



South Africa

Country Operational Plan

(COP/ROP) 2020

Strategic Direction Summary

March 5, 2020

Contents

List of Acronyms	4
1.0 Goal Statement	6
2.0 Epidemic, Response, and Program Context	7
2.1 Summary statistics, disease burden and country profile	7
Table 2.1.1 South Africa Host Country Government Results	11
Table 2.1.2 HIV diagnosis, treatment and viral suppression	12
Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment	13
Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV	13
Figure 2.1.5 Progress retaining individuals on ART in FY19	13
Figure 2.1.6 Proportion of clients from ART 2018 Q4 to 2019 Q4	14
Figure 2.1.7 Epidemiologic Trends and Program Response for South Africa	14
Figure 2.1.8 Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4	14
2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention	15
2.3 Investment Profile	18
Table 2.3.1 Annual Investment Profile by Program Area [1]	19
Table 2.3.2 Annual Procurement Profile for Key Commodities	20
Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration.	20
2.4 National Sustainability Profile Update	21
2.5 Alignment of PEPFAR investments geographically to disease burden	22
Figure 2.5.1 PLHIV, HIV Prevalence, ART coverage, and Viral Suppression, by District	24
2.6 Stakeholder Engagement	24
3.0 Geographic and Population Prioritization	25
Table 3.1 Current Status of ART saturation	27
4. Client Centered Program Activities for Epidemic Control	27
4.1 Finding the missing and getting them on treatment	27
4.1.1 Population-Specific Interventions	29
4.1.2 Getting Them on Treatment	30
4.2 Retaining clients on treatment and ensuring viral suppression	30
4.3 Prevention, specifically detailing programs for priority programming:	31
4.3.1 HIV prevention and risk avoidance for AGYW and OVC	31
4.3.2 Children / PMTCT	33
4.3.3 Key Populations	35
4.3.4 Voluntary Male Medical Circumcision (VMMC)	36
4.4 Additional country-specific priorities listed in the planning level letter	37

4.4.1	Client and Family Centered Treatment Services	37
4.4.2	Retention	38
4.4.3	Community-led Monitoring	39
4.4.4	Pre-Exposure Prophylaxis	39
4.4.5	TB Preventive Treatment (TPT)	40
4.4.6	DREAMS	40
4.4.7	Orphans and Vulnerable Children (OVC)	42
4.4.8	Voluntary Male Medical Circumcision (VMMC)	42
4.4.9	PLHIV Stigma Index 2.0	43
4.5	Commodities	43
4.6	Collaboration, Integration and Monitoring	43
4.7	Targets by population	46
	Table 4.7.1 ART Targets by Prioritization for Epidemic Control	46
	Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts	47
	Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control.	49
	Table 4.7.4 Targets for OVC and Linkages to HIV Services.	55
4.8	Cervical Cancer Program Plans	58
4.9	Viral Load and Early Infant Diagnosis Optimization	58
5.0	Program Support Necessary to Achieve Sustained Epidemic Control	58
6.0	USG Operations and Staffing Plan to Achieve Stated Goals	65
APPENDIX A -- PRIORITIZATION		67
	Table A.1 PEPFAR Priority Treatment Coverage for 27 Focus Districts by Age, Sex and District, by District Prioritization (fine age bands) Children <15 Years [1]	68
	Table A.2 PEPFAR Priority Treatment Coverage Centrally Supported Districts	77
APPENDIX B – Budget Profile and Resource Projections		82
	B1. COP20 Planned Spending in alignment with planning level letter guidance	82
	Table B.1.1 COP20 Budget by Program Area	82
	Table B.1.2 COP20 Total Planning Level	83
	B.2 Resource Projections	83
APPENDIX C – Tables and Systems Investments for Section 6.0		85
APPENDIX D– Minimum Program Requirements		90

