francisco. (2018). Consensus Cascades. [Dataset]

[8] SANAC Programmatic Mapping and Size Estimation Study of Key Populations in South Africa, 2015 Final Report, October 2015

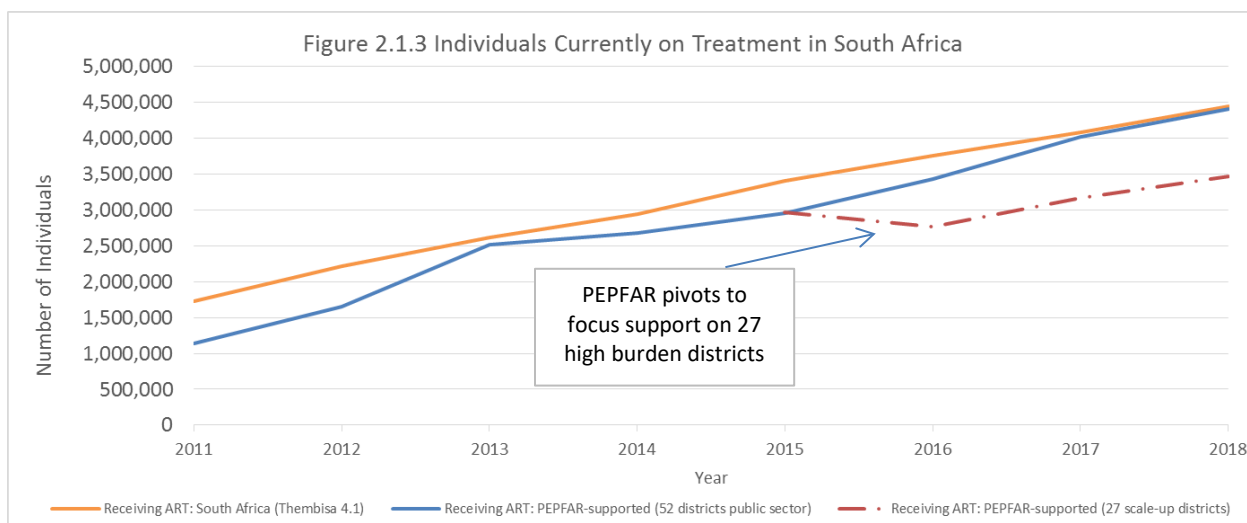
[9] Scheibe, A, Brown, B, dos Santos, M, Final Report: Rapid assessment of HIV prevalence and HIV-related risks among people who inject drugs in five South African cities, February 2015.

[10] South African Department of Defence Annual Report 2017/2018. Accessed April 29, 2019 at https://www.defenceweb.co.za/wp-content/uploads/joint/DoD_Annual_Report_2017-18.pdf (All DoD employees)

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate [1]	HIV Prevalence [2]	Estimated Total PLHIV [2]	PLHIV Diagnosed [2]	On ART [2]	ART Coverage [2]	Viral Suppression [3]	Tested for HIV [3]*	Diagnosed HIV Positive [3]*	Initiated on ART [3]
	(#)	(%)	(#)	(#)	(#)	(%)	(%)	(#)	(#)	(#)
Total population	57,725,606	13.1%	7,633,309	7,022,644	4,764,910	62%	92%	13,808,600	939,721	755,841
Population <15 years	17,043,517	1.7%	278,435	221,356	153,460	55%	78%	1,359,620	23,198	20,844
Men 15-24 years	4,851,541	3.8%	180,302	2,407,391	1,553,414	58%	78%	4,455,453	311,635	253,003
Men 25+ years	14,793,618	16.4%	2,485,690				91%			
Women 15-24 years	4,901,409	10.8%	511,247	4,393,482	3,058,037	65%	87%	7,954,925	588,801	480,344
Women 25+ years	16,135,520	24.7%	4,177,635				93%			
MSM [4]	312,397	30%	96,646	39,692	27,230	28%	26%	23,520	2,992	1,684
FSW [4]	113,325	54%	60,866	44,639	14,379	24%	11,033	14,310	993	682
PWID	75,700	14%	10,598	N/A	N/A	N/A	N/A	1,133	333	64
Priority Pop (People in prison)								154,241	14,191	9215
*Disaggregations do not sum to the totals due to unknown age in some HIV testing records										
[1] Statistics South Africa [StatsSA], Mid-year population estimates, 2018. Statistical Release P0302, Statistics South Africa: Pretoria										
[2] Johnson LF, May MT, Dorrington RE, Cornell M, Boule A, Egger M and Davies MA. (2017) Estimating the impact of antiretroviral treatment on adult mortality trends in South Africa: a mathematical modelling study. PLoS Medicine. 14(12): e1002468. Mid-year 2019 estimates.										
[3] PEPFAR reported data (APR 2018). PEPFAR partners have used TIER.Net for HIV testing and treatment reporting from FY17Q3 onward. Viral suppression results are patient-level viral suppression rates at the most recent test done within the past year, as reported in TIER.Net.										
[4] University of California, San Francisco. (2018). Consensus Cascades. [Dataset]										

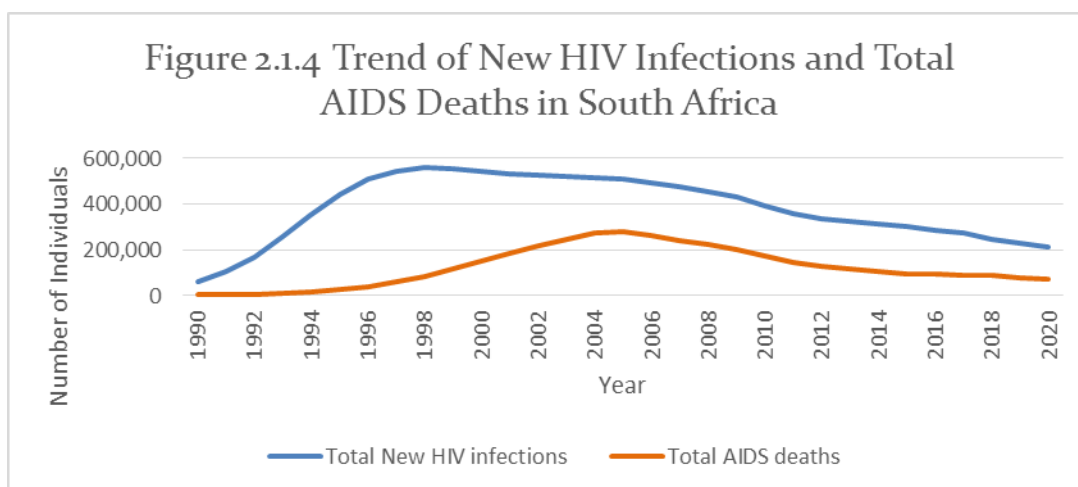
Figure 2.1.3 Individuals currently on Treatment in South Africa



Notes:

- 'South Africa' values (orange line) are derived from the Thembeisa model inputs, which estimate the number of individuals receiving ART in the public and private sector using program reporting inputs and estimated service provision via the private sector. Source: Johnson LF, May MT, Dorrington RE, Cornell M, Boule A, Egger M and Davies MA. (2017) Estimating the impact of antiretroviral treatment on adult mortality trends in South Africa: a mathematical modelling study. PLoS Medicine. 14(12): e1002468.
- 'PEPFAR-supported (52 districts public sector)' values (blue line) represent PEPFAR results from all 52 districts from the public sector for 2011-2018. 'PEPFAR-supported (27 scale-up districts)' values (red line) represent PEPFAR results from the 27 high burden scale-up districts where PEPFAR SA provides intensive support. PEPFAR SA provides systems support to the remaining 25 lower-burden districts through investments at the central level.
- Prior to 2017, the source for PEPFAR SA data on HIV testing and treatment was DHIS. PEPFAR SA partners started using TIER.Net for data on HIV testing and treatment in FY17Q3 (June 2017).
- Years are fiscal years for APR data (end of September) and mid-year estimates (end of June) for Thembeisa.

Figure 2.1.4 Trend of New HIV Infections and Total AIDS Deaths in South Africa

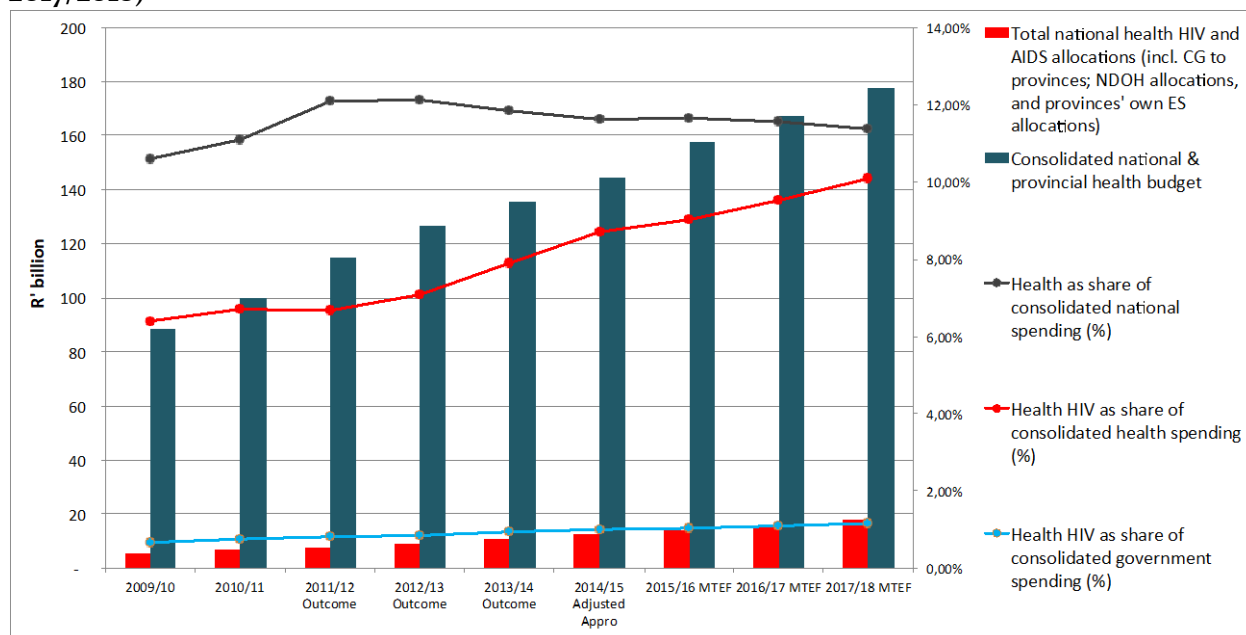


Source: Johnson LF, May MT, Dorrington RE, Cornell M, Boule A, Egger M, and Davies MA. (2017) Estimating the impact of antiretroviral treatment on adult mortality trends in South Africa: a mathematical modelling study. PLoS Medicine. 14(12): e1002468.

2.2 Investment profile

SA's national HIV response is funded primarily through public revenue, with additional funding from external development partners (donors) and the private sector. SA's financial commitment to HIV programs continues to grow. As illustrated in the figure below, funding for HIV has grown more than the health budget overall over the last nine years. From ZAR5.6 billion in 2009/2010,¹⁹ to over ZAR20 billion in 2017/2018, the GoSA has nearly tripled (280%) its domestic budget for HIV treatment.

Figure 2.2 Supplemental - Total National HIV/AIDS Allocations Increases at a Faster Rate Compared to Consolidated National and Provincial Health Budget (2009/2010 to 2017/2018)²⁰



In 2017/2018, the total budget on HIV and HIV/TB was ZAR 20.9 billion (USD 1.5 billion) and actual expenditure in that period was estimated at ZAR 21.3 billion (USD 1.5 billion). In the most recent version of the National AIDS Spending Assessments from 2016/17, the SA HIV response was funded primarily through the GoSA at ZAR19.6 billion (USD1.34 billion²¹) (Table 2.2.1). The 2016/2017 assessment is the most recent analysis of HIV/AIDS expenditure in South Africa broken down by program classifications. In this period, PEPFAR was the second largest source of funds and contributed ZAR6.62 billion (USD490.17 million²²). The Global Fund for AIDS, TB and Malaria (GFATM) was the next-largest funding source at ZAR776.9 million (USD54.29 million). The 2013 National AIDS Spending Assessment reported other external sources (bilaterals,

¹⁹ The GoSA fiscal year is April-March, and is referenced as two calendar years (e.g. FY2017/18 for the period April 2017-March 2018). The USG fiscal year is October to September, and is referenced in relation to the latter calendar year (e.g. FY2018 for the period October 2017-September 2018).

²⁰ Source: Health Economics and Epidemiology Research Office (HE2RO) analysis of Mid-Term Expenditure Framework and National AIDS Spending Assessment from 2009/2010 to 2017/2018.

²¹ Using the average Exchange Rate April 2016-March 2017 of ZAR14.58:USD1.

²² Using the PEPFAR FY2017 Expenditure Analysis Exchange Rate of ZAR13.5:USD1.

multilaterals, and foundations) accounting for about 3% of HIV response funding. Private companies and insurance contributed around 8%. According to the NSP 2017-2022, insurance costs for private ART patients are estimated to be ZAR1.6billion in 2017/18.

Within the GoSA response, the NDoH is the largest spender on HIV services, primarily via the HIV/TB Conditional Grant mechanism (ZAR20.5 billion in 2018/19), followed by the Department of Social Development (ZAR1.8 billion for 2018/19). An additional ZAR1.9 billion has been allocated in 2017/18 and 2018/19 to support implementation of the HIV and TB Investment Case and the NSP including the continued expansion of ART to PLHIV.²³

Due to SA's high HIV burden and the already large and growing number of patients on treatment, HIV costs are expected to increase over the next decade, primarily driven by costs of ARVs and ART service delivery. Introduction of TLD is expected to partially offset these increases. South Africa requires a steadily increasing investment in HIV programs to reach 90-90-90. The GoSA budget projects leveled funding for many services, and future rising HIV and TB treatment costs are projected to consume an increasing share of the health budget.

²³ Using the March 2018 Exchange Rate of ZAR12.0:USD1.

Table 2.2.1 Annual Investment Profile by Program Area

Table 2.2.1 Annual Investment Profile by Program Area				
Program Area	Total Expenditure (USD)	% GoSA (FY 2016/17)	% PEPFAR SA (FY 2017)	% GFATM (FY 2016/17)
Clinical care, treatment and support	978,045,721	84%	14%	2%
Community-based care, treatment and support	198,808,165	81%	17%	2%
Prevention of Mother-to-Child Transmission ^a	41,950,347	45%	55%	0%
HIV Testing Services	126,663,865	45%	55%	0%
VMMC	96,244,313	22%	78%	0%
Priority population prevention	82,030,609	48%	45%	7%
Key population prevention ^b	31,860,980	52%	23%	25%
OVC ^c	124,588,488	63%	37%	0%
Laboratory ^d	16,083,574	0%	100%	0%
SI, surveys and surveillance ^d	36,268,046	0%	89%	11%
Health Systems Strengthening (HSS) ^d	11,638,397	0%	81%	19%
Other HIV spending (not in COP table) ^d	143,889,770	93%	0%	7%
Total (USD)	1,888,072,275	71%	26%	3%
<p>General Notes:</p> <ul style="list-style-type: none"> GoSA figures are based on Basic Accounting System (BAS) actual expenditures for FY2016/17 (exchange rate: ZAR14.58:USD1). GFATM figures are actual expenditures from FY2016/17 (exchange rate: ZAR14.58:USD1). PEPFAR SA figures are based on FY2017 expenditures (exchange rate: ZAR13.5:USD1). The table provides a broad profile of expenditures and budgets for HIV spending in SA, and is not comprehensive of all HIV expenditures in SA. BAS data do not provide specific information on spending and budget allocation for several of the program areas or component areas listed, including laboratory, OVC, Communications, Monitoring and Evaluation, Other Prevention, Policy and Systems Development. This lack of information does not reflect a lack of GoSA expenditure in these program areas. <p>^a The 45% attributed to GoSA is an underestimate as it does not include ARVs, HTS or full estimates of staff time.</p> <p>^b The GoSA investment in key population prevention includes costs for interventions in high-transmission areas.</p> <p>^c The GoSA does not track OVC investments in the BAS. OVC investments in this table include HIV/AIDS investments by the Department of Social Development, and the life skills education grant from the Department of Basic Education. This lack of information does not reflect a lack of GoSA expenditure on OVC activities.</p> <p>^d GoSA Laboratory, HSS and SI expenditures are not coded in the BAS. All GoSA Laboratory, HSS and SI expenditures that do not relate to the PEPFAR SA Investment Profile program areas are included in "Other HIV Spending". PEPFAR SA Laboratory expenditures are related to systems strengthening. The majority of PEPFAR SA's SI and HSS expenditures are integrated across other program areas; the expenditures reflected here include only those that are not assigned to another program area.</p>				

Table 2.2.2 Annual Procurement Profile for Key Commodities

Table 2.2.2 Annual Procurement Profile for Key Commodities				
Commodity Category	Total Expenditure (USD)	% GoSA (FY 2017/18) ^a	% PEPFAR (FY 2018)	% GFATM (FY 2017/18) ^a
ARVs	517,908,317	97.9%	0.0%	2.1%
Rapid test kits	9,919,495	93.2%	6.8%	0.0%
Lab reagents	218,452,215	99.8%	0.2%	0.0%
Condoms	9,087,915	100.0%	0.0%	0.0%
VMMC Kits	7,085,488	36.5%	63.5%	0.0%
Total	762,453,429	97.9%	0.7%	1.4%

^a Exchange rate: ZAR14.5:USD1

Sources: GoSA- BAS, PEPFAR: FY2018 Expenditure Analysis "Health: Non-Pharmaceuticals" supplies

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
(USG) Funding Source	Total USG Non-PEPFAR Resources (USD)	Non-PEPFAR Resources Co-Funding PEPFAR IMs ^b (USD)	# Co-Funded IMs ^b	PEPFAR COP Co-Funding Contribution (USD)	Objectives
USAID Maternal and Child Health	N/A	N/A	N/A	N/A	N/A
USAID TB	13,479,000	N/A	N/A	N/A	TB technical assistance to <u>GoSA</u>
USAID Malaria	N/A	N/A	N/A	N/A	N/A
Family Planning	N/A	N/A	N/A	N/A	N/A
National Institutes of Health	104,000,000 ^a	N/A	N/A	N/A	To advance health objectives
Centers for Disease Control and Prevention (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
Department of Defense Ebola	N/A	N/A	N/A	N/A	N/A
Millennium Challenge Corporation	N/A	N/A	N/A	N/A	N/A
Total	119,779,000	0	0	0	

^a Of which 60-70% are HIV/TB-focused.

^b IM: Implementing Mechanism

Table 2.2.4 Annual PEPFAR Non-COP Resources

Table 2.2.4 Annual PEPFAR Non-COP Resources						
Funding Source	Total PEPFAR Non-COP Resources (USD)	Total Non-PEPFAR Resources (USD)	Total Non-COP Co-funding PEPFAR IMs ^a	# Co-Funded IMs ^a	PEPFAR COP Co-Funding Contribution (USD)	Objectives
Key Populations Innovation Fund	8,000,000	N/A	N/A	18480, 18482, 18484, 81892, 70306, 82199	11,700,700	Expand access to and retention in HIV prevention, treatment, and care services by members of key populations
HIV Treatment Surge	250,000,000	N/A	10	16772,14295, 18481, 18482,18483, 18484, 17537,70310,7028 7,70288,70289,7 0290,70301 ^a	245,012,002	Expand HIV treatment to retain an additional 2 million people on HIV treatment
Central Acceleration 19	17,000000	N/A	2	81887, 83001		Engage international technical expertise to further spur innovation in accelerating HIV treatment coverage

Other Public-Private Partnership	1,450,000	N/A	2	18482, 80065	800,000	VMMC demand creation via airtime voucher messaging Blue Label Partnership; HCT in private-sector pharmacies; improving management and leadership for the HIV response: <u>Ikapa Cares</u> .
Total	259,450,000	N/A	N/A	N/A	257,512,702	

^a Primary district support partners (DSPs) listed |

2.3 National sustainability profile update

The second round of PEPFAR SA's National Sustainability Profile was completed in November 2017 using the Sustainability Index and Dashboard (SID) 3.0. The process was led by the South African National AIDS Council (SANAC), GoSA, UNAIDS and PEPFAR SA, and included 45 multisectoral partners from government and non-governmental organizations (NGOs), the private sector, civil society, health bilateral and multilateral partners, and international NGOs working in South Africa's HIV program. The group completed the review of the index's 15 critical sustainability elements. The SID 2017 summary was approved through the bilateral Partnership Framework Implementation Plan (PFIP) Management Committee, and the results were presented in various stakeholders' meetings including through the PFIP, Health Partners Forum, SANAC Civil Society Forum, and UN Joint Team.

The SA SID 3.0 demonstrated a high level of sustainability (score of 8.5/10) in eight of the 15 critical elements,²⁴ and a score of 8 or higher in an additional three elements.²⁵ Four elements were identified with vulnerabilities to sustainability: service delivery; human resources for health (HRH); commodity security and supply chain; and epidemiological and health data.