List of Acronyms

Acronym	Definition
ACC	Advanced Clinical Care
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
CCMDD	Central Chronic Medicine Disease Dispensing and Distribution Programme
CDC	U.S. Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CHW	Community Health Worker
CODB	Cost of Doing Business
COP	Country Operational Plan (PEPFAR)
COP18	2018 Country Operational Plan
CSF	Civil Society Forum
DBE	Department of Basic Education
DoH	Department of Health
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DR	Drug Resistant
DSD	Direct Service Delivery
DTG	Dolutegravir
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
<u>GoSA</u>	Government of South Africa
HAST	HIV/AIDS, STIs, and TB (Directorate)
HIV	Human Immunodeficiency Virus
HPRS	Health Patient Record System
HRH	Human Resources for Health
HSRC	Human Sciences Research Council
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IAS	International AIDS Society
IM	Implementing Mechanism
IP	Implementing Partner
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex people
MDR	Multi-Drug Resistant
MMD	Multi-Month Dispensing
MSF	Medicines Sans Frontiers
MSM	Men who have sex with men
<u>NDoH</u>	National Department of Health
NGO	Non-Governmental Organization
NHLS	National Health Laboratory Service
NSP	South Africa National Strategic Plan for HIV, TB, and STIs, 2017-2022
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PFIP	Partnership Framework Implementation Plan
PICT	Provider Initiated Counseling and Testing
PLHIV	People Living with HIV

Acronym	Definition
PMTCT	Prevention of Mother to Child Transmission
<u>PrEP</u>	HIV pre-exposure prophylaxis
PWID	People Who Inject Drugs
SA	South Africa
SANAC	South African National AIDS Council
SI	Strategic Information
SID	Sustainability Index Dashboard
SIMS	Site Improvement Monitoring Systems
SMS	Short Message Service
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
<u>StatsSA</u>	Statistics South Africa
STI	Sexually Transmitted Infections
TB	Tuberculosis
TLD	Tenofovir/Lamivudine/Dolutegravir fixed-dose combination (ARV)
TPT	Tuberculosis Preventive Therapy
TVET	Technical and Vocational Education and Training College
U.S.	United States
UNAIDS	Joint United Nations <u>Programme on HIV/AIDS</u>
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 2020 (COP20), the United States (U.S.) Government (USG) will support the South African (SA) Government (GoSA) toward the goal of HIV epidemic control. GoSA and PEPFAR SA are fully committed to this goal. COP20 will focus on retaining People Living with HIV (PLHIV) on antiretroviral therapy (ART) and continuing to prevent new HIV infections through: (1) Enhancing community-led, site-level monitoring; (2) Improving pediatric treatment and continuing to provide support for Orphans and Vulnerable Children (OVC); (3) Expanding the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program and increasing funding to community grants to reduce HIV risk for adolescent girls and young women (AGYW); (4) Saturating voluntary medical male circumcision (VMMC) for men ages 15 and older; (5) Further enhancing collaboration with the Department of Health (DoH) across all levels, as well as with other stakeholders; and (6) Continuing to improve partner management through improved data use to sustain our gains and retain patients in care in COP20.

To achieve these goals, PEPFAR SA will work with the GoSA to accelerate achievements by responding to weekly site-level data to drive immediate, data-driven changes and maximize performance on case finding, linkage, and retention in order to identify, report, and escalate critical challenges. Findings from community-led monitoring will be integrated into this process. PEPFAR SA will continue to work closely with civil society through stakeholder engagement sessions, People's Country Operation Plan (COP) Activities, Civil Society Forum Meetings, Provincial AIDS Council Meetings, and continued community monitoring efforts.