Since completing the SID in 2017, there has been progress made that reduces the vulnerabilities within these four elements. For example, in the area of service delivery, ongoing investments in differentiated care and in integrated service delivery continue to increase efficiencies within the public health system. In terms of human resources for health, the substantial improvements made to leverage the strategic value of the Ward Based Primary Health Care Outreach Team program (Community Health Workers), including setting performance targets, is expected to lead to important gains in ART patient linkage and retention, all improving sustainability of the national HIV program by optimizing the value of these important community resources. In the area of commodity security and supply chain, the efforts to prepare for the transition to TLD will lead to reduced costs for this regimen, improving overall program sustainability. Finally, substantial progress in health data systems is underway, with the multi-partner investments in provincial Information Hubs that will significantly improve the quality, availability and use of data to inform effective program investments.

As noted in Section 2.2 (Investment Profile), the GoSA funds the vast majority of the HIV response in the country, with PEPFAR the next largest contributor, followed by GFATM with about 3% of the overall investment in the response. In COP19, PEPFAR SA will continue to invest in the four program elements with the weakest sustainability scores, consistent with the NDoH/PEPFAR HIV Treatment Surge Plan. The GoSA is also aware of the sustainability implications of significant PEPFAR investments in human resources through the HIV Treatment Surge.

²⁴ (1) Planning and coordination; (2) policies and governance; (3) private sector engagement; (4) civil society engagement; (5) laboratory; (6) domestic resource mobilization; (7) technical and allocative efficiencies; and (8) performance data.

²⁵ (1) Public access to information; (2) quality management; and (3) financial/expenditure data.

The GFATM has made specific commitments in each of the priority areas in the new funding covering the period April 2019-March 2022. In terms of Service Delivery, the GFATM grants prioritize programming for vulnerable populations, in particular layered, comprehensive prevention programs for AGYW and key populations. In the area of HRH, GFATM funding will support community health workers and investments to increase capacity of community-based organizations to contribute sustainably to prevention and treatment objectives. The GFATM has also made commitments to TPT and ARV buffer stocks. Other donors contribute to specific geographic or program areas, including the Bill and Melinda Gates Foundation that has invested in important formative research that informs PEPFAR investments as well as HIV-related information systems.

PEPFAR SA continues to work closely through the bilateral work streams to ensure that the COP19 investments both leverage and complement the investments of the GoSA and other donors. In particular, the USG has worked closely with the GFATM Country Coordination Mechanism (CCM) and the GFATM Fund Portfolio Manager to align the GFATM SA grants to maximize impact and to coordinate geographies to eliminate programmatic overlap. The ongoing USG participation on the CCM and GFATM Oversight Committee has resulted in increased efficiencies and proactive reprogramming to support additional effective interventions.

PEPFAR SA will continue to support activities and areas of investment that have impact on epidemic control in South Africa. Sustainability of investments and their impact is a significant consideration for all program investments made, including collaboration with the Department of Treasury. We also note that 83% of total PEPFAR SA COP19 investments are expected to be awarded to local South African organizations that will continue to contribute to the response for years to come.

2.4 Alignment of PEPFAR investments geographically to disease burden

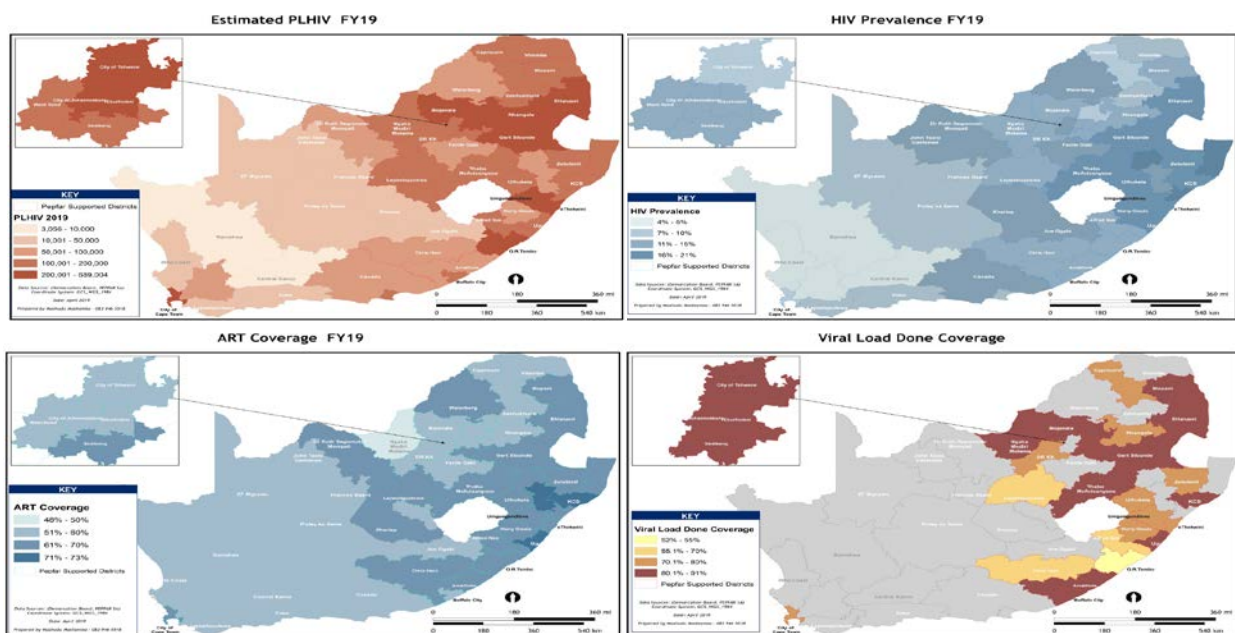
In COP19 PEPFAR SA continues to prioritize the 27 districts that account for 79% of the national HIV burden, which are the same 27 focus-for-impact districts in the NSP. To further focus the PEPFAR SA investment, COP19 resources are concentrated in the four largest metropolitan districts (Johannesburg, eThekweni, Ekurhuleni, Tshwane), which account for 29% of the national HIV burden. In COP18, the alignment analysis revealed the need to make additional investments in the 1,437 highest burden facilities that serve 90% of the PLHIV on treatment in the 27 priority districts. In COP19, PEPFAR SA will continue to provide targeted support to these facilities, but will further focus investments on the highest burden sites where PEPFAR SA investments will have the biggest impact on epidemic control (see Siyenza sites, Section 4.5).

PEPFAR SA will provide targeted support to facilities, with support linked to facility HIV burden and performance. In COP19 PEPFAR SA plans to continue intense facility support to high-volume facilities. Once facilities achieve performance standards in linkage and retention, PEPFAR SA will increase direct service delivery support to expand ART coverage. PEPFAR SA projects that approximately 457 facilities, representing 50% of the HIV burden in the 27 priority districts, will receive this full support, and these facilities are expected to demonstrate

accelerated growth in the number of PLHIV initiated on treatment and retained on ART. PEPFAR SA also plans to continue to support an additional 1,043 facilities representing 40% of the HIV burden in the 27 priority districts with interventions based on lessons learned from the COP18 Siyenza initiative. PEPFAR SA plans to provide technical assistance to an additional approximately 1,967 facilities in priority districts.

Investments in facilities will support supplemental human resources to implement a case management approach, defaulter tracing, optimized linkage and same-day ART initiation. These sites will also be prioritized for support to differentiated care options, including additional external ART pick-up points and ART lockers. PEPFAR SA, DoH, and Implementing Partners are monitoring performance at these facilities on a daily basis to ensure rapid course correction and optimized resource allocation (i.e., information technology, infrastructure, and equipment) to address identified barriers to performance.

Figure 2.4.1 PLHIV, HIV Prevalence, ART coverage, and Viral Suppression, by District



2.5 Stakeholder engagement

The process of developing COP19 has been open and consultative, and the proposed plan reflects the strong engagement with and input from a range of stakeholders. PEPFAR SA works with GoSA, and in particular NDoH, throughout the year to plan, monitor and improve programs and investments. In addition, input from the GFATM and other donors, civil society and the private sector supported prioritization of investments included in COP19.

Additionally, PEPFAR’s intense engagement with NDoH on the implementation of February 2019 Frenzy/Blitz activities in 220 facilities, and since March 2019 Siyenza activities in 343 facilities, has led to increased routine collaboration and input on COP19 priorities.

The GoSA continues to provide leadership in planning and implementing the PEPFAR program in South Africa, and is using Operation Phuthuma to guide this. The bilateral partnership is led by the PFIP Steering Committee, co-chaired by the Minister of Health and the U.S. Ambassador to SA, along with the deputy ministers from important GoSA

departments. The Steering Committee provides guidance to the PFIP Management Committee, co-chaired by a senior manager from the Department of Planning, Monitoring and Evaluation and the interagency PEPFAR Coordinator, and with representation of senior officials from all key GoSA departments. The Management Committee in turn guides the joint technical work streams, which oversee the implementation of the PEPFAR SA program throughout the year.

As part of the COP19 development process, PEPFAR SA organized targeted consultations and leveraged coordination meetings to engage with multilateral and bilateral donors and key international NGOs and foundations. These included meetings of the SANAC Civil Society Co-Chairs; SA Health Partners Forum; Bill and Melinda Gates Foundation; Clinton Health Access Initiative; the World Health Organization; Global Fund Portfolio Manager; United Nations International Children's Emergency Fund (UNICEF) and UNAIDS.

The PLHIV Sector has been actively engaged throughout the COP19 planning process, including consolidating strategic insights into “The People’s COP19”, presented at the COP19 Planning Meeting in Sandton on March 9, 2019. On February 3-5, 2019, PEPFAR SA worked with the PEPFAR Civil Society Community Advisory Group to convene COP19 consultations with the PLHIV sector at provincial level, Provincial Civil Society Co-Chairs and other sectors. On March 13-14, 2019 GoSA, Provincial HIV/AIDS, STI and TB Managers, and Implementing Partners provided strategic inputs. At each consultation PEPFAR SA presented on the COP19 planning process, on program results and COP19 priorities, and civil society representatives provided input on key program areas.

The COP19 plan incorporates recommendations from The People’s COP, such as: (1) funding service delivery staff at facilities and community health workers; (2) support for adherence clubs; (3) energizing the Welcome Back Campaign; (4) expanding demand creation communication and treatment literacy, particularly in connection with the roll-out of TLD; (5) partnering with civil society organizations for facility accountability; (6) expanding TB screening; (7) expanding TPT; and (8) supporting youth-friendly services.

Private Sector stakeholders also provided valuable insights in the COP19 planning process and during the current implementation year through multiple engagements with both U.S. private sector companies and South African domestic companies, including via participation in the South Africa HIV Innovations Accelerator co-creation process. These partners included Discovery Health, Vodacom, Johnson and Johnson, MassMart, SASOL, Blue Label Media, Anglo American and SA Breweries, among others.

Finally, there was robust participation of external partners in strategic discussions at the COP19 Planning Meeting. Representatives from GoSA were joined by South African PLHIV and key population sectors, as well as other representatives from advocacy, international NGOs and multilateral organizations. Inputs from these stakeholders resulted in a stronger investment plan for COP19.

Building on this annual planning process, PEPFAR SA will work with the GoSA and continue to engage with external partners, including the PLHIV sector at national, provincial, and district levels, to support optimized implementation of COP19. COP19 implementation will

include ongoing consultations, and sharing of quarterly results at the national and provincial levels. COP19 implementation will also leverage current efforts to deepen engagement with FBOs and the private sector, through the Treatment Surge.

3.0 Geographic and Population Prioritization

PEPFAR SA first pivoted to focus on the 27 (of 52) districts with the highest burden of HIV in COP15. These districts contain an estimated 79% of PLHIV. During COP18, an increased emphasis was placed on the four metropolitan districts with the highest unmet need (Johannesburg, eThekweni, Ekurhuleni and Tshwane). Recent data from the South African National HIV Prevalence, Incidence, Behavior, and Communication Survey, 2017 has been used to update national and provincial estimates of numbers of PLHIV.

Given the requirement to set targets by 5-year age/sex disaggregations within each district this year, PEPFAR SA completed additional modeling to estimate PLHIV and ART coverage within all of these sub-populations. These revised PLHIV estimates were agreed on with both NDoH and OGAC. PEPFAR SA's program will be focused on closing treatment gaps in each of these populations and thus targets were set to reflect aggressive increases in the number of patients on treatment in the sub-populations/districts with the highest unmet need. The resulting targets project for a range of growth trajectories, starting at a 5% annual increase in persons on treatment in populations already at 90% coverage and increasing up to 100% for populations with less than 20% coverage. The four metropolitan districts were given targets that were generally 3-5% more aggressive than the other districts consistent with PEPFAR SA's increased focus, and additional support, in these districts. Funding available to districts through the HIV/TB Conditional Grant has also been considered when setting district level targets, and funding aligned to ensure that districts are able to meet the targets set.

If these population-specific targets are met, the country will reach 6.7 million persons receiving treatment nationally by end of FY 2020 (including 600,000 persons in the private sector, 6.1 million in the public sector, and 4.8 million persons on treatment within the 27 PEPFAR priority districts). As the end of FY 2020 benchmark nears, PEPFAR SA will re-evaluate the total national burden of HIV and distribution of unmet need to ensure that all high burden districts have achieved saturation.

Consistent with COP18, much of the population focus will be placed on closing the treatment gap for men 25+ years, adolescents 15-24 years, and children <15 years. The core care and treatment interventions described below (Section 4.1) have been specifically designed to improve identification of HIV-positive men, adolescents and children, and to link and retain them in treatment. To expand coverage among men, PEPFAR SA will continue to apply lessons learned and strengthen linkages with the successful national VMMC program. By the end of COP18, the NDoH will take over all VMMC service provision in uMkhanyakude, and PEPFAR SA support will focus in the 27 priority districts in COP19, with a specific focus on accelerating VMMC targets in the 4 highest burden districts. In the latter part of COP18, the national VMMC program will review and assess saturation levels across all 27 priority districts

in order to identify the districts that have reached saturation among men 15-34 years old, and make informed programmatic decisions based on the assessment.

Among women, PEPFAR SA will continue to build upon the NDoH’s successful Prevention of Mother to Child Transmission (PMTCT) program, which has reached saturation levels across all districts and reduced perinatal transmission to below 1.5%. Strengthening quality of services and retention interventions through NDoH and PEPFAR SA’s enhanced granular site management approach (see Section 4.5) will further support the return to care and retention/adherence gains needed to improve coverage across adult populations as well. To close the treatment gap among children, PEPFAR-funded direct service delivery staff will roll out a pediatric case management strategy that will improve bilateral referrals between facilities and PEPFAR SA OVC programs, increasing the percent of CLHIV receiving these crucial wrap-around services and improving overall retention through late childhood and adolescence.

Among priority populations for prevention, the COP19 portfolios are concentrated in the four largest metropolitan districts. Priority populations for prevention were identified based on HIV risk profile, with highest priority focused on AGYW, men, and OVC. Key populations are characterized by high HIV prevalence with social marginalization and stigmatization contributing to high infections; key populations include female sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prisons. Focus districts for key populations are selected based on hot-spot mapping and needs assessments. By reaching saturation of treatment and prevention interventions among key and priority populations in the highest burden districts, South Africa will disrupt HIV transmission and reduce HIV incidence.

Table 3.1 Current Status of ART Saturation

Table 3.1 Current Status of ART saturation				
Prioritization Area	Total PLHIV/ % of all PLHIV for COP19 [1]	# Current on ART (Feb FY2019) [2]	# of Districts FY2019 (2018 COP)	# of Districts COP19 (FY2020)
Attained	-	-	-	-
Scale-up Saturation	2,229,630 (29.3%)	1,292,804	4	4
Scale-up Aggressive	3,759,016 (49.4%)	2,300,325	23	23
Sustained	-	-	-	-
Central Support	1,615,136 (21.2%)	976,488	25	25
[1] Eaton, J & Johnson, L. Personal communication – District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)				
[2] NDoH Program data (DHIS), February 2019.				

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations²⁶

All PEPFAR SA investments support GoSA-led interventions and are fully integrated into GoSA initiatives, which has Operation Phuthuma, as its cutting edge. In COP19 PEPFAR SA will invest in a range of targeted interventions to address identified barriers to epidemic control in the country, described in the sections that follow.

4.1 Case finding, linkage to ART, retention and viral suppression

Based on the Fifth South Africa National HIV Prevalence, Incidence, Behavior and Communications Survey,²⁷ ART coverage is around 62.3% and it only exceeds 75% in women and men aged 50 years or older. Among women living with HIV, 89% know their status but only 64% are on ART; among men living with HIV, 78% know their status and only 53% are on ART.²⁸

Case Finding

In COP19, PEPFAR SA will continue to support case finding through targeted geographic interventions for specific populations using a focused and strategic mix of modalities. Facility-based testing will continue to be the main case-finding strategy through full implementation of enhanced Provider-Initiated Counseling and Testing (PICT) at the acute, chronic and maternal-and-child-health patient care streams. Screening tools will be used to identify those likely at risk of undiagnosed HIV infection. Routine analysis of patient headcount vs. PICT will be used to identify gaps in testing service provision as well as help determine when facility testing opportunities have been saturated. PEPFAR SA will additionally support assisted HIV self-screening efforts for patient populations: (1) patients in the queues waiting to consult clinicians, with special focus on men, and (2) partners of pregnant and breastfeeding women.

Facility index testing will be fully implemented, targeting all PLHIV that access health facilities. Contacts of index cases with acute infection or who have a high viral load will be prioritized for tracing. Other priority populations will be pregnant and breastfeeding women as well as adolescent girls attending for contraceptives, and patients with STIs. For index clients, screening for and monitoring incidence of intimate partner violence is a high priority. To ensure fidelity in the scale-up of index testing, including alignment with WHO Five C's of HTS (consent, confidentiality, counselling, correct results and connection), the DoH supports ongoing trainings and refresher trainings for its staff on the correct implementation and monitoring of index testing. Similarly, PEPFAR-funded District Support Partners implement quarterly training for their staff. Index testing implementation reporting is part of the weekly nerve center meetings where clinical cascade performance is discussed at the sub-district level.

²⁶ This section summarizes the strategies and activities planned for COP19 to address identified gaps and provide effective services to prioritized populations and geographies. Additional detail was presented as part of the In-Person Planning Meeting in March 2019 (Johannesburg), the Outbrief for which is available at <https://za.usembassy.gov/our-relationship/pepfar/fact-sheets/>.

²⁷ <https://www.hsrbpress.ac.za/books/south-african-national-hiv-prevalence-incidence-behaviour-and-communication-survey-2017>

²⁸ Ibid.

Community testing in COP19 will primarily be focused on index testing and enhanced case-finding among men, which is expected to result in increased yield and more efficient testing in COP19. In COP16, index testing was introduced, and the yield was 27% by the end of COP17. In COP19, PEPFAR SA will scale up community self-screening focusing on patients not engaging in more traditional testing modalities and in coordination with the scale-up of index testing. Based on the results of recency testing, community hot-spots will be identified and targeted for enhanced testing.

PEPFAR SA will continue to engage religious and traditional leaders to empower them to create demand for HIV services among men and adolescents in the 14 highest burden districts. In COP19 these leaders will continue to influence social norms around gender-based violence and around HIV stigma and discrimination, which remain barriers to service access and retention. The FBOs will continue to provide targeted community HIV testing services as well as household testing for contacts of index cases in the 14 districts.

Linkage to ART

Strategies to improve linkage in COP19 include same-day ART initiation, community ART, and further scale-up of linkage officer/case manager support staff. Over the course of COP18, partners both through direct placement of staff and mentorship of NDoH staff have supported significant improvements in the implementation of same-day ART initiation across priority sites. Many districts are now meeting the 95% linkage proxy threshold and all districts will be expected to meet this target in COP19. Additionally funding has increased for the management of advanced clinical cases to improve clinical care and linkage to the appropriate treatment option.

Retention and Viral Suppression

Retention on ART is a significant challenge for the national HIV program. Historically the program has focused on finding patients who dropped out of care and relinking them to ART. During the second half of COP18 and during COP19, PEPFAR SA will focus on preventing disengagement from care by better understanding the individual characteristics and reasons for loss to follow-up, improving health and treatment literacy, eliminating drug stock-outs and providing enhanced-support SMS reminders. NDoH and PEPFAR SA are committed to reducing treatment disengagement from care by improving patient experience during clinic visits through a range of interventions, including:

- reducing queues
- improving filing systems
- decanting stable patients
- increasing access to facility and community Adherence Clubs
- scaling up access to mental health services
- expanding hours of operation
- providing population-specific services like Men's Corner or youth-friendly services after school hours
- providing "case managers"/"buddies" to patients initiating therapy

- working with NHLS and NDoH to use the eLAB system to send VL appointment reminders to patients, and rapid call-back for those with unsuppressed VL

In COP19, PEPFAR SA and Implementing Partners will identify the populations in each district most affected by adherence challenges and will increase support for them via community-based adherence clubs. Relevant community PLHIV organizations will be linked with community adherence clubs to support this work.