PEPFAR SA will focus heavily on retention and viral suppression through expanding access to patient-centered retention strategies, including appointment systems and decanting stable patients to adherence clubs, external pick up points, and spaced and fast-lane appointments (SFLA). In addition, PEPFAR will continue to support patient-centered interventions such as case management for all patients with unsuppressed viral loads. PEPFAR will support the national roll out of Multi-Month Dispensing (MMD) from the current 2-month supply to a 6-month supply. Pediatric focused approaches will include scale-up of postnatal clubs and pediatric focused case managers/facilitators. Within PEPFAR supported districts, overall viral load (VL) suppression was reported at 93% by the end of Fiscal Year (FY)19, and it is expected the program will achieve 95% VL suppression across all populations/sex bands by the end of COP20. The roll-out of Tenofovir Lamivudine Dolutegravir (TLD) will continue to scale during COP20 and 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 collected on demographics (e.g., age, sex,), residence, risk profile, and HIV testing history to help identify hot-spots, and results can be used to prioritize tracing of partners of persons with recent infection.

Prevention shifts will include DREAMS expansion to 24 total districts, increasing focus on VMMC coverage among >15-year old men, and surging the pre-exposure prophylaxis (PrEP) services. All interventions will be aligned with the 2017–2022 South Africa National Strategic Plan for HIV, Tuberculosis (TB) and Sexually Transmitted Infections (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) and in close collaboration with GoSA and other stakeholders.

PEPFAR SA has focused for impact both geographically and programmatically. During COP20, PEPFAR SA will continue to invest in South Africa’s 27 highest HIV burden districts—accounting for 80.4% of PLHIV. Within these districts, COP20 will further focus on the four largest metropolitan districts (accounting for 35% of PLHIV) and populations with largest treatment gaps.

PEPFAR SA is fully committed to active partner management and accountability, engagement at all spheres of government, and mobilizing all stakeholders to achieving these goals. PEPFAR SA is particularly committed to working closely with GoSA and Civil Society to ensure high-quality, client-centered HIV services.

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, ethnic groups, and religions. In 2019, the population was estimated at 58.8 million, of which approximately 51% (30 million) were female. Life expectancy at birth was estimated to be 67.7 years for females (72.7 without HIV/AIDS) and 61.5 years for males (65.6 without HIV/AIDS), and the infant mortality rate was estimated at 22.1 per 1,000 live births.¹

National Income per capita was estimated at U.S. Dollar (USD) 5,430 in 2017.² Total health expenditure was estimated to be about 8% of the Gross Domestic Product (GDP) in 2016 (\$428 per capita), with health spending expected to reach SA Rand (ZAR) 223 billion (approximately USD 15.6 billion³) in 2019/20.⁴ Domestic private expenditures (voluntary health insurance, out of pocket expenses) accounted for 44% of health expenditures in 2016.⁵ 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.

In 2019, SA’s HIV disease burden was an estimated 7,599,215 PLHIV,⁶ of which more than half (63%) were women. The estimated number of new infections among adults declined by 56% from

¹ Statistics South Africa [StatsSA], Mid-year population estimates, 2019. Statistical Release P0302, StatsSA: Pretoria.

² Gross National Income per capita, Atlas method (current USD). World Bank: World Development Indicators. Online: <http://data.worldbank.org/indicator/>

³ Using the current Exchange Rate (May 2019) of ZAR14.35:USD1.

⁴ Budget Review (2019). National Treasury, Republic of South Africa, February 20, 2019.

⁵ World Health Organization (2019). Global Health Expenditure Database.

<http://apps.who.int/nha/database/ViewData/Indicators/en> Accessed May 5, 2019.

⁶ Thembisa 4.2 (2019). Thembisa 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). Reference: Johnson LF, May MT, Dorrington RE, Cornell M, Boule A, Egger M and Davies MA. (2017) Estimating the impact of antiretroviral

1999 to 2019, yet incidence remained high, with an estimated 194,494 new infections in 2019.⁷ Among children, the estimated number of mother-to-child transmissions declined by 87% from 2004 to 2019, and 75% of those transmissions were estimated to occur during breastfeeding.⁸ This decline in incidence and shift of transmission from perinatal to postnatal has led to a shift in the age distribution of HIV-infected children, with over half (52%) of whom are now 10-14 years of age.⁹

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 and district levels lead the public-sector HIV treatment and biomedical prevention efforts to achieve epidemic control. As of December 2019, there were 5.9 million people on ART in the public sector, including 157,749 children (<15 years) and 4,411,868 adults.¹⁰ In addition, there were an estimated 378,000 PLHIV on ART in the private sector. SA manages the largest national treatment program in the world, although with universal ART eligibility, overall treatment coverage is only 65%.¹¹ ART coverage is higher among adult females (15+, 68%) than among adult males (15+, 62%) but is low among adolescent girls and young women (15-24, 38%). ART coverage among children is estimated to be 49% (Table 2.1.2).