PEPFAR SA will continue to engage religious and traditional leaders in order to empower them to conduct demand creation for HIV services among men and adolescents in the 14 high burden districts. The leaders will continue to influence social norms around gender-based violence and HIV stigma and discrimination for PLHIV, which continue to play a role in PLHIV accessing, being linked and retained in care and treatment programs. Faith based organizations (FBOs) will continue to provide targeted community HIV testing services as well as follow-up index cases for household testing in the 14 districts. The FBOs will support the high volume facilities in case management, tracing and tracking, linkage to care and treatment as well as provide support in adherence among PLHIV. In addition, the FBO sites will serve as pick up points to further assist with decanting of stable PLHIV on ART in high volume facilities. All these interventions will be monitored to measure the contribution of FBOs to epidemic control.

Although VL suppression rates are high among those currently on ARVs, the roll-out of TLD during COP18 and COP19 is expected to have a significant impact on community-level VL suppression rates. PEPFAR SA will continue to support the NDoH to roll out and monitor the transition to TLD in South Africa, including through pharmacovigilance.

Population-Specific Interventions

In addition to these broad national and site-level strategies, PEPFAR SA continues to focus effort on ensuring that population-specific gaps are addressed through population-specific strategic interventions. To address the case finding and retention gap among men, PEPFAR SA will support the GoSA through a diverse but complementary set of interventions including facility and community index testing, workplace testing, targeted community-based case finding (in identified hot spots), social network strategy, and increased self-screening. Linkage to treatment will be enhanced through further scale-up of community ART initiation and private sector implementation such as General Practitioner contracting as well as nurse-and pharmacist-led ART initiations where possible. Specific focus on expanding options for differentiated service delivery such as external pick-up points, adherence clubs, fast lanes, 24-hour ART lockers, and extended service hours will further support increased retention among men.

Similarly, to close the treatment gap for youth in general and AGYW in particular, PEPFAR SA will work with facility, community, faith-based and traditional structures. PEPFAR SA will support the GoSA to expand adolescent and youth friendly services in facilities and communities, after-school hours, school health services, self-screening, youth connectors, youth care clubs, and mHealth (including social media). PEPFAR SA will work with the Department of Basic Education (DBE) and provincial and local authorities to accelerate roll-

out of the comprehensive sexuality education (CSE) program, and the provision of school-based health services including HTS, in line with the National Adolescent and Youth Health Policy.

Similar to adults, case finding and clinical management remain the principal gaps in the clinical cascade for children. PEPFAR SA will utilize index testing, school health services, PICT, nutrition and growth monitoring, and additional mentoring and support for pediatric case management (i.e., phlebotomy, dosing, viral load monitoring). PEPFAR SA will support the NDoH to reach HIV-positive mothers with differentiated models of care that particularly respond to the needs of the mother-infant pair. In COP19 PEPFAR SA will fully support the National Health Screening, Testing and Treatment Campaign, which should result in a significant increase in new HIV treatment initiation. New in COP19, dedicated pediatric linkage officers will be placed in sites with high volumes of pediatric clients to ensure linkage to OVC programs and to ensure treatment of CLHIV identified within OVC programs. Most of these sites are Siyenza sites, and additional human resources for health will contribute to improved linkage and retention performance.

In line with the success of the February Frenzy/Blitz and subsequent Siyenza campaigns, PEPFAR SA will continue to strengthen its intensive partner management and support in COP19. Using developed Standard Operating Procedures (SOPs) and tools, many PEPFAR SA staff will spend a predominant part of their time providing direct support to facility personnel, sub-district and district HIV leadership, and more direct oversight to District Support Partners. PEPFAR SA will substantially increase its facility- and community-level human resource investments to enable increased HIV testing, same-day initiation, extended service hours, patient navigation, active linkage, “case management” of newly initiated patients, adherence and retention tracking and tracing, and differentiated care.

TB/HIV

In COP19, PEPFAR SA will support the GoSA to scale up TB prevention and treatment among PLHIV. Priorities include expanded implementation of universal TB screening at all PEPFAR-supported facilities, increased HIV testing among individuals with presumptive TB, ensuring rapid ART initiation for TB/HIV co-infected individuals, scaling up TB preventive therapy [INH] to include those currently on treatment who have not previously received TPT in addition to those newly initiating treatment, and support NDoH efforts to make urine mycobacterial lipoarabinomannan (LAM) available to patients hospitalized with advanced HIV disease. PEPFAR SA COP19 investments will also improve infection prevention and control practices, strengthen service delivery integration and ensure robust TB/HIV data reporting (e.g., EDRWeb).

In all these efforts, PEPFAR SA is committed to continue support for public health facilities, and to expand efforts in communities to improve case identification, linkage to ART, reduction in loss to follow-up, ART adherence, and other treatment support. PEPFAR SA’s important investment in supplemental staff at public health facilities, and in community human resources, provides direct support to these efforts.

4.2 Prevention, specifically detailing programs for priority programming

To maximize prevention impact in COP19, the PEPFAR SA prevention program will continue to ensure that HIV prevention resources are focused on priority populations and in geographic areas at elevated risk. In COP19 priority combination evidence-based prevention investments continue to be promoted for AGYW, OVC, key populations and men (15-34 years), and will include increased use of peer-led prevention approaches to reach priority populations.

For COP 19, PEPFAR SA will invest prevention resources in 11 districts prioritized on updated PLHIV estimates (City of Johannesburg, Tshwane, Ekurhuleni, eThekweni, King Cetshwayo, uMgungundlovu, Ehlanzeni, Gert Sibande, Nkangala, Bojanala and City of Cape Town). This will mean transitioning HIV prevention programs out of five districts at the end of COP18 implementation (uGu, Thabo Mofutsanyane, Ngaka Modiri Molema, Dr. Kenneth Kaunda, and Harry Gwala). These districts will be transitioned at the end of FY 18 per the recommendation of OGAC to focus DREAMS priority districts paired with HIV burden. PEPFAR SA will work closely with the DoH to ensure a smooth transition and handover of services.

DREAMS, Adolescents and Young People

Adolescent girls and young women will be targeted with evidence-based, age-specific, multi-session, and layered prevention interventions using both comprehensive community platforms and CSE interventions. In the four DREAMS districts (City of Johannesburg, Ekurhuleni, uMgungundlovu and eThekweni), PEPFAR SA will continue to scale up all DREAMS interventions and consolidate the expansion of DREAMS interventions in Ekurhuleni into three more sub-districts. In City of Johannesburg DREAMS interventions will be expanded into Regions B, C and F. The inclusion of Regions B, C and F is based on large-scale migration patterns across the regions within the City of Johannesburg; AGYW migrate between the regions for schooling, work, socializing, and convenient health and social services. The regions of the City of Johannesburg also include major transport networks, including the expansive taxi ranks that bring in migrant and mobile populations from neighboring countries, and from coastal regions and rural villages within South Africa.

In City of Johannesburg, DREAMS will expand the implementation of behavioral prevention interventions to AGYW in schools through a program in partnership with the Department of Basic Education. DREAMS expansion within the four districts will ensure acceleration towards 100% saturation and coverage of DREAMS interventions and ensure epidemic control within these hyperepidemic districts. Interventions will be focused on health promotion, correct and consistent use of condoms, and encouraging sexual risk reduction.

To ensure that DREAMS focuses on AGYW at greatest risk, the PEPFAR SA program will develop and refine standard criteria and standard operating procedures for the systematic identification, enrollment, and delivery of services to the most vulnerable AGYW across Implementing Partners and districts. Furthermore, DREAMS will continue to track and strengthen the layering of prevention interventions (particularly between Implementing Partners at community and facility levels) through the cohort tracking system (operational as of April 2019) to ensure that the most vulnerable AGYW receive a package of prevention interventions tailored to their specific needs.

The new DBE policy on HIV, STIs and TB²⁹ creates substantial opportunities to scale up effective CSE interventions, including HIV and violence prevention interventions in schools in the highest burden districts (in both DREAMS and non-DREAMS districts). As a result, PEPFAR SA scaled up its prevention efforts targeting school-aged young people in COP18, and re-directed resources to support CSE scale-up. In collaboration with the DBE and NDoH, schools implementing CSE interventions have been linked to local health facilities offering adolescent and youth friendly services, working through the PEPFAR SA Implementing Partners. These interventions are designed to increase the provision of biomedical sexual and reproductive health (SRH) services, mixed contraceptive methods including condoms, STI screening and treatment, counseling and referral for VMMC services, HTS counseling, and care and treatment services. In COP18, PEPFAR SA has supported NDoH and DBE to develop standard operating procedures for improving the provision of health services to adolescents in schools, including improving the tools to facilitate referral pathways and quality of services offered through the Integrated School Health Program. PEPFAR SA also supports the DBE to develop implementation plans to fully implement the new policy on HIV, STIs and TB. This support will continue in COP19.

Among 9-14 year-old adolescent girls and boys in DREAMS and non-DREAMS districts, PEPFAR SA will leverage the OVC, school-based, safe spaces and community platforms using a combination of high-impact interventions to prevent sexual violence; delay sexual debut; support healthy choices; and empower parents, caregivers and communities to support, protect, and educate girls. Among adolescent girls 15-19 years in DREAMS and non-DREAMS districts, HIV prevention investments will leverage OVC, school-based, safe spaces, community and clinical platforms using a combination of interventions to empower adolescent girls, strengthen families, mobilize communities, and link girls in this age group to SRH services including PrEP. Among young women 20-24 years in DREAMS and non-DREAMS districts, PEPFAR SA will leverage higher education (Technical and Vocational Education and Training colleges and universities), community and clinical platforms to prevent HIV by empowering young women, mobilizing communities, and linking young women to SRH including PrEP. A particular highlight for COP19 is the rapid scale-up of PrEP for AGYW targets when compared to COP18, from 15,695 in 5 districts to 62,120 in 11 districts. Investments in young women will also increase demand for services in both communities and facilities, and mobilize communities to support an end to violence against women.

OVC

In COP19, PEPFAR SA will continue to invest in comprehensive support to OVC through a family-centered case management approach in 24 districts. 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 HIV care services; reduce violence and abuse; and prevent

²⁹ National Policy on HIV, STIs and TB for Learners, Educators, School Support Staff and Officials in all Primary and Secondary Schools in the Basic Education Sector, August 2017.

HIV infection. In COP19, OVC funding will continue to focus on interventions that address sexual violence prevention for 9-14 year old children through evidence-based curricula such as 'Empower'. In addition, the OVC portfolio of investments will have greater focus on specialized post-violence care management through improved linkages to post-violence care and post-exposure prophylaxis (PEP) as well as using post-violence care facilities as an entry point to maximize uptake of HIV interventions. Community and faith leaders are key players in addressing GBV and are part of the target population for education, training, integration into programs and accountability.

New in COP19, the OVC Implementing Partners will be given targets for C/ALHIV enrollment by district and age and are rolling out an improved package of services for C/ALHIV that includes evidence-based adherence interventions, linkages to adolescent- and youth-friendly services, family-centered disclosure, and wraparound social services. PEPFAR SA will also support the roll-out of the new HTS Guidelines for Social Services Professionals released by the Department of Social Development in 2019. The guidelines leverage the household-level influence of social service providers to improve HIV service uptake among those at highest risk.

Key Populations

PEPFAR SA continues to strengthen its key population prevention, care and treatment investments targeted to female sex workers, men who have sex with men, transgender women, people who inject drugs, and incarcerated individuals, aligned with strong country strategic plans, and informed by the most recent population size estimations and bio-behavioral data. In 2016/2017, SANAC launched strategic plans for sex workers and lesbian, gay, bisexual, transgender and intersex people (LGBTI),³⁰ aligned with the NSP. These plans demonstrate strong consensus on the strategic direction and confirm GoSA support. SANAC is also planning for a new National Sex Worker Plan 2019-2022. The core of the COP19 program focuses on peer-led outreach and mobilization, targeted strategic communication and demand creation, and key population-friendly mobile and drop-in centers providing HIV, STI, and TB screening, testing and treatment services, and PrEP. Additional emphasis will be placed on case identification to increase HTS yield through social networking strategies such as the Enhanced Peer Outreach Approach. This core package is complemented by interventions focused on stigma reduction, community mobilization, and use of strategic information for program management. Resources from the PEPFAR Key Populations Implementation Fund will be leveraged on COP19 investments and will include innovations to improve yield, linkages and retention across the prevention, care and treatment cascades.

Men 15-34 Years

In COP19, PEPFAR SA will continue to assist the NDoH to scale up the national VMMC program through planning, coordination, and implementation including advocacy, communication, and social mobilization. PEPFAR SA aims to reach at least 80% of males 15-34 years old with free, safe and quality VMMC services in priority districts. Modeling has

³⁰ The South African National Sex Worker HIV Plan 2016-2019, and the South African National LGBTI HIV Plan 2017-2022.

shown that targeting this age group is the most cost-effective in terms of infections averted. By the end of COP18, PEPFAR SA will transition the VMMC services out of uMkhanyakude and therefore focus in the 27 priority districts in COP19. PEPFAR SA will work closely with the DoH to ensure a smooth transition in this district. PEPFAR SA implements 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 SA will strengthen quality elements of the VMMC program through routine external quality assurance and continuous quality improvement activities. VMMC services will address harmful male norms and behaviors that may promote high-risk sexual behaviors, contribute to GBV, and limit access and/or adherence to HIV prevention services. The PEPFAR SA VMMC program will continue to implement strong linkage to treatment for men with HIV, STIs, as well as those with TB.

In COP19 PEPFAR SA will continue its efforts to integrate mental health and substance abuse interventions across the portfolio to address these known contributors to poor treatment outcomes and HIV acquisition risk. The University of Cape Town and SAMSHA, a technical assistance partner, will increase direct training and capacity-building in evidence-based behavioral interventions to support national and provincial government and Implementing Partners in South Africa. A key strategy remains targeted screening for substance abuse and common mental disorders followed by brief interventions in community and clinical settings.

Similar to the community-based support for care and treatment services, FBOs will support communities in 14 high burden districts with prevention messaging, particularly focusing on men, and support community-based prevention programs for AGYW and OVC.

Peace Corps

Through collaboration with the PEPFAR Interagency Team at the U.S. Mission, Peace Corps (PC) strives to place Volunteers in priority districts while being responsive to host country requests for assistance. In FY19, Volunteers were placed in seven PEPFAR priority districts. These Volunteers focus on HIV prevention activities such as primary prevention education for adolescents, gender based violence prevention, life skills, and linkages to health services. Additionally, PCVs in those districts provide services to orphans and vulnerable children – a critical portion of the PEPFAR portfolio. Volunteers are placed with organizations that are identified based on their commitment to HIV epidemic control as well as an expressed need that can be met by PCVs using evidence-based interventions. In FY20, Peace Corps plans to place 38 PCVs in five priority districts.

Currently, the Volunteers focus on support to adolescents and OVC with HIV prevention and sexual reproductive health education through youth groups, as well as support to parent and caregivers of those adolescents and OVC. PCVs are trained to use evidence-based curriculums for these ongoing interventions. Additionally, Peace Corps strives to support PLHIV to access treatment and remain in care. This is done through supporting support groups and linkages to clinical and community HIV services. 4.3 Additional country-specific priorities listed in the planning level letter

The PEPFAR SA COP19 planning level letter identified technical priorities that must be addressed to increase the impact of PEPFAR SA investments in SA. Solutions to address these priorities have been identified as part of COP19 planning, and are described in other sections of this document, as indicated below.

1. Tuberculosis: Sections 2.0, 4.1 and Appendix D.5.
2. DREAMS: Section 4.2.
3. VMMC: Sections 3.0 and 4.2.
4. Cervical Cancer Screening and Treatment: Section 4.7.
5. Linkage to Treatment: Sections 2.0, 4.1, 6.0, Appendix D.6 and Appendix D.10.
6. PrEP: Sections 4.2 and Appendix D.10.
7. Human Resources for Health: Sections 2.3, 2.4, 4.1, 4.5 and 6.0.
8. Partner Performance: Sections 1.0, 2.0, 4.1, 4.5 and 7.0.

4.4 Commodities

The GoSA maintains an investment of approximately \$746 million for the procurement of HIV-related commodities in 2018/19. The Global Fund invested \$10.7 million in ARVs in 2018/19 and has committed \$14.8 million for the procurement of ARV buffer stock during the COP19 period.

South Africa is on track to transition the majority of adult patients beginning in August 2019, including women of childbearing potential, to TLD by January 2020. During COP18, global shortages of INH and some second line antiretrovirals affected medicine availability in South Africa. PEPFAR SA is working with NDoH and SANOFI through the TB Think Tank TPT sub-working group to determine available INH quantities by facility and to find ways of addressing the shortage. The NDoH is working with the South African Health Products Regulatory Authority (SAHPRA) to ensure timely review and approval for alternative sources.

In COP19 PEPFAR SA will invest nearly \$26 million for the procurement of ARVs, PrEP, and TPT (including INH). This investment includes support for multi-month ART scripting and private sector expansion (procuring ARVs for private sector clinicians initiating HIV treatment for targeted priority populations). No other funding gaps for commodities have been projected for the period covered under COP19.

4.5 Collaboration, integration and monitoring

For the past few years, substantial gaps emerged in performance related to getting new PLHIV onto ART, and in keeping them on ART. PEPFAR SA, working under the leadership of NDoH, has taken steps to collaborate on approaches to improve these critical programs. The progress identified in COP18 will continue into COP19. Specifically, these include building off of the intense, site-level work that PEPFAR SA and NDoH launched in February 2019, strengthening the commitment to Minister Motsoaledi's March 18, 2019 circular about interventions needed to reach 90-90-90 targets (now known as Operation Phuthuma), and building off of NDoH's SOP for all HIV/AIDS, STI and TB Managers, increasing commitments to HRH and VL result reporting, and documenting and addressing facility-level challenges. The ten points included in the March 2019 circular include: (1) ensure patient-centered care in all facilities; (2) strengthen data systems; (3) implementation of same-day ART initiation; (4) utilization of the HPRS to implement a unique patient identifier; (5) ensure all nurse-initiated management of

ART (NIMART)-trained nurses initiate patients on ART; (6) set performance targets for NIMART-trained nurses, lay counselors, data clerks and community health workers; (7) strengthen CCMDD and expand external pick-up points; (8) decrease waiting times at facilities and improve patient record filing systems; (9) provide services in extended working hours; and (10) ensure accountability for facility performance by operational managers and provincial officials. Careful monitoring of the fidelity of the implementation of these interventions will help South Africa reach the 90-90-90 targets.

Underperformance by facilities and by Implementing Partners has and will continue to be addressed through management and technical interventions:

- PEPFAR SA and the NDoH began a focused site-level activity in February 2019, coordinated through the NDoH Operation Phuthuma. The initiative was initially called the February Frenzy/Blitz, which focused on finding PLHIV and initiating them on ART, finding PLHIV who were out of care and reinitiating them on ART, and addressing data backlogs and data quality. The overall success of this approach contributed to the next campaign—called “Siyenza” or “we’re doing it”, which is part of Operation Phuthuma. Siyenza built off of February’s successes while increasingly focusing on retaining PLHIV in care. PEPFAR SA and NDoH crafted a case management approach to improve poor performance in retention. To ensure Implementing Partners share accountability for their performance, Implementing Partners are reporting daily data to PEPFAR SA. In COP19, PEPFAR SA will continue its focus on scaling up PLHIV newly initiated on treatment, while continuing to prioritize retention in care. To support these efforts, PEPFAR SA will increase its investment in facility-based staff critical to increasing and retaining PLHIV on ART.
- In COP18, PEPFAR SA adapted its prior “Operation 10-10” for a more rapid, target-oriented approach. Continuing in COP19, PEPFAR SA will collaborate closely with NDoH and provincial and district DoHs to intensify site-level monitoring of the interventions specified in the NDoH March 2019 circular. Specifically, PEPFAR SA and DoH will ensure “Welcome Back Services” are maximizing opportunities to re-engage people who have interrupted treatment into care to achieve stable outcomes, all NIMART-trained nurses are initiating PLHIV onto ART, lay counselors and data capturers are performing against targets, and filing systems are strengthened to improve data quality and the patient experience by reducing waiting times. PEPFAR SA and NDoH will work together to ensure that best practices are disseminated across all Siyenza facilities, PEPFAR-supported districts and nationally as applicable.
- To better operationalize Siyenza and the NDoH circular, NDoH issued an SOP for site-level activities. This SOP built off of Siyenza’s technical approach, and it assigned specific responsibilities to District DoH staff and facility operational managers. By assigning specific roles and responsibilities to district and facility staff, the commitment to Siyenza was strengthened in COP18, which will continue into COP19. Leadership and management responsibilities of DoH staff will be promoted through the continued implementation of Siyenza activities, by PEPFAR and through Operation Phuthuma’s activities through NDoH. The SOP will drive the operational activities for PEPFAR SA and NDoH’s technical collaboration. In addition, PEPFAR SA will continue to monitor fidelity to the SOP throughout COP19 and will report back frequently on best practices and performance gaps

to NDoH. Building on these intensive efforts, PEPFAR SA is committed to scaling up supplemental staff in prioritized PEPFAR-supported facilities in South Africa. PEPFAR SA's Implementing Partners will surge in hiring of needed supplemental staff in order to reach Siyenza targets and achieve 90-90-90 goals. In addition, PEPFAR SA and NDoH will work together to improve VL tests completion, documentation, and reporting and will implement innovative activities to ensure that PLHIV are aware of VL results and that clinical providers are equipped to respond to them.