HIV prevalence and incidence vary significantly across geographic areas; over half (52%) of PLHIV are concentrated in the Gauteng and KwaZulu-Natal provinces.¹² 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

The South Africa Human Sciences Research Council (HSRC) issued results the Fifth South Africa National HIV Prevalence, Incidence, Behavior and Communications Survey.¹³ Overall the Survey

treatment on adult mortality trends in South Africa: a mathematical modelling study. *PLoS Medicine*. 14(12): e1002468

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Johnson LF, Dorrington RE (2019) Thembisa 4.2: A model for estimating the impact of HIV/AIDS in South Africa.

¹¹ Based on conversations with the Government of South Africa's National Department of Health

¹² Johnson, *op. cit.*

¹³ South Africa Human Sciences Research Council (HSRC), Fifth South Africa National HIV Prevalence, Incidence, Behavior and Communications Survey. Accessible: <https://www.hsrbpress.ac.za/books/south-african-national-hiv-prevalence-incidence-behaviour-and-communication-survey-2017>

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 2017 survey, South Africa has reached 85–71–88 toward the UNAIDS 90–90–90 targets. South Africa has made considerable progress toward testing and identifying PLHIV, with 92 percent of HIV-positive South Africans aware of their status in 2019. However, South Africa has a significant gap to reach these people living with HIV 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 had 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 found 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 had decreased slightly. The survey indicated a significant increase in adult male circumcision over the past five years, primarily with medical circumcision.

PEPFAR South Africa awarded 73% of COP18 funding to local indigenous partners; this increased to over 80% in COP19 and is expected to stay at the same ratio or higher for COP20 (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 has set a target of 35 million patients with more than 43 million enrolled as of October 2019.

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 (DSD) in the 27 priority districts that account for 82% of the HIV burden in SA. The plan included high-impact technical assistance and above-site interventions that support the national ART program.

In March 2019, PEPFAR and DoH expanded an intensive facility-based support to cover high-volume facilities providing HIV treatment through a program known as "Siyenza!" ("We are doing it!" in Nguni). Siyenza has since been absorbed by the NDoH "Operation Phuthuma" initiative. The Siyenza approach is based on repeated site visits by PEPFAR, DoH, and implementing partner staff, with the goal of ensuring full implementation of HIV testing and treatment policies with a focus on improving retention. Guided by the Minister of Health's circular that defined and outlined performance standards and expectations for DoH staff, facility staff and managers work 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

into facilities for care. The circular outlined performance standards for health care workers including nurses, community health workers, lay counsellors, and data clerks. Siyenza's objectives at the patient level are to increase retention by providing a better experience through improved health worker engagement and reduced waiting times. Siyenza's goals at the facility are to increase numbers of PLHIV initiated and retained on treatment and reduction in the number of patients disengaging from care.

With the end of the \$500 million USD 2-year Surge (COPs 18 and 19), PEPFAR SA must ensure appropriate transition to the GoSA and adequate USG support to maintain those on treatment, The GoSA and PEPFAR SA's local partners need to work together closely to develop strategies for long term maintenance of people receiving ART, while also ensuring that highly focused case finding strategies are effective in bringing missed population groups into treatment. This change in focus from Surge accelerated case finding to post Surge maintenance of patient care will require close collaboration with local civil society organizations to be highly effective with the available resources.

Table 2.1.1 South Africa Host Country Government Results

	Total		<15				15-24				25+				Source, Year
	Total		Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	58,775,022	100%	8,348,540	14.2%	8,550,747	14.6%	4,754,816	8.1%	4,819,371	8.2%	16,998,919	28.9%	15,302,629	26.0%	Statistics South Africa (StatsSA), Mid-year population estimates, 2019 [1]
HIV Prevalence (%)		13.1%		1.9%		1.9%		10.3%		3.7%		47.8%		29.5%	Thembisa 4.2 2019 [2]
AIDS Deaths (per year)	66,694		AIDS deaths in male & female children <15= 5,954				N/A		N/A		AIDS deaths in female adults ≥15= 30,307		AIDS deaths in male adults ≥15= 33,952		Thembisa 4.2, 2019 [2]
# PLHIV	7,599,215		138,820		139,615		492,075		180,333		4,143,145		2,042,800		Thembisa 4.2, 2019 [2]
Incidence Rate (Yr)		0.39%		0.06% (10-14)		<0.01% (10-14)		1.39%		0.37%		0.55%		0.49%	Thembisa 4.2, 2019 [2]
New Infections (Yr)	197,102		6,702 (1,615 ages 10-14)		5,141 (54 ages 10-14)		75,562		21,305		92,383		73,805		Thembisa 4.2, 2019 [2]
Annual births	1,200,436	100%													StatsSA, 2018 [1]
% of Pregnant Women with at least one ANC visit	N/A	98%	DHS has age disaggregations <20 (94.7%), 20-34(93.5%) and 35-49 (93.4%).												Thembisa 4.2, 2019 [2] and DHS 2016
Pregnant women needing ARVs	250,350	21.7%													Thembisa 4.1, 2019 [2]

Table 2.1.2 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	58,775,022	13.1%	7,599,215	6,900,822	4,974,883	65%	85%	14,989,051	776,909	723,401
Population <15 years	16,899,287	1.9%	318,856	210,714	156,381	49%	68%	1,294,107	16,890	17,906
Men 15–24 years	4,819,371	3.7%	180,333	127,578	105,630	59%	66%	6,216,442	218,443	175,330
Men 25+ years	15,302,629	16.1%	2,466,947	2,216,220	1,630,013	66%	85%			
Women 15–24 years	4,754,816	10.3%	492,075	363,257	258,117	52%	78%	7,478,503	541,575	530,165
Women 25+ years	16,998,919	24.7%	4,190,894	3,970,783	3,228,800	77%	88%			
MSM [4]	346,799	30%	107,815	44,971	30,624	28%	63%	30,863	1,467	1,115
FSW [4]	124,706	54%	67,597	51,137	34,328	51%	76%	25,112	3675	2899
PWID [7,8]	75,000	21%	15,750	N/A	N/A	N/A	N/A	1,322	419	274
Priority Pop (People in prison)								94,765	9,847	7531

*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, 2019. Statistical Release P0302, Statistics South Africa: Pretoria

[2] Johnson LF, Dorrington RE (2019) Thebisa 4.2: A model for estimating the impact of HIV/AIDS in South Africa.

[3] PEPFAR reported data (APR 2019). 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. (2019). Consensus Cascades. [Dataset]

[5] Naomi South Africa district estimation model

[6] NHLS Viral Load dashboard

[7] UNAIDS. Do no harm. Health, human rights and people who use drugs. Report. Geneva: UNAIDS; 2016. Available from: http://www.unaids.org/sites/default/files/media_asset/donoharm_en.pdf.

[8] Scheibe, A., Young, K., Moses, L. et al. Understanding hepatitis B, hepatitis C and HIV among people who inject drugs in South Africa: findings from a three-city cross-sectional survey. Harm Reduct J 16, 28 (2019). <https://doi.org/10.1186/s12954-019-0298-2>.