- PEPFAR SA and NDoH will track key barriers to reaching targets and 90-90-90 goals in South Africa. PEPFAR SA has begun sharing weekly updates with its Implementing Partners and with NDoH to improve accountability and documentation of site-level improvements and challenges. These include service delivery challenges, as well as any above-site or structural issues that are impeding progress towards epidemic control. PEPFAR SA has developed a template for documenting site-level challenges, and this document is circulated weekly to PEPFAR SA Implementing Partners and NDoH. Once appropriate solutions are reached, these will be shared with other facilities to ensure that all facilities can benefit from promising approaches to site-level problem solving.
- PEPFAR SA and NDoH are committed to improving the use of unique identifiers across sites and programs in clinical settings. As noted in the NDoH circular, PEPFAR SA and NDoH will monitor full implementation of HPRS as the unique identifier to track patients across facilities and for disengaged ART patients. Both PEPFAR SA and NDoH will work to strengthen the implementation and routine use of HPRS within South Africa and using this unique identifier to both track individual patients through the health system as well as link datasets so that overall monitoring and evaluation of the HIV programmes at all levels of the system is improved, based on the evidence of enhanced information availability.
- Siyenza is an intense site-monitoring approach that quickly adapts to be responsive to the most critical elements of our program. As a result, it can be expected that interventions and indicators will evolve over the course of COP19.

In addition to these routine practices in partner monitoring and management, underperformance by individual Implementing Partners has been and will continue to be addressed aggressively. PEPFAR SA has directed attention to improving Implementing Partner capacities to retain PLHIV on treatment and to re-engage those who have disengaged from care.

In COP19, PEPFAR SA will fund a coordinated community monitoring system lead by PLHIV and KP organizations to monitor the state of service provision at PEPFAR supported sites and escalate issues including (but not limited to): poor performance, poor quality of services, poor health worker attitudes, health and rights violations, and stockouts/ shortages of diagnostics and treatment. Widespread or repeating issues will be discussed at Community Advisory Group in order to attempt to generate systemic solutions.

To optimize the PEPFAR SA investments in addressing these gaps, PEPFAR SA will continue to collaborate with GoSA, GFATM and other important partners to ensure that resources are leveraged and that investments are planned to be complementary both technically and

geographically. PEPFAR SA is working with the SANAC and GFATM Principal Recipients to harmonize interventions, indicators, and geographies aimed at preventing HIV and GBV among AGYW and key populations. These harmonization efforts are a result of strengthened collaborative relationships between PEPFAR SA staff and the GFATM Fund Portfolio Team (based in Geneva), the Country Coordinating Mechanism Secretariat (based at SANAC), and the Principal Recipients. PEPFAR SA, SANAC, and GFATM Principal Recipients are exploring opportunities to consolidate monitoring and evaluation and routine reporting tools (a health information system assessment is on-going to guide these decisions).

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	Tested for HIV	Newly Identified Positive	Newly Initiated on ART
	(APR FY2020)	(APR FY2020)	(APR FY2020)
	<i>HTS_TST</i>	<i>HTS_TST_POS</i>	<i>TX_NEW</i>
Total Men	4,647,595	424,327	398,177
Total Women	7,289,293	641,762	637,042
Total Children (<15)*	1,156,423	23,024	24,598
<u>Adults</u>			
TB Patients (15+)	70,249	28,733	28,415
Pregnant & Breastfeeding Women (15+)*	1,115,459	66,512	74,488
VMMC clients (15+)	367,172	6,236	5,594
Key populations***	106,350	12,705	11,852
Other Testing	10,384,008	964,608	926,722
Previously diagnosed and/or in care	---	---	26,020
<u>Pediatrics (<15)</u>			
HIV Exposed Infants	203,092	1,300	1,287
TB Patients (<15)	9,950	1,537	1,615
Pregnant & Breastfeeding Girls (<15)**	2,329	532	187
VMMC clients (<15)	92,333	779	720
Other pediatric testing	1,051,811	23,252	22,089
Previously diagnosed and/or in care	---	---	625
<i>*Excludes EID testing but includes infants who test positive and who are newly initiated on ART</i>			
<i>**Testing for pregnant & breastfeeding women includes repeat testing post ANC1; TX_NEW for pregnant women includes some women who were previously diagnosed</i>			
<i>***Key population testing and TX_NEW targets are duplicated within other adult targets</i>			

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
District	Target Populations	Population Size Estimate (FY2020)	Current Coverage* (FY2019 expected)	VMMC_CIRC (in FY2020)	Expected Coverage* (in FY2020)
ec Alfred Nzo District Municipality	15-34 year olds	120,612	Not Available	8000	To Be Determined
ec Amathole District Municipality	15-34 year olds	136,411	Not Available	8000	To Be Determined
ec Buffalo City Metropolitan Municipality	15-34 year olds	125,181	Not Available	8000	To Be Determined
ec Chris Hani District Municipality	15-34 year olds	119,308	Not Available	8000	To Be Determined
ec Oliver Tambo District Municipality	15-34 year olds	232,534	Not Available	8000	To Be Determined
fs Lejweleputswa District Municipality	15-34 year olds	118,291	Not Available	5991	To Be Determined
fs Thabo Mofutsanyane District Municipality	15-34 year olds	130,961	Not Available	8000	To Be Determined
gp City of Johannesburg Metropolitan Municipality	15-34 year olds	1,022,040	Not Available	37600	To Be Determined
gp City of Tshwane Metropolitan Municipality	15-34 year olds	665,307	Not Available	10890	To Be Determined
gp Ekurhuleni Metropolitan Municipality	15-34 year olds	729,923	Not Available	16684	To Be Determined
gp Sedibeng District Municipality	15-34 year olds	180,680	Not Available	9600	To Be Determined
kz eThekweni Metropolitan Municipality	15-34 year olds	803,477	Not Available	108490	To Be Determined
kz Harry Gwala District Municipality	15-34 year olds	86,312	Not Available	10080	To Be Determined
kz King Cetshwayo District Municipality	15-34 year olds	165,758	Not Available	16441	To Be Determined
kz Ugu District Municipality	15-34 year olds	117,460	Not Available	12845	To Be Determined
kz uMgungundlovu District Municipality	15-34 year olds	201,335	Not Available	12000	To Be Determined
kz Uthukela District Municipality	15-34 year olds	122,044	Not Available	12000	To Be Determined
kz Zululand District Municipality	15-34 year olds	142,660	Not Available	18400	To Be Determined
lp Capricorn District Municipality	15-34 year olds	223,461	Not Available	9698	To Be Determined
lp Mopani District Municipality	15-34 year olds	201,111	Not Available	5600	To Be Determined
mp Ehlanzeni District Municipality	15-34 year olds	304,975	Not Available	16490	To Be Determined
mp Gert Sibande District Municipality	15-34 year olds	223,857	Not Available	9894	To Be Determined
mp Nkangala District Municipality	15-34 year olds	297,828	Not Available	16294	To Be Determined
nw Bojanala Platinum District Municipality	15-34 year olds	328,784	Not Available	9845	To Be Determined
nw Dr Kenneth Kaunda District Municipality	15-34 year olds	125,778	Not Available	5614	To Be Determined
nw Ngaka Modiri Molema District Municipality	15-34 year olds	150,581	Not Available	6551	To Be Determined
wc City of Cape Town Metropolitan Municipality	15-34 year olds	742,842	Not Available	17707	To Be Determined
TOTAL	15-34 year olds	7,819,511	Not Available	416,714	To Be Determined

*DISCLAIMER: In previous COP years, VMMC coverage referenced DMPPT data which has been suggesting high VMMC coverage. These past estimates have contradicted the demand for VMMC services in multiple districts. Other national level data sources (Thembisa and HSRC surveys) are clearly indicating that the coverage levels are significantly less; therefore, PEPFAR SA did not use DMPPT data to estimate VMMC coverage for COP19. Additionally, Thembisa and HSRC data are also not specific enough to accurately derive coverage at the district level. Hence, PEPFAR SA has set aside funding for HSRC to conduct additional analysis in collaboration with SA stakeholders to provide more refined projections which will be available later this year.

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control (continued on next page)

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control						
Target Populations		Population Size Estimate (scale-up SNUs)	FY19 Results	Coverage Goal (in FY19)	Coverage Goal (in FY20)	FY20 Target
AGYW [10-24 yrs] (PP_PREV)	gp City of Johannesburg Metropolitan Municipality	626,263	90,699	14%	14%	86,487
	gp Ekurhuleni Metropolitan Municipality	439,038	33,304	8%	7%	32,837
	kz eThekweni Metropolitan Municipality	484,470	76,334	16%	15%	74,341
	kz uMgungundlovu District Municipality	155,470	49,095	32%	34%	52,910
AGYW [10-24 yrs] (PP_PREV) - subtotal*		1,705,241	249,432	-	-	246,575
Female Sex Workers (KP_PREV)	ec Oliver Tambo District Municipality	2,933	3,327	113%	79%	2,328
	gp City of Johannesburg Metropolitan Municipality	7,697	13,580	176%	176%	13,580
	gp City of Tshwane Metropolitan Municipality	5,719	9,061	158%	158%	9,060
	gp Ekurhuleni Metropolitan Municipality	5,899	5,361	91%	91%	5,361
	kz eThekweni Metropolitan Municipality	9,323	6,992	75%	44%	4,128
	kz uMgungundlovu District Municipality	2,436	1,554	64%	76%	1,854
	lp Vhembe District Municipality	3,003	2,206	73%	73%	2,205
	mp Ehlanzeni District Municipality	3,819	2,461	64%	42%	1,605
	mp Gert Sibande District Municipality	2,292	1,691	74%	49%	1,120
	mp Nkangala District Municipality	2,933	2,206	75%	42%	1,218
	nw Dr Kenneth Kaunda District Municipality	1,582	1,065	67%	81%	1,281
	nw Ngaka Modiri Molema District Municipality	1,836	0	0%	55%	1,012
wc City of Cape Town Metropolitan Municipality	6,500	4,452	68%	53%	3,450	
FSW (KP_PREV) - subtotal*		55,973	53,956	-	-	48,202
MSM (KP_PREV)	ec Buffalo City Metropolitan Municipality	3,725	1,261	34%	34%	1,260
	ec Nelson Mandela Bay Municipality	5,848	1,979	34%	34%	1,978
	gp City of Johannesburg Metropolitan Municipality	39,515	16,642	42%	42%	16,642
	gp City of Tshwane Metropolitan Municipality	25,747	6,116	24%	20%	5,116
	gp Ekurhuleni Metropolitan Municipality	28,664	2,406	8%	8%	2,405
	kz eThekweni Metropolitan Municipality	28,533	6,848	24%	17%	4,848
	kz uMgungundlovu District Municipality	4,956	2,191	44%	44%	2,190
	mp Ehlanzeni District Municipality	7,654	1,827	24%	24%	1,810
wc City of Cape Town Metropolitan Municipality	31,409	10,465	33%	33%	10,465	
MSM (KP_PREV) - subtotal*		176,050	49,735	-	-	46,714
TGW (KP_PREV)**	ec Buffalo City Metropolitan Municipality	N/A	415	-	-	414
	ec Nelson Mandela Bay Municipality	N/A	630	-	-	629
	gp City of Johannesburg Metropolitan Municipality	N/A	1,946	-	-	1,946
	wc City of Cape Town Metropolitan Municipality	N/A	1,206	-	-	1,206
TGW (KP_PREV) - subtotal*		N/A	4,197	-	-	4,195
People Who Inject Drugs (KP_PREV)***	gp City of Tshwane Metropolitan Municipality	4,514	4,333	96%	48%	2,169
	mp Ehlanzeni District Municipality	N/A	1,221	-	-	991
People Who Inject Drugs (KP_PREV) - subtotal*		4,514	5,554	-	-	3,160

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control (continued)

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control (continued)						
Target Populations	Population Size Estimate (scale-up SNUs)	FY19 Results	Coverage Goal (in FY19)	Coverage Goal (in FY20)	FY20 Target	
Inmates (KP_PREV)	ec Amathole District Municipality	2,270	1,135	50%	34%	773
	ec Buffalo City Metropolitan Municipality	4,648	2,324	50%	56%	2,598
	ec Nelson Mandela Bay Municipality	4,500	0	0%	44%	1,999
	ec Oliver Tambo District Municipality	3,348	1,674	50%	53%	1,782
	ec Sarah Baartman District Municipality	2,554	1,277	50%	27%	684
	fs Fezile Dabi District Municipality	4,718	2,359	50%	19%	896
	fs Lejweleputswa District Municipality	3,596	1,798	50%	28%	995
	fs Mangaung Metropolitan Municipality	3,700	1,850	50%	58%	2,129
	fs Xhariep District Municipality	2,266	1,133	50%	54%	1,217
	gp City of Johannesburg Metropolitan Municipality	12,246	6,123	50%	58%	7,089
	gp City of Tshwane Metropolitan Municipality	12,142	6,071	50%	60%	7,273
	gp Ekurhuleni Metropolitan Municipality	9,142	4,571	50%	58%	5,258
	kz Amajuba District Municipality	3,384	1,692	50%	49%	1,646
	kz eThekweni Metropolitan Municipality	6,000	0	0%	53%	3,150
	kz King Cetshwayo District Municipality	4,246	2,123	50%	43%	1,828
	kz Ugu District Municipality	1,262	631	50%	49%	619
	kz uMgungundlovu District Municipality	1,764	882	50%	46%	806
	kz Umzinyathi District Municipality	1,678	839	50%	43%	722
	kz Uthukela District Municipality	1,148	574	50%	60%	694
	kz Zululand District Municipality	3,210	1,605	50%	48%	1,545
	lp Capricorn District Municipality	1,438	719	50%	64%	916
	lp Vhembe District Municipality	5,852	2,926	50%	49%	2,870
	mp Ehlanzeni District Municipality	2,240	1,120	50%	41%	920
	mp Gert Sibande District Municipality	3,010	1,505	50%	23%	697
	mp Nkangala District Municipality	2,438	1,219	50%	51%	1,248
	nc Frances Baard District Municipality	4,246	2,123	50%	63%	2,667
	nc Zwelentlanga Fatman Mgcawu District Municipality	1,306	653	50%	64%	832
	nw Bojanala Platinum District Municipality	2,520	1,260	50%	25%	623
	nw Dr Kenneth Kaunda District Municipality	3,674	1,837	50%	61%	2,250
	wc City of Cape Town Metropolitan Municipality	7,176	3,588	50%	64%	4,568
	wc Eden District Municipality	3,000	1,500	50%	27%	801
	wc Overberg District Municipality	1,816	908	50%	46%	844
	wc West Coast District Municipality	4,790	2,395	50%	43%	2,036
Inmates (KP_PREV) - subtotal*	131,328	60,414	-	-	64,975	
TOTAL*		423,288			413,821	
*TOTALS and SUBTOTALS here reflect ONLY the sum of the estimates for the listed SNUs, and DO NOT represent the national totals for each KP group						
**Population size estimates for transgender women are currently not available. These will be estimated in COP19.						
***Citation for population size estimate in City of Tshwane: University of California San Francisco; Anova Health Institute, National Institute for Communicable Diseases (2018). Brief Report of the TipVal Study: An Integrated Bio-Behavioral Surveillance Survey among People who Inject Drugs. San Francisco: UCSF. Global Strategic Information, Institute for Global Health Sciences						

Table 4.6.4 Targets for OVC and Linkages to HIV Services

Table 4.6.4 Targets for OVC and Linkages to HIV Services				
District	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY20Target) (<18 years)	Target # of active OVC (FY20Target) (18+ years)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target)
		OVC_SERV	OVC_SERV	OVC_HIVSTAT [<18 ONLY]
ec Alfred Nzo District Municipality	53,226	8,600	1,400	8,600
ec Amathole District Municipality	83,519	6,880	1,120	6,880
ec Buffalo City Metropolitan Municipality	37,922	13,761	2,240	13,761
ec Chris Hanani District Municipality	77,033	8,609	1,399	8,609
ec Oliver Tambo District Municipality	252,601	8,604	1,404	8,604
fs Thabo Mofutsanyane District Municipality	69,372	6,878	1,121	6,878
gp City of Johannesburg Metropolitan Municipality	154,382	106,372	12,393	106,372
gp City of Tshwane Metropolitan Municipality	90,469	33,973	7,025	33,973
gp Ekurhuleni Metropolitan Municipality	133,873	29,314	3,544	29,314
gp Sedibeng District Municipality	47,649	13,760	2,240	13,760
kz eThekweni Metropolitan Municipality	221,572	110,242	12,325	110,242
kz Harry Gwala District Municipality	55,785	8,600	1,400	8,600
kz King Cetshwayo District Municipality	99,107	8,608	1,400	8,608
kz Ugu District Municipality	78,122	8,601	1,400	8,601
kz uMgungundlovu District Municipality	88,618	30,046	4,099	30,046
kz Uthukela District Municipality	75,420	6,881	1,119	6,881
kz Zululand District Municipality	104,278	6,885	1,121	6,885
lp Capricorn District Municipality	95,223	8,593	1,400	8,593
lp Mopani District Municipality	81,600	12,046	1,958	12,046
mp Ehlanzeni District Municipality	135,560	31,143	6,205	31,143
mp Gert Sibande District Municipality	88,571	21,718	4,248	21,718
mp Nkangala District Municipality	71,577	15,857	4,145	15,857
nw Bojanala Platinum District Municipality	77,076	8,591	1,400	8,591
wc City of Cape Town Metropolitan Municipality	96,687	31,879	4,874	31,879
TOTAL	2,369,242	546,441	80,980	546,441

4.7 Cervical cancer program plans

PEPFAR District Support Partners may implement activities related to cervical cancer screening as part of routine care of HIV-infected women, through technical assistance, mentoring and direct patient care. These activities are in line with PEPFAR and NDoH clinical guidance for the care of HIV-infected women. There are no targets set for these activities, and no budget allocated.

4.8 Viral load and early infant diagnosis optimization

In South Africa, VL and early infant diagnosis (EID) testing is highly centralized, with a lab network of 16 VL labs (14 of which are SANAS accredited) and 6 EID labs (all of which are accredited). All VL and EID labs are equipped with high throughput and medium size testing platforms. The testing is run by the NHLS, which has its own sample transport system and which uses courier service when necessary. There is a courier to every single facility once per day to collect specimens and deliver results, and the average turnaround time is 105 hours from specimen collection to results return.

Point-of-care (POC) VL testing is being piloted in pregnant and breastfeeding women with funding from UNITAID, but currently there are no plans to scale up POC VL or EID instruments in 2020. No funding has been allocated for POC in COP19, and there are no POC platforms being transitioned in PEPFAR-supported sites. Because South Africa is not using POC for VL testing, there is no integration between TB and VL testing as TB is diagnosed using Cepheid GeneXpert while VL is run using Roche and Abbott platforms.

5.0 Program Activities for Epidemic Control in Centrally Supported Locations and Populations

In COP19 PEPFAR SA will continue to focus for impact on the 27 highest burden districts. In addition, PEPFAR SA will continue to invest in the NDoH and other central level activities that support the 25 lower-burden districts. These investments are described in Section 6.o.

6.o Systems Support Necessary to Achieve Sustained Epidemic Control

Systems support activities strengthen components of the health system that are critical to the successful implementation of HIV prevention, care, and treatment health services. This is both the focus of COP19 and Surge funding. Systems investments implemented at the above-the-site level are designed to address the most critical systems-based barriers that inhibit epidemic control in SA. These key systems barriers were identified through a range of strategic processes, including the NSP, the PEPFAR Monitoring, Evaluation and Reporting system, and intensive site improvement and monitoring (including the Siyenza Campaign), and are linked to the SID scores. The investments are aligned with the GoSA and with other development partners, and in particular the GFATM, to optimize opportunities to leverage and complement and to ensure the best return on these investments. Clearly defined and agreed benchmarks of progress are established and documented for each of the funded activities (summarized below and documented in detail in the full Table 6, see Appendix C). The benchmarks will be monitored actively to ensure that activities are on track and continue to address barriers to the success of the broader portfolio (see also Section 4.5 on partner management).

COP19 focuses on addressing the following areas of system barriers:

1. Human Resources for Health
2. Efficient and Effective Patient Linkage and Retention
3. Interoperable Patient Data Systems
4. Strategic Allocation of HIV Resources
5. Utilization of Civil Society Resources
6. Drugs and Commodities Planning

7. Utilization of the Private Sector

Each of these barriers is presented below with a summary of the planned COP19 investments and expected outcomes of the investment. The COP19 minimum requirements (see Appendix D) related to the investment are also included below.