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment

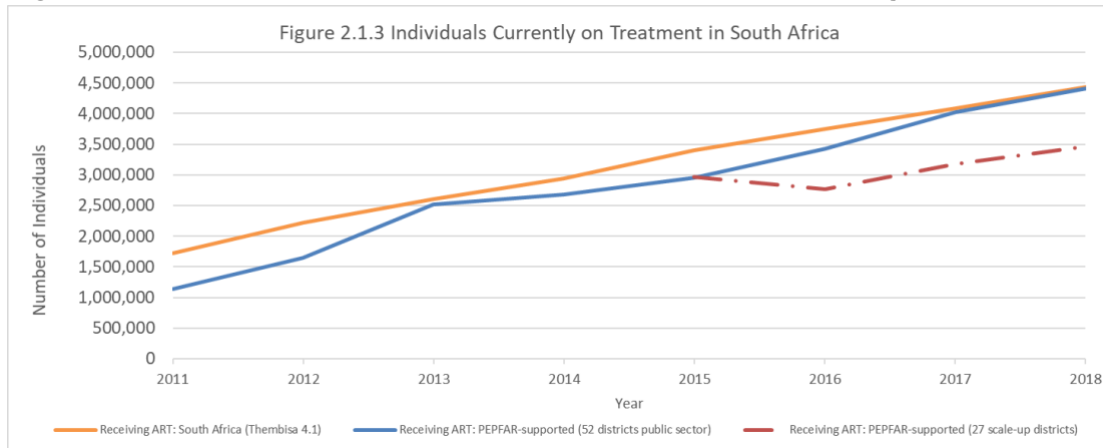


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

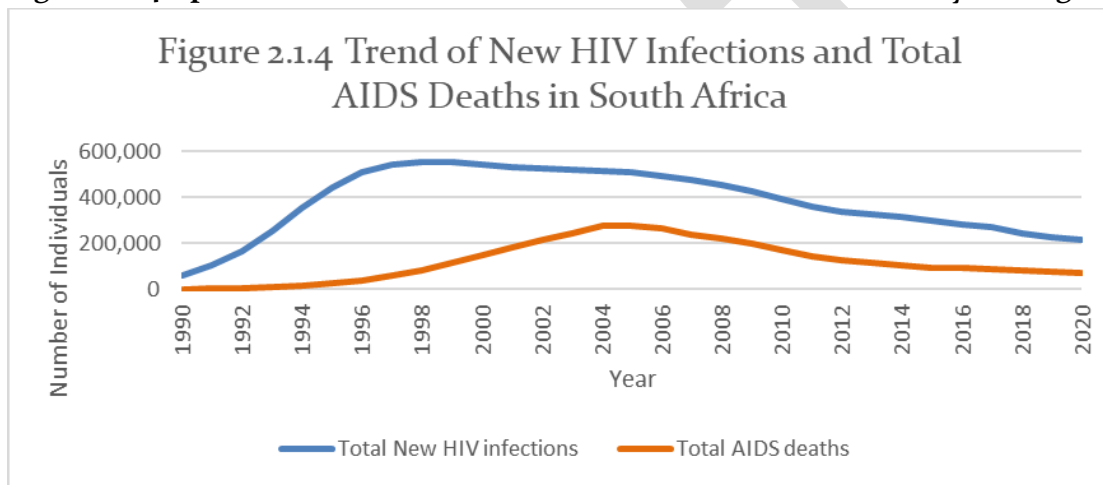


Figure 2.1.5 Progress retaining individuals on ART in FY19