Key Systems Barrier 1: Human Resources for Health

Central coordination of the health workforce will improve workforce enumeration, planning, coordinated skills building, and opportunities to increase efficient and effective service delivery.

Summary of COP19 Above-Site Investments (HRH)	Expected Outcomes
<ul style="list-style-type: none"> • PEPFAR SA will invest in information systems to collect and synthesize data on human resources for health, HIV-related programmatic achievement and disease burden to generate dynamic decision analytic tools to optimize PEPFAR and government investments and allocation of human resources across cadres and geography. • PEPFAR SA will support the expansion and enhancement of the <u>NDoH</u> Ward Based Primary Health Care Outreach Team program (referred to here as community health workers, CHW). PEPFAR above-site investments will capacitate CHWs to provide quality services that increase treatment uptake, adherence and retention among PLHIV; support supervisory staff and systems that support effective CHW interventions; and support a comprehensive monitoring and evaluation system to track quality and quantity of service provision at the community level. • PEPFAR SA will support a competency-based e-learning platform to deliver critical HIV-related in-service capacity building at the site level while minimizing the time, lost service delivery, and costs associated with off-site in-service trainings. • PEPFAR SA will improve incentive systems to optimize the performance of PEPFAR-Funded direct service delivery workforce in line with <u>NDoH</u> policies. PEPFAR SA will also provide technical assistance to the government of South Africa to improve execution of the HIV/AIDS conditional grant. 	<p>HRH planning/ coordination and systematic capacity building for service delivery will result in an optimized health workforce to achieve epidemic control.</p> <p>The Human Resources Inventory Database (HRID) and Human Resources Information System (HRIS) will be supported. These systems will allow for triangulation with HRH information systems and programmatic data for program planning and optimization.</p> <p>25% growth of public sector primary healthcare workforce in accessing the Knowledge Hub for HIV-related in-service capacity building.</p> <p>Refresher training provided to up to 10,000 CHW, curricula revised.</p>

Key Systems Barrier 2: Efficient and effective patient linkage and retention

The range of interventions for HIV service linkage and patient retention can be more fully optimized and monitored.

Related COP19 Minimum Requirements: Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups; Adoption and implementation of differentiated service delivery models, including multi-month scripting and delivery models to improve identification and ARV coverage of men and adolescents; Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting.

Summary of COP19 Above-Site Investments (Patient Linkage and Retention)	Expected Outcome
<ul style="list-style-type: none"> • PEPFAR SA will continue to invest in supporting the <u>GoSA</u> to develop and implement evidence-based technical guidelines and policies that improve program impact. • PEPFAR SA will support differentiated service delivery through the CCMDD program investing in a range of activities to improve management, implementation, and distribution of chronic medicines outside of routine clinical care. Support includes geospatial analysis and mapping of new external pick-up-points, assessing and instituting internal pick-up-points, and ensuring the CCMDD program complements the full range of patient decanting options in accordance with the National Adherence Guidelines. • PEPFAR SA will support the integration of CCMDD information systems with other HIV information systems (e.g. Tier) through ensuring CCMDD information systems are interoperable and adhere to eHealth normative standards of GOSA, as well as using HPRS • PEPFAR SA will support a series of demand creation interventions. Demand creation will utilize best available data on client barriers to care, health seeking behavior, and client treatment preferences and will utilize expertise from private sector partners (e.g. from the <u>MenStar</u> coalition including Coca-Cola Inc., Johnson & Johnson Inc., and Gilead Inc.). Campaigns will focus on addressing treatment needs of men as well as adapting “Undetectable = Un-transmissible” to welcome patients back to care and increase treatment linkage and retention rates within PEPFAR priority districts. • COP19 resources will strengthen the laboratory services by expanding access to the <u>eLAB</u> system, Results for Action, and quality assurance interventions to monitor specimen quality, time to results, and use of laboratory results in clinical care. 	<p>Strengthened policy, guidelines, and implementation accountability structures on linkage to care and differentiated service delivery will result in more efficient and effective HIV services.</p> <p>>65% of eligible patients stable on ARVs are receiving drugs from the CCMDD program; partial <u>SyNCH</u> for monitoring patient outcomes on CCMDD is fully implemented nationally and used by the <u>NDoH</u> to inform program planning.</p> <p>Tier-net incorporates full regular (at least bi-weekly) updates of CCMDD databases</p> <p>>25% reduction in loss to follow up due to demand generation campaign among targeted population.</p> <p>Strengthened laboratory infrastructure by accrediting all VL labs, (2 out of 16 still need accreditation) and processes (using <u>eLAB</u> to decrease turnaround time, and specimen rejection rates, as well as VL appointment reminders and immediate call-back of patients with unsuppressed VL). This will improve VL monitoring and use of results to inform clinical service delivery and improve the rate of viral suppression.</p>

Key Systems Barrier 3: Interoperable patient data systems

Interoperable patient data systems will improve the availability of robust and consistent monitoring and surveillance data for program planning.

Related COP19 Minimum Requirements: Scale up of unique identifiers for patients across all sites; Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.

Summary of COP19 Above-Site Investments (Interoperable Patient Data Systems)	Expected Outcome
<ul style="list-style-type: none"> • COP19 resources will support the expansion of provincial Information Hubs in eight provinces. Investments in provincial Information Hubs will integrate TIER.Net with other key databases (including NHLS) to avoid duplication of patient information and greatly improve the ability to link patients to care, monitor progress, support program management and optimize resource allocation. • PEPFAR SA will develop data systems to track cohorts of orphans and vulnerable children and the layering of DREAMS interventions to assess the impact of these critical interventions. • COP19 resources will provide site-level and above-site-level technical assistance and capacity building around data quality and use for <u>webDHIS</u> and support systems integration into Information Hubs. 	<p>Better integrated and higher quality surveillance and programmatic data will result in a strong public health response to achieve epidemic control. Improved patient-level data coordination will result in better care and management of health resources.</p> <p>District-level HIV estimates including on prevalence and burden (PLHIV) for South Africa are available for 2018. Local capacity will be developed to improve the generation, interpretation and use of sub-national estimates.</p> <p>Provincial Information Hubs able to provide TB-HIV dashboards and trend graphs in eight provinces.</p>

Key Systems Barrier 4: Strategic Allocation of HIV Resources

Ensuring that strategic investments are optimally allocated and that investments are fully executed within the health sector will maximize health outcomes.

Related COP19 Minimum Requirements: Evidence of resource commitments by host governments with year after year increases.

Summary of COP19 Above-Site Investments (Strategic Allocation of HIV Resources)	Expected Outcome
<ul style="list-style-type: none"> PEPFAR SA will provide technical assistance at national, provincial and district levels in the development of business cases to increase domestic investment and ensure budgetary execution specific to HIV programming. Investments will include support to the development of GoSA bi-annual budget estimates and provincial allocation formulas for HIV/TB Conditional Grants to ensure appropriate alignment with NDoH and PEPFAR strategic priorities. At the district level (new to COP19), PEPFAR SA will ensure that procurements are executed for equipment and supplies required for HIV care and treatment. 	<p>The GoSA will leverage domestic resources to more strategically invest to maximize HIV-related health outcomes at national, provincial, and district levels.</p>

Key Systems Barrier 5: Utilization of Civil Society Resources

Civil society, and in particular organizations of PLHIV, bring valuable and complementary skills to supporting effective HIV programs; there are opportunities to increase participation of civil society in public health sector support and accountability structures.

Summary of COP19 Above-Site Investments (Civil Society)	Expected Outcomes
<ul style="list-style-type: none"> Strengthen key population sector coordination, key population cascade completion and M&E plans for relevant national plans. 	<p>A more engaged, coordinated, and capacitated civil society will hold the public health sector accountable to the needs of their constituents.</p> <p>Relevant key population national plans are evaluated, accompanied by implementation and monitoring and evaluation plans and effectively rolled out to Implementing Partners and DoH.</p>

Key Systems Barrier 6: Drugs and Commodities Planning

Improving integration and triangulation of programmatic data and supply data will better inform planning for drugs and commodities.

Related COP19 Minimum Requirements: Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens.

Summary of COP19 Above-Site Investments (Drugs and Commodities Planning)	Expected Outcome
<ul style="list-style-type: none"> • COP19 funds will support the maintenance of the central selection and contracting framework for medical supplies, and its incorporation into the NDoH's Stock Visibility and Analytics Network blueprint. • COP19 funds will support demand and supply planning as part of the TLD supply chain transition and TLD roll out. • Procure TLD, PrEP, and TPT to support the program. Whenever possible, existing government systems for procurement will be supported and utilized. 	<p>Routine integration and triangulation of Supply Chain National Surveillance Centre and program data implemented for all PEPFAR supported sites.</p> <p>100% of eligible and willing patients transitioned to TLD.</p> <p>NVP has been removed for all persons >4 weeks and >3 kg.</p> <p>95% availability of Master Procurement Catalogue items at healthcare facilities.</p>

Key Systems Barrier 7: Utilization of the Private Sector

Evidence demonstrates a comparative advantage of the private sector in serving hard-to-reach populations in South Africa; there are opportunities to optimize the private sector in the HIV response.

Summary of COP19 Above-Site Investments (Utilization of the Private Sector)	Expected Outcome
<ul style="list-style-type: none"> • Train and accredit private sector nurses in NIMART, enabling them to counsel, test, initiate, and manage ART clients in retail and community pharmacies. Support proposals to expand the pharmacist scope of practice to include ART initiation and management. • Install containerized service delivery and pick-up-points (PUP) where distance poses as a challenge to retention. 	<p>A better integrated private-public health system will result in greater accessibility and population coverage of HIV services.</p> <p>Expanded scope of practice for pharmacists, enabling them to initiate and manage ART. Increased case finding and ART initiation in private sector.</p> <p>25 container PUPs installed where distance poses a challenge to retention. Loss to follow-up rates reduced by 30% among patients using container PUPs.</p>

7.0 Staffing Plan

Staffing Optimization Update

PEPFAR South Africa implementing agencies completed a formal “staffing optimization” exercise in 2017 to ensure that all USG agencies implementing PEPFAR SA programs are staffed for efficiency and success, a process outlined in the COP18 Strategic Direction Summary. The exercise has guided staffing operations, including the interagency organizational structure, to balance interagency business process coverage, technical roles and intra-agency partner management. Of note during COP18:

- PEPFAR SA interagency staff continued in specific roles through Core Interagency Teams. These teams cover program areas and critical targeted populations, including AGYW and men.
- Interagency staff served as provincial points of contact to coordinate the monitoring, support and trouble-shooting at provincial level to improve district- and facility-level outcomes.
- Both USAID and CDC aligned staff to meet intensified site and partner management goals, described in more detail below. The Technical Working Groups will also be a key piece of this process.

For COP19, S/GAC is providing an additional \$3 million (\$1.5 million each for CDC and USAID) to hire term-limited positions in support of the Phuthuma/Siyenza HIV treatment acceleration initiatives.

Staff Alignment for Intensified Site and Partner Management

In Q2 FY 2019, PEPFAR South Africa shifted operational and programmatic activities substantially to a model of intensive site-level management, known as the February Frenzy/Blitz, and later as *Siyenza*. From February through April, implementing agencies deployed staff to prioritized clinical sites, accompanied by District Support Partners and NDoH, to provide direct technical assistance for immediate program improvement. A supportive cadre of Headquarters-based TDY staff from USAID, CDC, Peace Corps and State Department was added to the intervention in March. Though agencies recognize *Siyenza*’s substantial demand on staff level of effort, they agreed that adding significant numbers of new staff would not be optimal for cost and efficiency reasons. Agencies identified some misalignment in staff with the “new normal” of *Siyenza* site visits, and shifted resources internally to address these deficiencies. For example, the PEPFAR Coordination Office (PCO) aligned its staff by focusing the PCO Strategic Information (SI) Lead on *Siyenza* data collation efforts and Provincial Liaisons on *Siyenza*-related facilities. A Peace Corps Response Volunteer supported February’s Frenzy/Blitz efforts with site-level technical assistance for quality improvement of clinic filing systems. All CDC and USAID technical staff have been engaged in *Siyenza* activities.

APPENDIX A – Prioritization

Table A.1.1 Treatment Coverage in Scale-Up Districts (27 priority districts)

- a. Children less than 15 years
- b. Women 15+ years
- c. Men 15+ years

Table A.1.2 Treatment Coverage in Centrally Supported Districts (25 districts)

Table A.2 ART Targets by Prioritization for Epidemic Control

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization – Children <15 years

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization (fine age bands) - Children <15 Years [1]														
District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall								Child ART Coverage (PEPFAR) <15 Years	Adult ART Coverage (PEPFAR) 15+ Years
					Female (<15 years)*				Male (<15 years)*					
					<1 year	1-4 years	5-9 years	10-14 years	<1 year	1-4 years	5-9 years	10-14 years		
gp City of Johannesburg Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	54%				53%				54%	53%
	COP 17	Scale-Up Saturation	APR 18	reported	101%	37%		42%	100%	37%		39%	40%	54%
	COP 18	Scale-Up Saturation	FY19 Q1	reported	---	35%		36%	---	30%		33%	33%	48%
	COP 19	Scale-Up Saturation	APR 20	expected	39%	50%	50%	53%	39%	50%	50%	53%	51%	84%
gp City of Tshwane Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	49%				47%				48%	53%
	COP 17	Scale-Up Aggressive	APR 18	reported	97%	35%		35%	96%	35%		32%	35%	53%
	COP 18	Scale-Up Saturation	FY19 Q1	reported	88%	42%		46%	69%	37%		42%	43%	56%
	COP 19	Scale-Up Saturation	APR 20	expected	43%	67%	66%	69%	42%	67%	66%	69%	50%	84%
gp Ekurhuleni Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	43%				42%				43%	47%
	COP 17	Scale-Up Saturation	APR 18	reported	73%	41%		44%	72%	41%		39%	42%	54%
	COP 18	Scale-Up Saturation	FY19 Q1	reported	66%	36%		39%	49%	32%		36%	36%	48%
	COP 19	Scale-Up Saturation	APR 20	expected	38%	53%	53%	56%	37%	53%	53%	55%	54%	82%
kz eThekweni Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	72%				60%				66%	56%
	COP 17	Scale-Up Saturation	APR 18	reported	69%	54%		53%	67%	53%		48%	52%	60%
	COP 18	Scale-Up Saturation	FY19 Q1	reported	118%	49%		51%	79%	45%		46%	48%	57%
	COP 19	Scale-Up Saturation	APR 20	expected	59%	63%	63%	66%	57%	63%	63%	66%	64%	86%
ec Alfred Nzo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	38%				35%				37%	50%
	COP 17	Scale-Up Aggressive	APR 18	reported	137%	40%		40%	137%	40%		35%	40%	60%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	88%	35%		34%	70%	32%		30%	33%	53%
	COP 19	Scale-Up Aggressive	APR 20	expected	30%	50%	50%	52%	30%	50%	50%	52%	51%	80%
ec Amathole District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	54%				50%				52%	54%
	COP 17	Scale-Up Aggressive	APR 18	reported	1124%	78%		30%	1081%	76%		22%	60%	63%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	1080%	72%		27%	877%	67%		19%	54%	55%
	COP 19	Scale-Up Aggressive	APR 20	expected	52%	69%	69%	73%	50%	69%	69%	73%	71%	84%
ec Buffalo City Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	107%				103%				105%	47%
	COP 17	Scale-Up Aggressive	APR 18	reported	213%	30%		25%	204%	30%		24%	29%	37%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	78%	37%		43%	54%	30%		39%	37%	40%
	COP 19	Scale-Up Aggressive	APR 20	expected	48%	78%	77%	80%	46%	77%	77%	80%	48%	68%
ec Chris Hani District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	48%				30%				39%	53%
	COP 17	Scale-Up Aggressive	APR 18	reported	39%	17%		51%	38%	16%		38%	31%	57%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	57%	108%	0%	35%	24%	100%	0%	33%	33%	55%
	COP 19	Scale-Up Aggressive	APR 20	expected	39%	47%	46%	49%	38%	46%	47%	49%	43%	85%
ec Oliver Tambo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	38%				24%				31%	50%
	COP 17	Scale-Up Aggressive	APR 18	reported	167%	32%		38%	165%	32%		30%	34%	60%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	77%	28%		32%	39%	23%		26%	27%	51%
	COP 19	Scale-Up Aggressive	APR 20	expected	35%	46%	46%	49%	35%	46%	46%	49%	48%	82%

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization – Children <15 years

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization (fine age bands) - Children <15 Years (continued) [1]															
District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall								Child ART Coverage (PEPFAR) <15 Years	Adult ART Coverage (PEPFAR) 15+ Years	
					Female (<15 years)*				Male (<15 years)*						
					<1 year	1-4 years	5-9 years	10-14 years	<1 year	1-4 years	5-9 years	10-14 years			
fs Lejweleputswa District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	78%				40%				59%	51%	
	COP 17	Scale-Up Aggressive	APR 18	reported	---	55%			67%	---	56%		63%	60%	59%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	104%	45%			60%	72%	46%		59%	53%	53%
	COP 19	Scale-Up Aggressive	APR 20	expected	44%	69%	69%	72%	44%	69%	69%	72%	70%	83%	
fs Thabo Mofutsanyane District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	49%				97%				73%	56%	
	COP 17	Scale-Up Aggressive	APR 18	reported	53%	46%			51%	53%	46%		49%	48%	64%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	68%	41%			49%	35%	41%		45%	44%	59%
	COP 19	Scale-Up Aggressive	APR 20	expected	45%	58%	58%	61%	45%	58%	58%	61%	59%	84%	
gp Sedibeng District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	52%				48%				50%	56%	
	COP 17	Scale-Up Aggressive	APR 18	reported	62%	50%			50%	60%	48%		48%	49%	63%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	---	38%			49%	---	36%		44%	41%	61%
	COP 19	Scale-Up Aggressive	APR 20	expected	32%	60%	60%	63%	31%	60%	60%	63%	61%	85%	
kz Harry Gwala District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	43%				42%				42%	55%	
	COP 17	Scale-Up Aggressive	APR 18	reported	100%	48%			46%	96%	48%		41%	46%	66%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	77%	45%			42%	30%	44%		38%	42%	63%
	COP 19	Scale-Up Aggressive	APR 20	expected	46%	56%	56%	58%	44%	56%	56%	58%	57%	86%	
kz King Cetshwayo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	44%				39%				42%	54%	
	COP 17	Scale-Up Aggressive	APR 18	reported	119%	46%			42%	117%	47%		40%	44%	62%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	104%	44%			40%	79%	38%		37%	40%	59%
	COP 19	Scale-Up Aggressive	APR 20	expected	38%	56%	55%	58%	38%	55%	55%	58%	57%	82%	
kz Ugu District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	55%				52%				54%	66%	
	COP 17	Scale-Up Aggressive	APR 18	reported	84%	54%			55%	84%	55%		58%	56%	74%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	116%	50%			52%	72%	47%		53%	51%	71%
	COP 19	Scale-Up Aggressive	APR 20	expected	44%	65%	65%	68%	44%	65%	65%	68%	66%	92%	
kz uMgungundlovu District Municipality	COP 16	Scale-Up Saturation	APR 17	reported	44%				34%				39%	47%	
	COP 17	Scale-Up Saturation	APR 18	reported	98%	35%			36%	98%	35%		41%	38%	56%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	65%	42%			45%	52%	35%		44%	42%	53%
	COP 19	Scale-Up Aggressive	APR 20	expected	42%	55%	55%	57%	42%	55%	55%	57%	53%	82%	
kz Uthukela District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	51%				32%				41%	52%	
	COP 17	Scale-Up Aggressive	APR 18	reported	103%	47%			41%	100%	47%		35%	43%	62%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	89%	41%			39%	53%	36%		33%	37%	58%
	COP 19	Scale-Up Aggressive	APR 20	expected	34%	54%	54%	57%	33%	54%	54%	56%	55%	85%	
kz Zululand District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	54%				32%				43%	64%	
	COP 17	Scale-Up Aggressive	APR 18	reported	109%	46%			43%	106%	45%		41%	44%	65%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	80%	43%			39%	66%	39%		37%	40%	59%
	COP 19	Scale-Up Aggressive	APR 20	expected	41%	55%	55%	58%	40%	56%	56%	58%	57%	86%	

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization – Children <15 years

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization (fine age bands) - Children <15 Years (continued) [1]														
District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall									
					Female (<15 years)*				Male (<15 years)*				Child ART Coverage (PEPFAR) <15 Years	Adult ART Coverage (PEPFAR) 15+ Years
					<1 year	1-4 years	5-9 years	10-14 years	<1 year	1-4 years	5-9 years	10-14 years		
lp Capricorn District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	52%				50%				51%	56%
	COP 17	Scale-Up Aggressive	APR 18	reported	88%	51%		50%	88%	51%		49%	51%	59%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	---	41%		43%	---	36%		42%	40%	55%
	COP 19	Scale-Up Aggressive	APR 20	expected	50%	61%	61%	64%	50%	61%	61%	64%	63%	81%
lp Mopani District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	56%				55%				56%	59%
	COP 17	Scale-Up Aggressive	APR 18	reported	127%	56%		58%	124%	56%		56%	57%	65%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	---	43%		51%	---	38%		50%	45%	57%
	COP 19	Scale-Up Aggressive	APR 20	expected	39%	66%	66%	69%	38%	66%	66%	69%	67%	87%
mp Ehlanzeni District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	52%				53%				53%	60%
	COP 17	Scale-Up Aggressive	APR 18	reported	120%	46%		54%	127%	46%		54%	51%	66%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	115%	45%		53%	72%	40%		52%	48%	63%
	COP 19	Scale-Up Aggressive	APR 20	expected	42%	61%	61%	64%	41%	61%	61%	64%	62%	87%
mp Gert Sibande District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	36%				35%				35%	42%
	COP 17	Scale-Up Aggressive	APR 18	reported	66%	34%		41%	66%	34%		41%	38%	50%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	61%	32%		41%	58%	30%		40%	36%	49%
	COP 19	Scale-Up Aggressive	APR 20	expected	35%	52%	52%	55%	35%	52%	52%	55%	53%	77%
mp Nkangala District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	45%				44%				44%	49%
	COP 17	Scale-Up Aggressive	APR 18	reported	106%	31%		31%	104%	31%		28%	31%	42%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	80%	33%		42%	63%	28%		39%	36%	45%
	COP 19	Scale-Up Aggressive	APR 20	expected	42%	48%	48%	50%	41%	48%	48%	50%	44%	72%
nw Bojanala Platinum District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	46%				43%				44%	45%
	COP 17	Scale-Up Aggressive	APR 18	reported	76%	39%		49%	74%	39%		46%	44%	51%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	84%	37%		47%	62%	36%		44%	41%	49%
	COP 19	Scale-Up Aggressive	APR 20	expected	46%	55%	55%	58%	45%	55%	55%	58%	56%	75%
nw Dr Kenneth Kaunda District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	161%				131%				147%	70%
	COP 17	Scale-Up Aggressive	APR 18	reported	53%	33%		42%	52%	33%		36%	36%	51%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	56%	28%		33%	48%	27%		29%	30%	46%
	COP 19	Scale-Up Aggressive	APR 20	expected	34%	50%	50%	52%	33%	49%	50%	52%	51%	79%
nw Ngaka Modiri Molema District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	42%				43%				42%	47%
	COP 17	Scale-Up Aggressive	APR 18	reported	56%	42%		42%	55%	43%		42%	43%	52%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	71%	40%		41%	48%	38%		40%	40%	50%
	COP 19	Scale-Up Aggressive	APR 20	expected	29%	54%	53%	56%	29%	54%	53%	56%	55%	80%
wc City of Cape Town Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	62%				41%				51%	52%
	COP 17	Scale-Up Aggressive	APR 18	reported	116%	40%		64%	113%	39%		50%	48%	60%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	103%	41%		55%	42%	33%		46%	43%	57%
	COP 19	Scale-Up Aggressive	APR 20	expected	43%	67%	67%	69%	42%	67%	67%	69%	58%	81%

[1] Source for PLHIV estimates by age, sex, and district: Eaton, J & Johnson, L. Personal communication – District-level modeling of South Africa Prevalence by Age and Sex. (Datapack) Source for number of PLHIV on ART by age, sex, and district: PEPFAR reported data (from TIER.Net) for reported data and PEPFAR targets (from datapack) for expected data.

*Assumes half of <15 with unknown sex are male and half are female.

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization – Women 15+ Years

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization (fine age bands) - Women 15+ Years [1]															
District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall									Female ART Coverage (PEPFAR) 15+ Years	Overall ART Coverage (PEPFAR) All Ages
					Female (15+ years)								50+ years		
					15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years				
gp City of Johannesburg Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	55%								55%	53%	
	COP 17	Scale-Up Saturation	APR 18	reported	33%	45%	49%	54%	60%	64%	59%	57%	54%		
	COP 18	Scale-Up Saturation	FY19 Q1	reported	26%	27%	34%	43%	54%	63%	63%	50%	48%		
	COP 19	Scale-Up Saturation	APR 20	expected	72%	72%	75%	75%	94%	94%	94%	93%	86%	83%	
gp City of Tshwane Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	49%								49%	52%	
	COP 17	Scale-Up Aggressive	APR 18	reported	37%	48%	49%	51%	58%	64%	59%	56%	52%		
	COP 18	Scale-Up Saturation	FY19 Q1	reported	39%	44%	45%	50%	63%	72%	69%	59%	55%		
	COP 19	Scale-Up Saturation	APR 20	expected	79%	79%	75%	75%	92%	92%	92%	91%	85%	83%	
gp Ekurhuleni Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	52%								52%	47%	
	COP 17	Scale-Up Saturation	APR 18	reported	37%	49%	54%	60%	66%	65%	55%	59%	54%		
	COP 18	Scale-Up Saturation	FY19 Q1	reported	30%	38%	44%	51%	60%	60%	51%	52%	48%		
	COP 19	Scale-Up Saturation	APR 20	expected	80%	80%	73%	73%	90%	90%	90%	89%	81%		
kz eThekweni Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	60%								60%	56%	
	COP 17	Scale-Up Saturation	APR 18	reported	50%	66%	75%	73%	71%	65%	59%	68%	60%		
	COP 18	Scale-Up Saturation	FY19 Q1	reported	41%	58%	66%	67%	66%	61%	55%	62%	57%		
	COP 19	Scale-Up Saturation	APR 20	expected	84%	84%	82%	82%	97%	97%	97%	96%	89%	86%	
ec Alfred Nzo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	52%								52%	49%	
	COP 17	Scale-Up Aggressive	APR 18	reported	28%	44%	49%	60%	73%	81%	74%	62%	59%		
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	26%	38%	42%	52%	62%	70%	65%	54%	51%		
	COP 19	Scale-Up Aggressive	APR 20	expected	70%	70%	78%	78%	92%	92%	92%	92%	82%	78%	
ec Amathole District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	62%								62%	54%	
	COP 17	Scale-Up Aggressive	APR 18	reported	71%	107%	94%	76%	82%	67%	38%	72%	63%		
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	58%	92%	83%	68%	67%	61%	35%	63%	55%		
	COP 19	Scale-Up Aggressive	APR 20	expected	109%	109%	77%	77%	91%	91%	91%	91%	89%	83%	
ec Buffalo City Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	44%								44%	49%	
	COP 17	Scale-Up Aggressive	APR 18	reported	28%	48%	55%	47%	46%	40%	32%	42%	37%		
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	25%	36%	43%	45%	50%	51%	44%	46%	39%		
	COP 19	Scale-Up Aggressive	APR 20	expected	73%	73%	74%	74%	93%	93%	93%	93%	74%	67%	
ec Chris Hani District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	34%								34%	52%	
	COP 17	Scale-Up Aggressive	APR 18	reported	52%	71%	66%	64%	71%	50%	30%	55%	56%		
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	28%	47%	55%	59%	70%	141%	0%	61%	62%	54%	
	COP 19	Scale-Up Aggressive	APR 20	expected	85%	85%	80%	80%	96%	96%	96%	96%	83%	82%	
ec Oliver Tambo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	31%								31%	49%	
	COP 17	Scale-Up Aggressive	APR 18	reported	46%	65%	64%	68%	74%	71%	58%	66%	58%		
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	25%	44%	50%	59%	67%	72%	59%	58%	50%		
	COP 19	Scale-Up Aggressive	APR 20	expected	85%	85%	78%	78%	92%	92%	92%	92%	84%	80%	

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization – Women 15+ Years

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization (fine age bands) - Women 15+ Years (continued) [1]														
District	COP	Prioritization	Results Reported	Coverage: Reported / Expected	Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall								Female ART Coverage (PEPFAR) 15+ Years	Overall ART Coverage (PEPFAR) All Ages
					Female (15+ years)									
					15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years	50+ years		
fs Lejweleputswa District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	54%								54%	51%
	COP 17	Scale-Up Aggressive	APR 18	reported	43%	57%	70%	74%	77%	76%		52%	67%	59%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	37%	49%	61%	65%	71%	65%		55%	61%	53%
	COP 19	Scale-Up Aggressive	APR 20	expected	82%	82%	77%	77%	91%	91%	91%	91%	86%	82%
fs Thabo Mofutsanyane District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	50%								50%	57%
	COP 17	Scale-Up Aggressive	APR 18	reported	43%	53%	64%	68%	76%	80%		57%	67%	63%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	38%	47%	58%	63%	71%	76%		55%	62%	59%
	COP 19	Scale-Up Aggressive	APR 20	expected	81%	81%	78%	78%	92%	92%	92%	91%	86%	83%
gp Sedibeng District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	60%								60%	55%
	COP 17	Scale-Up Aggressive	APR 18	reported	45%	50%	57%	64%	79%	82%		64%	68%	63%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	34%	35%	44%	57%	75%	85%		72%	65%	60%
	COP 19	Scale-Up Aggressive	APR 20	expected	79%	79%	78%	78%	94%	94%	94%	93%	87%	84%
kz Harry Gwala District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	53%								53%	54%
	COP 17	Scale-Up Aggressive	APR 18	reported	39%	58%	64%	70%	75%	79%		69%	69%	64%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	36%	51%	59%	66%	73%	78%		72%	66%	62%
	COP 19	Scale-Up Aggressive	APR 20	expected	81%	81%	84%	84%	96%	96%	96%	96%	89%	84%
kz King Cetshwayo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	56%								56%	53%
	COP 17	Scale-Up Aggressive	APR 18	reported	34%	55%	66%	70%	70%	68%		65%	65%	61%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	31%	49%	60%	66%	69%	66%		65%	62%	58%
	COP 19	Scale-Up Aggressive	APR 20	expected	83%	83%	90%	90%	101%	101%	101%	100%	84%	81%
kz Ugu District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	70%								70%	65%
	COP 17	Scale-Up Aggressive	APR 18	reported	49%	71%	82%	94%	93%	82%		59%	78%	73%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	44%	65%	78%	90%	93%	80%		59%	76%	70%
	COP 19	Scale-Up Aggressive	APR 20	expected	84%	84%	90%	90%	102%	102%	102%	101%	96%	90%
kz uMgungundlovu District Municipality	COP 16	Scale-Up Saturation	APR 17	reported	43%								43%	47%
	COP 17	Scale-Up Saturation	APR 18	reported	44%	55%	57%	63%	60%	54%		50%	56%	56%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	35%	43%	50%	56%	59%	62%		57%	55%	53%
	COP 19	Scale-Up Aggressive	APR 20	expected	80%	80%	81%	81%	94%	94%	94%	93%	82%	81%
kz Uthukela District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	33%								33%	52%
	COP 17	Scale-Up Aggressive	APR 18	reported	33%	52%	68%	77%	80%	69%		61%	67%	61%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	30%	47%	63%	72%	74%	67%		62%	64%	57%
	COP 19	Scale-Up Aggressive	APR 20	expected	80%	80%	86%	86%	98%	98%	98%	97%	87%	83%
kz Zululand District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	60%								60%	63%
	COP 17	Scale-Up Aggressive	APR 18	reported	35%	55%	69%	76%	77%	75%		67%	69%	64%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	30%	45%	59%	68%	71%	70%		63%	62%	58%
	COP 19	Scale-Up Aggressive	APR 20	expected	79%	79%	84%	84%	98%	98%	98%	97%	90%	84%

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization – Women 15+ Years

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization (fine age bands) - Women 15+ Years (continued) [1]														
District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall								Female ART Coverage (PEPFAR) 15+ Years	Overall ART Coverage (PEPFAR) All Ages
					Female (15+ years)									
					15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years	50+ years		
lp Capricorn District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	49%								49%	56%
	COP 17	Scale-Up Aggressive	APR 18	reported	30%	40%	49%	58%	68%	73%	81%	64%	59%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	26%	29%	39%	51%	64%	72%	84%	60%	54%	
	COP 19	Scale-Up Aggressive	APR 20	expected	69%	69%	74%	74%	90%	90%	90%	89%	80%	
lp Mopani District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	64%								64%	59%
	COP 17	Scale-Up Aggressive	APR 18	reported	37%	37%	45%	59%	71%	81%	107%	70%	64%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	29%	26%	33%	47%	62%	75%	103%	62%	56%	
	COP 19	Scale-Up Aggressive	APR 20	expected	70%	70%	83%	83%	98%	98%	98%	97%	86%	
mp Ehlanzeni District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	56%								56%	60%
	COP 17	Scale-Up Aggressive	APR 18	reported	36%	48%	59%	72%	78%	77%	99%	72%	65%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	33%	43%	55%	69%	76%	75%	98%	69%	62%	
	COP 19	Scale-Up Aggressive	APR 20	expected	74%	74%	83%	83%	98%	98%	98%	90%	85%	
mp Gert Sibande District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	47%								47%	42%
	COP 17	Scale-Up Aggressive	APR 18	reported	33%	49%	55%	55%	56%	58%	67%	56%	49%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	30%	46%	52%	54%	57%	58%	68%	55%	49%	
	COP 19	Scale-Up Aggressive	APR 20	expected	74%	74%	81%	81%	94%	94%	94%	93%	76%	
mp Nkangala District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	49%								49%	49%
	COP 17	Scale-Up Aggressive	APR 18	reported	30%	40%	50%	42%	48%	48%	61%	47%	41%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	27%	36%	44%	46%	52%	58%	77%	52%	45%	
	COP 19	Scale-Up Aggressive	APR 20	expected	69%	69%	71%	71%	89%	89%	89%	88%	71%	
nw Bojanala Platinum District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	54%								54%	45%
	COP 17	Scale-Up Aggressive	APR 18	reported	38%	50%	55%	57%	63%	64%	64%	60%	50%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	35%	45%	50%	54%	61%	63%	64%	57%	48%	
	COP 19	Scale-Up Aggressive	APR 20	expected	78%	78%	70%	70%	86%	86%	86%	86%	74%	
nw Dr Kenneth Kaunda District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	74%								74%	73%
	COP 17	Scale-Up Aggressive	APR 18	reported	36%	43%	49%	51%	59%	62%	64%	56%	51%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	30%	35%	39%	45%	52%	57%	62%	50%	45%	
	COP 19	Scale-Up Aggressive	APR 20	expected	68%	68%	71%	71%	90%	90%	90%	89%	78%	
nw Ngaka Modiri Molema District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	51%								51%	47%
	COP 17	Scale-Up Aggressive	APR 18	reported	36%	43%	48%	52%	62%	68%	62%	57%	52%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	32%	38%	43%	48%	59%	66%	61%	54%	49%	
	COP 19	Scale-Up Aggressive	APR 20	expected	68%	68%	71%	71%	93%	93%	93%	92%	79%	
wc City of Cape Town Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	49%								49%	52%
	COP 17	Scale-Up Aggressive	APR 18	reported	41%	53%	57%	63%	70%	70%	69%	65%	60%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	40%	52%	56%	59%	65%	64%	61%	60%	56%	
	COP 19	Scale-Up Aggressive	APR 20	expected	80%	80%	74%	74%	89%	89%	89%	89%	80%	

[1] Source for PLHIV estimates by age, sex, and district: Eaton, J & Johnson, L. Personal communication – District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)
 Source for number of PLHIV on ART by age, sex, and district: PEPFAR reported data (from TIER.Net) for reported data and PEPFAR targets (from datapack) for expected data.

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization – Men 15+ Years

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization (fine age bands) - Men 15+ Years [1]																
District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall										Male ART Coverage (PEPFAR) 15+ Years	Overall ART Coverage (PEPFAR) All Ages
					Male (15+ years)								Male ART Coverage (PEPFAR) 15+ Years	Overall ART Coverage (PEPFAR) All Ages		
					15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years	50+ years				
gp City of Johannesburg Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	50%								50%	53%		
	COP 17	Scale-Up Saturation	APR 18	reported	38%	26%	28%	44%	44%	61%	59%	50%	54%			
	COP 18	Scale-Up Saturation	FY19 Q1	reported	38%	20%	19%	32%	38%	57%	63%	45%	48%			
	COP 19	Scale-Up Saturation	APR 20	expected	63%	63%	53%	53%	84%	84%	84%	115%	81%	83%		
gp City of Tshwane Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	59%								59%	52%		
	COP 17	Scale-Up Aggressive	APR 18	reported	35%	25%	29%	40%	43%	61%	56%	48%	52%			
	COP 18	Scale-Up Saturation	FY19 Q1	reported	45%	25%	26%	37%	42%	64%	62%	50%	55%			
	COP 19	Scale-Up Saturation	APR 20	expected	67%	67%	56%	56%	85%	85%	85%	114%	82%	83%		
gp Ekurhuleni Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	41%								41%	47%		
	COP 17	Scale-Up Saturation	APR 18	reported	37%	21%	26%	42%	45%	59%	51%	47%	54%			
	COP 18	Scale-Up Saturation	FY19 Q1	reported	32%	17%	21%	35%	39%	53%	48%	42%	48%			
	COP 19	Scale-Up Saturation	APR 20	expected	66%	66%	54%	54%	83%	83%	83%	111%	80%	81%		
kz eThekweni Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	50%								50%	56%		
	COP 17	Scale-Up Saturation	APR 18	reported	52%	25%	35%	56%	56%	65%	16%	48%	60%			
	COP 18	Scale-Up Saturation	FY19 Q1	reported	46%	23%	31%	50%	50%	59%	51%	49%	57%			
	COP 19	Scale-Up Saturation	APR 20	expected	76%	76%	61%	61%	88%	88%	88%	110%	82%	86%		
ec Alfred Nzo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	45%								45%	49%		
	COP 17	Scale-Up Aggressive	APR 18	reported	28%	11%	18%	41%	59%	90%	106%	54%	59%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	30%	20%	19%	35%	50%	78%	94%	49%	51%			
	COP 19	Scale-Up Aggressive	APR 20	expected	83%	83%	62%	62%	89%	89%	89%	112%	75%	78%		
ec Amathole District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	41%								41%	54%		
	COP 17	Scale-Up Aggressive	APR 18	reported	13%	20%	31%	47%	45%	62%	62%	47%	63%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	12%	16%	26%	40%	39%	55%	57%	41%	55%			
	COP 19	Scale-Up Aggressive	APR 20	expected	82%	82%	58%	58%	84%	84%	84%	106%	75%	83%		
ec Buffalo City Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	52%								52%	49%		
	COP 17	Scale-Up Aggressive	APR 18	reported	22%	12%	19%	24%	27%	34%	32%	28%	37%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	35%	12%	14%	21%	24%	37%	43%	29%	39%			
	COP 19	Scale-Up Aggressive	APR 20	expected	63%	63%	46%	46%	73%	73%	73%	99%	56%	67%		
ec Chris Hanu District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	88%								88%	52%		
	COP 17	Scale-Up Aggressive	APR 18	reported	74%	84%	67%	68%	67%	56%	44%	62%	56%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	32%	12%	14%	26%	36%	110%	0%	82%	43%	54%		
	COP 19	Scale-Up Aggressive	APR 20	expected	93%	93%	62%	62%	91%	91%	91%	118%	87%	82%		
ec Oliver Tambo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	91%								91%	49%		
	COP 17	Scale-Up Aggressive	APR 18	reported	33%	25%	30%	40%	46%	65%	91%	49%	58%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	19%	9%	16%	28%	35%	58%	88%	38%	50%			
	COP 19	Scale-Up Aggressive	APR 20	expected	77%	77%	62%	62%	90%	90%	90%	113%	78%	80%		

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization – Men 15+ Years

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization (fine age bands) - Men 15+ Years (continued) [1]																
District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall									Male ART Coverage (PEPFAR) 15+ Years	Overall ART Coverage (PEPFAR) All Ages	
					Male (15+ years)								15+ years			15+ Years
					15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years	50+ years				
fs Lejweleputswa District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	45%								45%	51%		
	COP 17	Scale-Up Aggressive	APR 18	reported	46%	19%	24%	40%	44%	61%	48%	45%	59%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	40%	16%	21%	35%	37%	51%	48%	41%	53%			
	COP 19	Scale-Up Aggressive	APR 20	expected	70%	70%	56%	56%	82%	82%	82%	104%	77%	82%		
fs Thabo Mofutsanyane District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	70%								70%	57%		
	COP 17	Scale-Up Aggressive	APR 18	reported	42%	19%	30%	46%	54%	81%	79%	58%	63%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	38%	17%	27%	42%	50%	75%	74%	54%	59%			
	COP 19	Scale-Up Aggressive	APR 20	expected	77%	77%	59%	59%	85%	85%	85%	107%	79%	83%		
gp Sedibeng District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	49%								49%	55%		
	COP 17	Scale-Up Aggressive	APR 18	reported	49%	34%	32%	45%	51%	73%	61%	56%	63%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	49%	28%	24%	36%	44%	71%	68%	53%	60%			
	COP 19	Scale-Up Aggressive	APR 20	expected	70%	70%	56%	56%	83%	83%	83%	107%	81%	84%		
kz Harry Gwala District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	59%								59%	54%		
	COP 17	Scale-Up Aggressive	APR 18	reported	34%	17%	30%	55%	63%	84%	88%	59%	64%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	32%	16%	26%	50%	61%	80%	90%	56%	62%			
	COP 19	Scale-Up Aggressive	APR 20	expected	86%	86%	66%	66%	92%	92%	92%	112%	80%	84%		
kz King Cetshwayo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	50%								50%	53%		
	COP 17	Scale-Up Aggressive	APR 18	reported	36%	22%	30%	56%	61%	73%	72%	56%	61%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	34%	18%	27%	51%	58%	72%	71%	53%	58%			
	COP 19	Scale-Up Aggressive	APR 20	expected	96%	96%	66%	66%	87%	87%	87%	102%	77%	81%		
kz Ugu District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	58%								58%	65%		
	COP 17	Scale-Up Aggressive	APR 18	reported	42%	26%	41%	73%	73%	82%	66%	64%	73%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	38%	23%	36%	66%	69%	78%	65%	61%	70%			
	COP 19	Scale-Up Aggressive	APR 20	expected	85%	85%	67%	67%	91%	91%	91%	109%	84%	90%		
kz uMgungundlovu District Municipality	COP 16	Scale-Up Saturation	APR 17	reported	55%								55%	47%		
	COP 17	Scale-Up Saturation	APR 18	reported	49%	34%	40%	69%	61%	62%	54%	57%	56%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	44%	23%	29%	48%	53%	63%	57%	50%	53%			
	COP 19	Scale-Up Aggressive	APR 20	expected	71%	71%	63%	63%	89%	89%	89%	110%	83%	81%		
kz Uthukela District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	90%								90%	52%		
	COP 17	Scale-Up Aggressive	APR 18	reported	32%	20%	31%	52%	58%	71%	69%	54%	61%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	31%	16%	25%	43%	50%	66%	66%	48%	57%			
	COP 19	Scale-Up Aggressive	APR 20	expected	89%	88%	65%	65%	89%	89%	89%	107%	79%	83%		
kz Zululand District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	73%								73%	63%		
	COP 17	Scale-Up Aggressive	APR 18	reported	33%	17%	27%	51%	59%	86%	91%	57%	64%			
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	31%	15%	21%	44%	52%	78%	86%	52%	58%			
	COP 19	Scale-Up Aggressive	APR 20	expected	81%	81%	64%	64%	90%	90%	90%	112%	79%	84%		

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization – Men 15+ Years

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization (fine age bands) - Men 15+ Years (continued) [1]															
District	COP	Prioritization	Results Reported	Coverage: Reported/Expected	Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall									Male ART Coverage (PEPFAR) 15+ Years	Overall ART Coverage (PEPFAR) All Ages
					Male (15+ years)										
					15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years	50+ years			
lp Capricorn District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	73%									73%	56%
	COP 17	Scale-Up Aggressive	APR 18	reported	35%	13%	13%	28%	34%	69%		94%	49%	59%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	38%	13%	9%	21%	28%	65%		97%	45%	54%	
	COP 19	Scale-Up Aggressive	APR 20	expected	67%	67%	56%	56%	85%	85%	85%	111%	78%	80%	
lp Mopani District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	48%									48%	59%
	COP 17	Scale-Up Aggressive	APR 18	reported	41%	13%	12%	24%	33%	70%		127%	53%	64%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	41%	12%	9%	17%	26%	60%		121%	46%	56%	
	COP 19	Scale-Up Aggressive	APR 20	expected	73%	73%	58%	58%	85%	85%	85%	109%	78%	86%	
mp Ehlanzeni District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	68%									68%	60%
	COP 17	Scale-Up Aggressive	APR 18	reported	41%	17%	21%	41%	48%	69%		103%	54%	65%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	39%	15%	19%	37%	45%	65%		98%	51%	62%	
	COP 19	Scale-Up Aggressive	APR 20	expected	77%	77%	61%	61%	89%	89%	89%	112%	80%	85%	
mp Gert Sibande District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	35%									35%	42%
	COP 17	Scale-Up Aggressive	APR 18	reported	32%	17%	24%	36%	38%	51%		59%	41%	49%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	31%	15%	23%	34%	38%	51%		60%	40%	49%	
	COP 19	Scale-Up Aggressive	APR 20	expected	82%	81%	62%	62%	87%	87%	87%	108%	70%	76%	
mp Nkangala District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	51%									51%	49%
	COP 17	Scale-Up Aggressive	APR 18	reported	27%	12%	20%	24%	30%	41%		51%	33%	41%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	34%	12%	15%	23%	28%	45%		62%	34%	45%	
	COP 19	Scale-Up Aggressive	APR 20	expected	65%	65%	48%	48%	75%	75%	75%	102%	62%	71%	
nw Bojanala Platinum District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	34%									34%	45%
	COP 17	Scale-Up Aggressive	APR 18	reported	41%	16%	18%	27%	31%	48%		56%	38%	50%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	39%	15%	17%	25%	29%	47%		55%	36%	48%	
	COP 19	Scale-Up Aggressive	APR 20	expected	64%	64%	47%	47%	72%	72%	73%	97%	67%	74%	
nw Dr Kenneth Kaunda District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	63%									63%	73%
	COP 17	Scale-Up Aggressive	APR 18	reported	39%	18%	24%	34%	36%	54%		58%	43%	51%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	33%	15%	19%	28%	32%	49%		55%	39%	45%	
	COP 19	Scale-Up Aggressive	APR 20	expected	58%	58%	48%	48%	77%	77%	77%	105%	74%	78%	
nw Ngaka Modiri Molema District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	40%									40%	47%
	COP 17	Scale-Up Aggressive	APR 18	reported	38%	14%	18%	30%	36%	60%		68%	44%	52%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	35%	13%	16%	28%	34%	57%		67%	42%	49%	
	COP 19	Scale-Up Aggressive	APR 20	expected	51%	51%	48%	48%	79%	79%	79%	115%	75%	79%	
wc City of Cape Town Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	57%									57%	52%
	COP 17	Scale-Up Aggressive	APR 18	reported	37%	27%	32%	46%	50%	67%		61%	53%	60%	
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	38%	31%	33%	44%	47%	62%		58%	50%	56%	
	COP 19	Scale-Up Aggressive	APR 20	expected	72%	72%	55%	55%	82%	82%	82%	106%	77%	80%	

[1] Source for PLHIV estimates by age, sex, and district: Eaton, J & Johnson, L. Personal communication – District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)
 Source for number of PLHIV on ART by age, sex, and district: PEPFAR reported data (from TIER.Net) for reported data and PEPFAR targets (from datapack) for expected data.

Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization

Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (Central Support Districts) [1]						
District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Targets by Age and Sex	Overall ART Coverage (PEPFAR)
ec Joe Gqabi District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	63%
	COP 18	Central Support	APR 19	expected	N/A: No target required	63%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
ec Nelson Mandela Bay Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	48%
	COP 18	Central Support	APR 19	expected	N/A: No target required	48%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
ec Sarah Baartman District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	48%
	COP 18	Central Support	APR 19	expected	N/A: No target required	51%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
fs Fezile Dabi District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	49%
	COP 18	Central Support	APR 19	expected	N/A: No target required	56%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
fs Mangaung Metropolitan Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	44%
	COP 18	Central Support	APR 19	expected	N/A: No target required	44%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
fs Xhariep District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	77%
	COP 18	Central Support	APR 19	expected	N/A: No target required	74%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
gp West Rand District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	47%
	COP 18	Central Support	APR 19	expected	N/A: No target required	61%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
kz Amajuba District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	58%
	COP 18	Central Support	APR 19	expected	N/A: No target required	64%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
kz iLembe District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	55%
	COP 18	Central Support	APR 19	expected	N/A: No target required	60%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
kz Umkhanyakude District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	66%
	COP 18	Central Support	APR 19	expected	N/A: No target required	77%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
kz Umzinyathi District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	70%
	COP 18	Central Support	APR 19	expected	N/A: No target required	76%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
lp Sekhukhune District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	53%
	COP 18	Central Support	APR 19	expected	N/A: No target required	59%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
lp Vhembe District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	50%
	COP 18	Central Support	APR 19	expected	N/A: No target required	53%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
lp Waterberg District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	53%
	COP 18	Central Support	APR 19	expected	N/A: No target required	58%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A

A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (continued)

District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Targets by Age and Sex	Overall ART Coverage (PEPFAR)
nc Frances Baard District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	55%
	COP 18	Central Support	APR 19	expected	N/A: No target required	60%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
nc John Taolo Gaetsewe District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	38%
	COP 18	Central Support	APR 19	expected	N/A: No target required	62%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
nc Namakwa District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	41%
	COP 18	Central Support	APR 19	expected	N/A: No target required	50%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
nc Pixley ka Seme District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	58%
	COP 18	Central Support	APR 19	expected	N/A: No target required	61%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
nc Zwelentlanga Fatman Mgcawu District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	35%
	COP 18	Central Support	APR 19	expected	N/A: No target required	44%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
nw Dr Ruth Segomotsi Mompati District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	58%
	COP 18	Central Support	APR 19	expected	N/A: No target required	62%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
wc Cape Winelands District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	52%
	COP 18	Central Support	APR 19	expected	N/A: No target required	61%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
wc Central Karoo District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	53%
	COP 18	Central Support	APR 19	expected	N/A: No target required	66%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
wc Eden District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	52%
	COP 18	Central Support	APR 19	expected	N/A: No target required	55%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
wc Overberg District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	55%
	COP 18	Central Support	APR 19	expected	N/A: No target required	57%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
wc West Coast District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	43%
	COP 18	Central Support	APR 19	expected	N/A: No target required	47%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A

[1] Source for PLHIV estimates by age, sex, and district: Eaton, J & Johnson, L. Personal communication – District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)
Source for number of PLHIV on ART by age, sex, and district: PEPFAR reported data (from TIER.Net) for reported data and PEPFAR targets (from datapack) for expected data.

Table A.2 ART Targets by Prioritization for Epidemic Control

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV [1] (Estimated at the end of FY20)	Expected current on ART (APR FY19)	Additional patients required for 80% ART coverage	Target current on ART (APR FY20) TX_CURR	Newly initiated (APR FY20) TX_NEW	ART Coverage (APR 20)
Attained	N/A	N/A	N/A	N/A	N/A	N/A
Scale-Up Saturation	2,229,630	1,455,451	328,253	1,858,331	502,898	83%
Scale-Up Aggressive	3,759,016	2,457,018	550,195	3,017,969	725,266	80%
Sustained	N/A	N/A	N/A	N/A	N/A	N/A
Central Support	1,615,136	1,085,000	207,109	1,220,000	N/A	76%
Total	7,603,782	4,997,469	1,085,557	6,096,300	1,228,164	80%

[1] Eaton, J & Johnson, L. Personal communication – District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)

APPENDIX B – Budget Profile and Resource Projections

B.1 COP19 Planned Spending

Table B.1.1 COP19 Budget by Approach and Program Area (USD) – these visuals exclude Central Funding

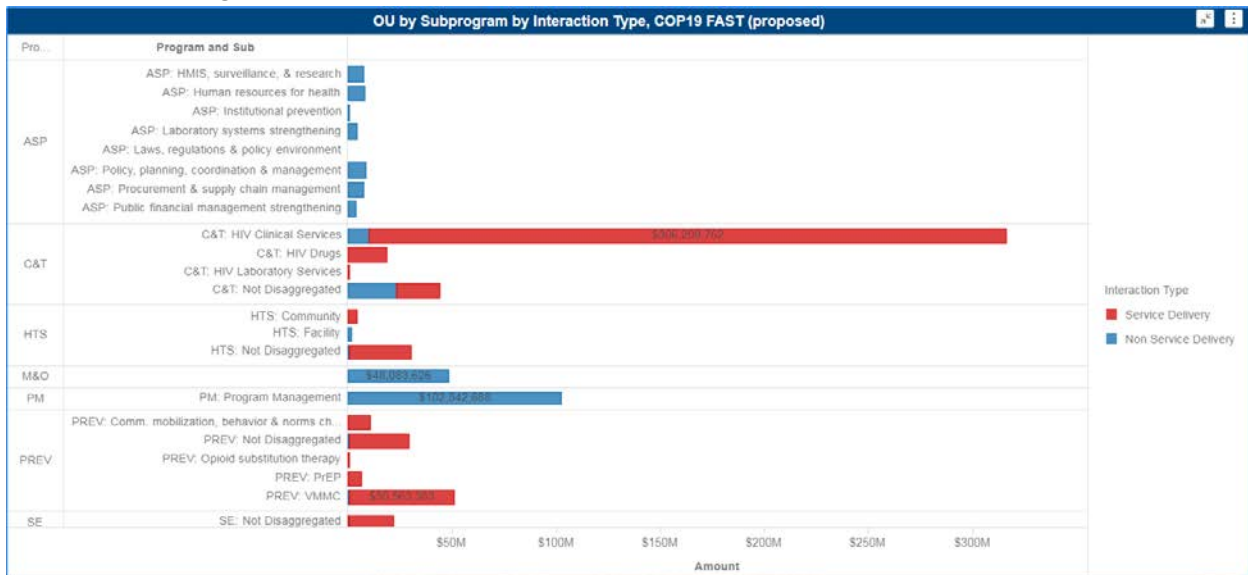


Table B.1.2 COP19 Total Planning Level (new funds only) – these visuals exclude Central Funding

Initiative Type	Fiscal Year	2020
	Funding Agency	Amount
Planning Level	DOD	\$2
	HHS/CDC	\$328,072,615
	PC	\$2,375,000
	State	\$2,691,666
	State/AF	\$1,689,057
	State/SGAC	\$29,950,002
	USAID	\$359,055,240

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only) – these visuals exclude Central Funding

Initiative Type	Fiscal Year	2020
	Budget Code	Amount
Planning Level	APPLIED PIPELINE	\$2,098,722
	CIRC	\$62,725,483
	HBHC	\$47,975,886
	HKID	\$37,828,932
	HLAB	\$5,485,948
	HTXD	\$24,871,600
	HTXS	\$311,114,950
	HVAB	\$10,476,593
	HVCT	\$48,058,037
	HVMS	\$18,586,030
	HVOP	\$37,908,598
	HVSI	\$891,533
	HVTB	\$62,282,286
	IDUP	\$562,373
	MTCT	\$8,149,597
	OHSS	\$130,259
	PDCS	\$21,886,690
PDTX	\$22,800,065	

B.2 Resource Projections

All COP19 budget planning was completed using the Funding Allocation to Strategy Tool. The resource projections used estimated service package costs, unit expenditures and budgets for site-level and above-site activities.

APPENDIX C – Tables and Systems Investments for Section 6.o

Table 6 Summary of Systems Investments, COP19

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	HUMAN SCIENCE RESEARCH COUNCIL	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 637,000	Surveillance	Epidemiology PEPFAR Minimum Requirement: Scale up of unique identifiers for patients across all sites; Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity; Key Systems Barrier: Lack of interoperable patient data systems and need for robust and consistent surveillance data for program planning	COP16	COP20	i) Curation and release of full survey data from the 5th survey (ii) Protocol development for 6th survey completed including a module for a nested VMMC coverage survey (iii) Piloting for implementation of the 6th survey protocol
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 80,000	Program and data quality management	Epidemiology PEPFAR Minimum Requirement: Scale up of unique identifiers for patients across all sites; Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity; Key Systems Barrier: Lack of interoperable patient data systems and need for robust and consistent surveillance data for program planning	COP17	COP20	i) District-level HIV estimates including on prevalence and burden (PLHIV) for South Africa is available for 2018 (ii) Local capacity developed for the generation, interpretation and use of sub-national estimates
HHS/CDC	HEALTH INFORMATION SYSTEMS PROGRAM	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 1,218,000	HMIS systems	Epidemiology PEPFAR Minimum Requirement: Scale up of unique identifiers for patients across all sites; Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity; Key Systems Barrier: Lack of interoperable patient data systems and need for robust and consistent surveillance data for program planning	COP16	COP20	Increased proportion of facilities with DHIS2; DHIS2 skills transfer activities continue; Dissemination and capacity building for 909090 dashboards from facility to provincial level; dissemination of data quality reports; improved interoperability between key facility-level health information systems
HHS/CDC	TRUST FOR HEALTH SYSTEM PLANNING & DEVELOPMENT IT1098/92	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 1,540,000	Service organization and management systems	Policy Minimum Requirement: Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups; Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16)	COP17	COP20	>65% of eligible patients stable on ARVs are receiving drugs from the CCMDD program; SyNCH for monitoring patient outcomes on CCMDD is fully implemented in selected PEPFAR districts and used by the NDOH to inform program planning
HHS/CDC	Unicef	ASP: Policy, planning, coordination & management	Pregnant & Breastfeeding Women: Not disaggregated	\$ 120,000	Oversight, technical assistance, and supervision to subnational levels	Lab PEPFAR Minimum Requirement: Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting;	COP19	COP20	EID coverage of >97% at 6 months & 95% VLS in BF women at 6 months

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	THE AURUM INSTITUTE	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 3,482,996	HRH recruitment and retention	HRH Key Systems Barrier: Health workforce is not centrally coordinated resulting under enumeration, lack of coordinated skills building, under optimized for efficient and effective service delivery,	COP18	COP20	Use of mHealth for program and performance M&E by 10,000 CHW and OTL
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 2,702,085	Forecasting, supply chain plan, budget, and implementation	Commodity PEPFAR Minimum Requirement: Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens; Key Systems Barrier: Sub-optimal integration and triangulation of programmatic data and supply data to inform planning for drugs and commodities	COP18	COP20	1) 100% eligible patients transitioned from TEE to TLD 2) 95% availability of Master Procurement Catalogue items at healthcare facilities
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 3,022,691	Forecasting, supply chain plan, budget, and implementation	Commodity PEPFAR Minimum Requirement: Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens; Key Systems Barrier: Sub-optimal integration and triangulation of programmatic data and supply data to inform planning for drugs and commodities	COP19	COP20	1) 95% availability of Master Procurement Catalogue items at healthcare facilities 2) Three provinces with an integrated supply chain and program data review process
USAID	WITS HEALTH CONSORTIUM (PTY) LTD	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	\$ 1,660,000	Resource tracking and costing	Resource Mobilization PEPFAR Minimum Requirement: Evidence of resource commitments by host governments with year after year increases; Key Systems Barrier: Lack of strategic investments within the health sector to maximize health outcomes	COP19	COP21	1) Positive trend of resource commitments by host government as compared to previous year. Target of at least 10% increase in 2018/19 to 2019/2020 budget cycles. 2) 60 interactions with GOSA on analytics
USAID	WITS HEALTH CONSORTIUM (PTY) LTD	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	\$ 664,000	Administrative and financial systems	Resource Mobilization PEPFAR Minimum Requirement: Evidence of resource commitments by host governments with year after year increases; Key Systems Barrier: Lack of strategic investments within the health sector to maximize health outcomes	COP17	COP19	1) 8 conditional provincial grant business cases submitted using quality data 2) 95 - 99% of target budget execution 3) 8 provinces able to monitor HIV budget and execution without USG support

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	PATH	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 2,368,714	HMIS systems	Epidemiology PEPFAR Minimum Requirement: Scale up of unique identifiers for patients across all sites; Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity; Key Systems Barrier: Lack of interoperable patient data systems and need for robust and consistent surveillance data for program planning	COP18	COP19	1. Provincial Information Hubs able to provide TB-HIV 90-90-90 Cascades in 8/8 provinces 2. Info Hub prototype testing of interoperability and entity resolution for additional centralized national data sets such as NHLS, Synch, RX Solutions (subject to change based on NDoH prioritization) in 4 / 8 provinces 3. Costed 'Health Connectivity Unit' solution provided to 8/8 provinces for implementation through appropriate procurement channels as determined by provincial leadership
USAID	Administrators of the Tulane Educational Fund, The	ASP: HMIS, surveillance, & research	OVC & care givers: Not disaggregated	\$ 210,447	Program and data quality management	Epidemiology PEPFAR Minimum Requirement: Scale up of unique identifiers for patients across all sites; Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity; Key Systems Barrier: Lack of interoperable patient data systems and need for robust and consistent surveillance data for program planning	COP18	COP20	i) Ongoing tracking of OVC cohorts and capturing data on the tracking system ii) Ongoing assessment of risky behavior leveraging on routing outcome data, and documenting findings iii) Ongoing feedback to the implementing partner for program improvement and documentation of program effects on beneficiary behavior.
USAID	PATH	ASP: HMIS, surveillance, & research	Females: Young women & adolescent females	\$ 289,100	Program and data quality management	Epidemiology PEPFAR Minimum Requirement: Scale up of unique identifiers for patients across all sites; Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity; Key Systems Barrier: Lack of interoperable patient data systems and need for robust and consistent surveillance data for program planning	COP18	COP20	Continue Cohort Tracking
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 1,096,078	Forecasting, supply chain plan, budget, and implementation	Commodity PEPFAR Minimum Requirement: Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens; Key Systems Barrier: Sub-optimal integration and triangulation of programmatic data and supply data to inform planning for drugs and commodities	COP19	COP20	3,200 facilities receiving stock on the Stock Visibility Solution
HHS/CDC	HUMAN SCIENCE RESEARCH COUNCIL	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 45,500	Surveillance	Epidemiology PEPFAR Minimum Requirement: Scale up of unique identifiers for patients across all sites; Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity; Key Systems Barrier: Lack of interoperable patient data systems and need for robust and consistent surveillance data for program planning	COP17	COP19	Dissemination of results

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	COUNCIL FOR SCIENTIFIC & INDUSTRIAL RESEARCH	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 350,000	Oversight, technical assistance, and supervision to subnational levels	HRH Key Systems Barrier: Health workforce is not centrally coordinated resulting under enumeration, lack of coordinated skills building, under optimized for efficient and effective service delivery,	COP16	COP20	1750 facilities and congregate settings implementing appropriate IC interventions, collecting data on TB among HCW, and conducting assessments at facilities and community sites 150 facilities with mechanical sputum booths functional and used 27 PEPFAR-focused district led facility and community risk assessments in their 10 highest TX_CURR facilities IC models developed and piloted by NDoH and IC policy and guidelines operationalized by NDoH
HHS/CDC	World Health Organization	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 160,000	Clinical guidelines, policies for service delivery	Policy Minimum Requirement: Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups; Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16)	COP18	COP20	40% of patients on TDL and 3HP
USAID	WITS HEALTH CONSORTIUM (PTY) LTD	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	\$ 810,800	Administrative and financial systems	Resource Mobilization PEPFAR Minimum Requirement: Evidence of resource commitments by host governments with year after year increases; Key Systems Barrier: Lack of strategic investments within the health sector to maximize health outcomes	COP19	COP20	1) Pay-for-performance mechanisms designed and implemented in appropriate contexts across all DSPs. 2) outcomes-based payment modality agreed upon by Treasury, NDOH, and provincial DOH.
USAID	WITS HEALTH CONSORTIUM (PTY) LTD	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	\$ 830,000	Administrative and financial systems	Resource Mobilization PEPFAR Minimum Requirement: Evidence of resource commitments by host governments with year after year increases; Key Systems Barrier: Lack of strategic investments within the health sector to maximize health outcomes	COP19	COP20	1) 27 districts receiving technical support on budgeting and budget execution to procure necessary equipment, supplies, and other expenditures essential to HIV service delivery 2) 95% financial execution at district level of HIV conditional grant against budget planning tool 3) 0 districts that can monitor HIV budget and execution and ensured procurement of necessary equipment, supplies, and other expenditures essential to HIV service delivery
USAID	GLOBAL ENVIRONMENT AND TECHNOLOGY FOUNDATION	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 373,500	Clinical guidelines, policies for service delivery	Policy Minimum Requirement: Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups; Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16)	COP18	COP19	1) 2,000 PUPs registered for the CCMDD program 2) 25 locker PUP sites established 3) 25 other alternative collection points established (e.g. containers)

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	WITS HEALTH CONSORTIUM (PTY) LTD	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 2,640,000	Lab quality improvement and assurance	Lab PEPFAR Minimum Requirement: Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting;	COP18	COP20	-Reduce specimens' rejection rate to below 2% in the facilities accessing eLAB (524) - Expand eLAB to 500 more facilities (Total should be 924 at the end of FY2020) -Reduced turnaround time (TAT) for VL results acknowledgement in the 524 facilities. 6 staff in place -Expand RFA to 500 more facilities (Total should be 1150 at the end of FY2020). -The module that will allow reaching out to patients with high VL, and or VL due at 6 and 12 month is accessible by 500 facilities.S7
USAID	GLOBAL ENVIRONMENT AND TECHNOLOGY FOUNDATION	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 2,476,200	Clinical guidelines, policies for service delivery	Policy Minimum Requirement: Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups; Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16)	COP19	COP20	1) National campaign delivered 2) Proxy linkage to target 90% in U=U campaign districts 3) LTFU rates reduced to 15% in U=U campaign districts
HHS/CDC	HUMAN SCIENCE RESEARCH COUNCIL	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Adults	\$ 273,000	Research	HRH Key Systems Barrier: Health workforce is not centrally coordinated resulting under enumeration, lack of coordinated skills building, under optimized for efficient and effective service delivery,	COP19	COP20	1) survey completed among PLHIV in all PEPFAR supported districts

APPENDIX D – Minimum Program Requirements

This section briefly reviews South Africa’s status in meeting the 13 minimum program requirements. See previous narrative sections for more detailed information.

D.1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups

The National Department of Health (NDoH) in South Africa adopted a policy of universal test and treat in 2016, and it has since been scaled across all age, sex and risk groups. In 2017, the NDoH followed the universal test and treat policy with a national circular emphasizing the importance of same-day ART initiation in improving linkage to treatment. While initial uptake of same-day ART was slow, the intervention has been significantly scaled in high-volume/prioritized sites during COP18 with resulting improvements in facility-based linkage to treatment as described below (Appendix D.6). During COP19 the PEPFAR SA program will continue to work with NDoH to support implementation and monitoring of both Test and Start and same-day ART initiation through continued mentorship and training of DoH nursing staff as well as through the placement of direct service delivery nurses at high volume facilities.

D.2. Adoption and implementation of differentiated service delivery models, including multi-month scripting and delivery models to improve identification and ARV coverage of men and adolescents

DSD for stable patients is extensive in South Africa, with options for ARV pick-up through external pick-up points, fast lanes, and through adherence clubs available across the country once a patient has been on ART for 12 months and has two suppressed VLs. South Africa has made significant progress in expanding differentiated service delivery with 1.47 million stable patients receiving two months’ supply of medicine through adherence clubs (including youth clubs) and centralized chronic medicines dispensing and distribution (CCMDD). PEPFAR and partners will work with NDoH to provide evidence for the benefit of extended refill length, including 6-months’ supply for stable patients through CCMDD, Adherence Clubs or through Fast Track ART collection. PEPFAR will support any transition to 6-month scripting through development and implementation of operational plans.

In COP19, PEPFAR SA will invest \$3.4 million dollars to support the expansion of CCMDD models. In addition, \$12.7 million will be invested to support procurement of ARVs to start the process of implementing multi-month dispensing for eligible patients.

Alternative medicine collection options, for example lockers (a self-service prescribed medication parcel collection service similar to that used by Amazon in the U.S.), will be used to provide more convenient options for men and adolescents. Extended hours, including weekend services, coupled with behavioural nudges will be used to further improve ART coverage for these two

population groups. Importantly, NDoH and PEPFAR SA are also invested in improving data quality and patient monitoring related to these modalities as the programs expand.

In COP19 \$5 million is being allocated to provide central support to the NDoH to finalize and roll-out a package of services for Advanced Clinical Care, including harmonized training materials, standardized referral and primary care services, virtual support, and monitoring and evaluation tools.

D.3. Completion of Tenofovir/Lamivudine/Dolutegravir fixed-dose combination (TLD) transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens

The South African government is on course to start an aggressive transition of the majority of adult first line patients to TLD. All men, adolescent boys, women and adolescents of childbearing potential based on informed choice, and pregnant women after the first trimester will be eligible for TLD. Women of childbearing potential will be counselled on Dolutegravir- and Efavirenz-containing regimens, including the benefits and potential risks of neural tube defects with Dolutegravir use during the periconception period, as well as known risks of Efavirenz-based regimens. Women will also be provided a choice of contraceptive options (which includes condoms, oral contraceptives, implants, injectables and intrauterine contraceptive devices).

Nevirapine has been removed for all patients except for children <4 weeks as Raltegravir is not yet registered for neonates in South Africa. The revised treatment guidelines provide Dolutegravir to pediatric patients from 20kg in combination with Abacavir and Lamivudine.

The South African government has achieved several key milestones in preparation for the TLD transition to start from the 1st of August 2019.

- The ARV tender awarded in February 2019 includes TLD from eight suppliers.
- The Draft National ART Guidelines have been updated to include TLD.
- Training plans for healthcare workers have been developed. The training plan includes a training of trainers that is expected to be rolled out in May 2019.
- Facility commodity uptake monitoring systems have been updated to enable TLD tracking.

The majority of patients are expected to transition to TLD by January 2020. PEPFAR has initiated discussions with NDoH regarding the potential to decant stable patients on TLD to CCMDD after a single suppressed VL.

D.4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence is established

The NDoH has prioritized and is supporting full implementation of index testing for sexual partners and children of PLHIV. HIV self-screening is also being scaled up and fully supported. Both these modalities

are now included in the revised National HTS register, which is being rolled out in phases, prioritizing high burden districts. The NDoH index testing guidance includes specific procedures to ensure consent, protect confidentiality and prevent harm related to intimate partner violence, informed by broad consultations. The NDoH and PEPFAR SA are working to ensure structures are in place to support disclosure to spouse and sexual partners and to manage risks and incidence of intimate partner violence related to HIV disclosure.

Pediatric case finding modalities prioritize improved PICT, including through case managers, and index case testing. Adolescent case finding is optimized through youth friendly services and “Youth Zones” in facilities, through after-school hours, school health services, and mHealth (including social media). The Department of Basic Education and provincial and local authorities are also rolling out the comprehensive sexuality education (CSE) program, and the provision of school-based health services including HTS, in line with the NDoH National Adolescent and Youth Health Policy (July 2017).

D.5. TB preventive therapy for all PLHIV must be scaled up as an integral and routine part of the HIV clinical care package

The NDoH is working with PEPFAR SA to rapidly scale up TB Preventive Therapy (TPT). In May 2018, NDoH released a TPT circular to address some of the barriers impacting negatively on TPT scale-up. The circular states that Tuberculin Skin Test is no longer a requirement for TPT; TPT can be initiated at ART initiation; and all adults on ART with no active TB disease should receive 12 months of Isoniazid Preventive Therapy (IPT) and CLHIV should receive 6 months if eligible for IPT. This was an effort to address some of the concerns raised by clinicians around the complexity of the TPT guidelines. In COP18, PEPFAR SA included TPT in the clinical care implementation guidelines to provide guidance to Implementing Partners on key interventions to rapidly scale up TPT in the 27 priority districts. Monitoring of TPT initiation and completion is done routinely during facility support visits by PEPFAR SA staff. Implementing Partners also report on IPT initiations weekly for Siyenza sites and this allows for real-time monitoring of IPT initiation in high volume sites.

In the current implementation period, PEPFAR SA is not projected to meet TB_PREV targets due to Isoniazid (INH) shortage/stock outs. Due to the significant increase in patients initiated on TPT (from 84,327 in FY17 to 126,119 in FY18 and still increasing in FY19), many PEPFAR-supported facilities are experiencing INH stock outs. This is largely due to inaccurate quantification and projection of the required quantities and inability of SANOFI (the only supplier at this time) to meet the demand. PEPFAR SA has been working with NDoH and SANOFI through the TB Think Tank TPT sub-working group to determine available INH quantities by facility and find ways of addressing the shortage.

In COP19 PEPFAR SA will support NDoH to increase TPT coverage among patients newly and previously initiated on ART. A total of 836,401 (85%) patients on ART receiving TPT are expected to complete the course from the 984,001 initiated on TPT. This is in line with the COP19 TB_PREV

target in the planning letter. To ensure alignment with the latest WHO guidelines for the management of latent TB infection and a smooth transition to the new TPT regimen, PEPFAR SA is currently supporting the review of National TPT guidelines. The new TPT guidelines will also focus on increasing TPT coverage among patients previously initiated on ART by providing guidance on the provision of TPT for stable ART patients who are in differentiated care. The current policy does not allow for provision of TPT as part of the package of care for patients on differentiated care and as such it is envisaged that this change will significantly improve TPT coverage among this cohort of patients.

D.6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups

After being diagnosed HIV positive, all patients need to be actively linked to ART services. In South Africa, an enhanced focus on the provision of linkage services as well as the significant scale-up of same-day ART initiation in COP18 (see Appendix D.1) has led to a significant improvement in linkage with proxy linkage reaching 94% nationally in January-March 2019 and the majority of districts exceeding 95% during the same quarter. Challenges still exist with ensuring those who aren't initially eligible for treatment (e.g., due to TB symptoms) are rapidly and continuously engaged and in ensuring those identified in the community are quickly linked to treatment as well. In COP19, through the assignment of case managers at the time of diagnosis, every patient not initiating on the same day should receive a follow-up call within one week to ensure their engagement in treatment as soon as possible. Children (10-14 years) and AGYW will be a particular focus of these linkage efforts. The expansion of community ART within targeted community testing platforms will further ensure that linkage across the program exceeds the targeted 95% threshold.

D.7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as antenatal care, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention

South Africa prohibits, through legislation, informal and formal user fees for HIV, TB, antenatal care and all primary level care in the public sector. PEPFAR SA South Africa continues to work at the national, provincial, and district levels to ensure that this policy is implemented in facilities and that all people have access to HIV services. Instances of non-compliance with user fee policies are quickly reported by PEPFAR SA South Africa to national-level counterparts for remediation.

D.8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting

Overall, the country's estimated VL testing coverage is 80-95% (NHLS). VL testing coverage based on data from TIER.Net (*VL Done*) is lower (64%) because of incomplete data capture and recording in TIER.Net. According to PEPFAR SA Q1 data, overall viral suppression rates among those testing are 90% for males and 94% for females. Viral suppression rates are low in infants less than 1 year old (71% for males, 76% for females), children 1 to 4 years old (73% for males, 76%

for females), and adolescents 15 to 19 years old (77% for males, 82% for females). According to NDoH, national EID testing coverage at birth was 94% for April through June 2018. By province, the range was from 72% (in Northern Cape) to 100% (in Eastern Cape, Gauteng, Limpopo and Mpumalanga).

NHLS has the capacity to provide 10 million VL tests per annum. In 2018, NHLS performed 5.2 million tests with an average turnaround time of 105 hours from specimen collection to results return. Results are returned to facilities in many formats including electronically (Labtrack), through SMS printers, and via hard copies delivered to the facilities by couriers collecting the samples. Because NHLS is leasing the platforms, procurement of reagents and consumables is not problematic except in facilities where stock management is an issue.

VL and EID optimization activities: Optimization activities target identified gaps in (1) coverage and (2) use of test results for patient management.

Activities to improve coverage include:

- SMS reminders (14, 7 and 1 day prior to appointment date for VL testing).
- Same-day or next-day follow-up phone calls for missed appointments (including for VL testing), and if unsuccessful, community tracking/tracing by CHW.
- Continued capacity building for providers to improve VL specimen collection (including pediatric phlebotomy), stock management, etc., and implementation of eLab to monitor specimen quality and implement corrective action at facility level to improve turnaround time and decrease specimen rejection rate.
- Extended clinic hours to increase coverage among those who cannot seek care during regular clinic hours.
- At the national level, PEPFAR SA is advocating for dried blood spot VL testing for children under 5 years old.

Activities to improve monitoring and use of test results include:

- Implementing/generating the 'Waiting for Results' list in TIER.Net.
- Integrating NHLS with TIER.Net to enable direct upload of results into TIER.Net.
- Implementing case management to ensure immediate intervention for patients with unsuppressed VL, EID positive and crypto positive, supported by implementation of the NHLS Results for Action (NHLS flags results for VL>1000/ml, EID positive and crypto positive to PEPFAR-supported facilities). eLAB will be used to immediately call back patients with unsuppressed VL and for VL sample collection.

In addition, the planned U=U campaign is intended to target both providers and patients to improve coverage and use of VL testing.

D.9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity

South Africa's national morbidity and mortality reporting system is supported by a range of data sources and institutions, including the District Health Information System, Birth and Death Registries, Census and cause-specific data reporting systems. These data are critical to understanding program impact, and South Africa is committed to improving the quality of the data used. Current GoSA investments include capacity development to improve the completeness and accuracy of existing data systems and to strengthen reconciliation and triangulation of data from various sources and at all levels (national provincial, district).

PEPFAR SA is supporting expansion of effective national HIV data reporting systems including Provincial Information Hubs and implementation of the HPRS infrastructure support at the facility level.

D.10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management

The South Africa OVC program package of services provides comprehensive prevention and treatment services to OVC aged 0-17 years. For children 0-8 years, the programmatic focus is on case finding and linkage to HIV treatment, and on developmental stimulation. Among 9-14 year-old adolescent girls and boys, PEPFAR SA investments leverage the OVC, school-based, safe spaces and community platforms using a combination of high impact interventions to prevent sexual violence; delay sexual debut; support healthy choices; and empower parents, caregivers and communities to support, protect, and educate girls. Among adolescent girls 15-19 years, HIV prevention investments leverage OVC, school-based, safe spaces, community, and clinical platforms using a combination of evidence-based interventions to empower adolescent girls, increase economic stability, strengthen families, mobilize communities, and link girls in this age group to SRH services including PrEP. Through effective case management, household visits, and improved use of data and targeting, OVC Implementing Partners identify the most vulnerable children (including AGYW, children and adolescents living with HIV) and provide one-on-one support that empowers OVC to stay in and progress in school; access health services and grants; reduce violence and abuse; prevent HIV infection; and be adherent and retained in HIV care services. The OVC program is closely aligned with the care and treatment and prevention programs. CLHIV enrolled in the program increased from 9,079 (2%) in APR17 to 28,376 (11%) in SAPR19 due to intense partner management, improved case finding strategies, new interventions targeting CLHIV, and increased collaboration between clinical and community Implementing Partners. Over twenty percent of the total OVC caseload is expected to be CLHIV by APR19; this would be approximately 80% of the number of CLHIV on ART in the 24 districts covered by the OVC program.

D.11. Evidence of resource commitments by host governments with year after year increases

There is clear commitment by the GoSA to continuously increase budgetary support towards the HIV response. The recent GoSA budget allocation for HIV indicates a continued increase from \$1.7 billion in 2018/19, to \$2.1 billion in 2020/21, accounting for over 70% of the country's HIV expenditure.

D.12. Clear evidence of agency progress toward local, indigenous partner prime funding

In COP17 and COP18, PEPFAR SA South Africa awarded 84% and 73% of funding to local indigenous organizations respectively. Funding levels to local indigenous organizations in COP19 are projected to be 83% including Treatment Surge funding; final levels will be determined once remaining TBD awards are specified.

D.13. Scale Up of Unique Identifiers for Patients Across All Sites. Scale up of unique identifiers for patients across all sites

South Africa's Health Patient Registration System (HPRS) was developed in answer to the need for a Patient Registration System/Unique Identifier as identified in Ch. 18, Par 140 of the Policy Paper (Green Paper) on National Health Insurance (NHI) in South Africa dated 12 August 2011 and as cornerstone of the move to an electronic patient record system, on which all modern health systems information systems rest. The system was developed by the NDoH in partnership with the Department of Science and Technology and the Council for Scientific and Industrial Research. Development commenced in July 2013. HPRS roll out began as the "700 clinic project" within the NHI pilot districts and by 31 March 2017, more than 6.3 million South Africans were registered in the system. The NDoH is expected to meet its HPRS expansion targets under the 2018/2019 Annual Performance Plan of 35 million registered patients in 3,470 primary and community health care facilities and 22 hospitals. *Note: Targets for 2019/2020 Annual Performance Plan are in draft form.*

The Treatment Surge will accelerate roll-out of South Africa's HPRS, including unique patient identifiers, and establish provincial Information Hubs to integrate TIER.Net with other key databases using the unique identifier. This HMIS support will strengthen: (i) longitudinal patient tracking within and across facilities, (ii) patient-level clinical monitoring and management, (iii) HIV/AIDS case-based reporting and monitoring, and (iv) robust and timely program monitoring and evaluation. To facilitate the generation and use of the unique patient identifier, PEPFAR and NDoH will purchase and deploy required equipment, including barcode printers, scanners, routers and consumables.

Additional Policy Information Required in the SA COP19 Planning Level Letter

S.1. VL Management

Please refer to the complete response provided under Appendix D, Minimum Requirement 10.

S.2. Community Health Workers: Hiring freeze must be lifted and CHWs must be scaled immediately and optimized to support high burden areas and sites.

PEPFAR-supported Implementing Partners are aggressively scaling up hiring Community Human Resources in the 27 highest burden districts to implement the HIV/TB activities of the NDoH's community health worker scope of work. Their efforts will focus on outreach, linkage, adherence and retention related to HIV and TB. Training roll-out is on track to meet COP18 targets, and focuses on optimizing the effectiveness and impact of these Community Human Resources.

S.3. Screen better and test smarter: Stop over-testing. Policy of optimized testing that targets patients who are at risk of HIV, including focus on index testing should be adopted and implemented by the start of COP19

As noted elsewhere in this document, with the current Siyenza focus on retention, Implementing Partners have reduced testing efforts until patient retention and re-engagement is successfully addressed. Current testing efforts focus on full implementation of index testing, validation of a risk screening tool for adults, and high yield HIV entry points in facilities. All testing modalities focus on linkages to same-day initiation.