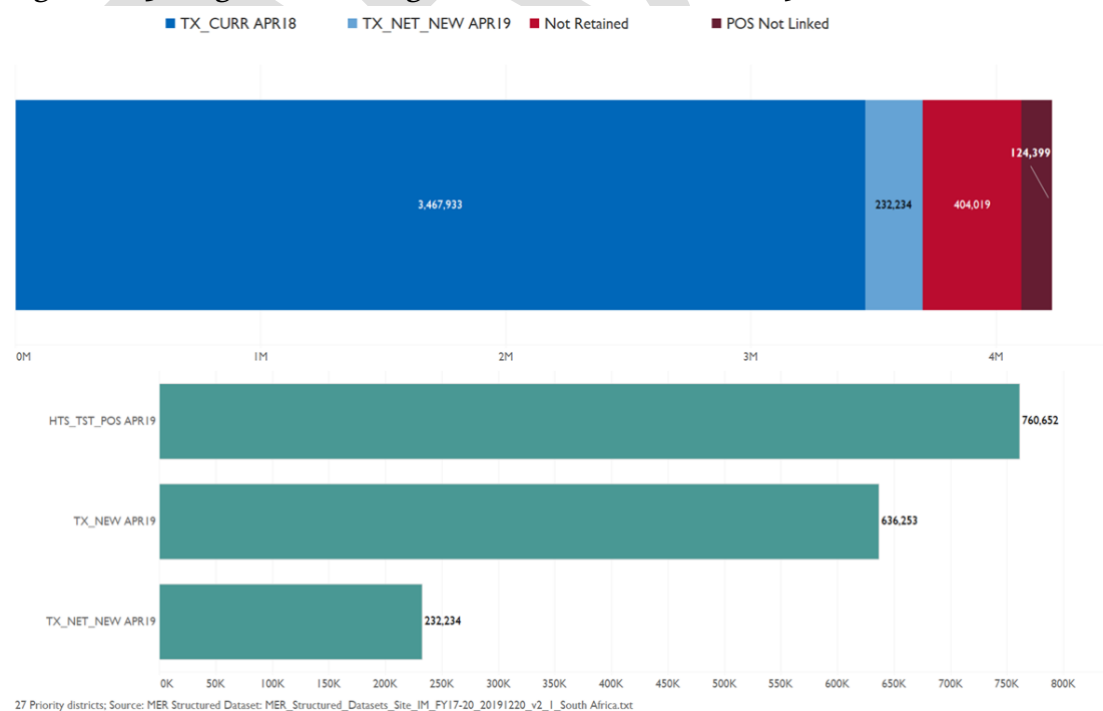
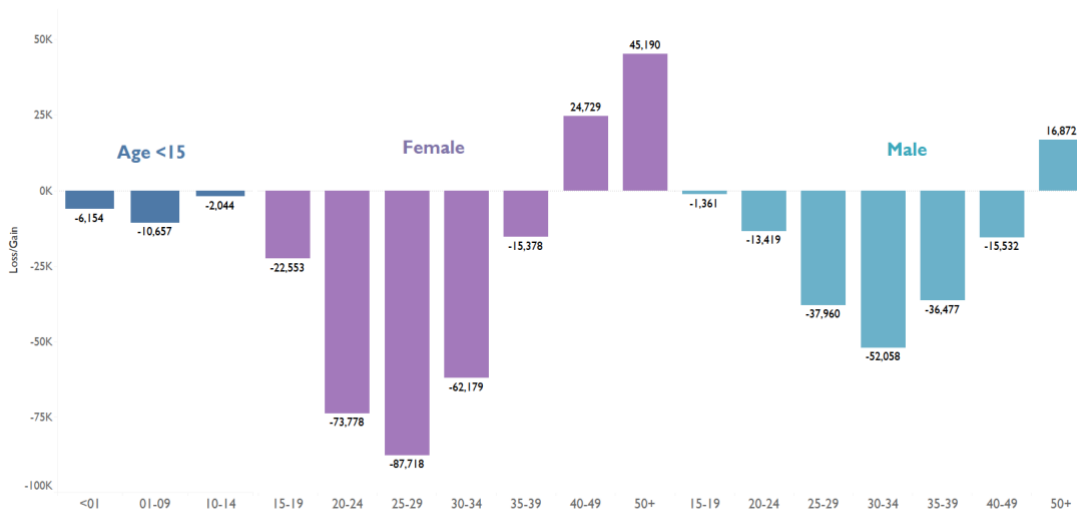


Figure 2.1.6 Proportion of clients from ART 2018 Q4 to 2019 Q4

Clients Gained/Lost by Age/Sex from FY2018 Q4 to FY2019 Q4



27 Priority Districts. Source: MER_Structured_Datasets_Site_IM_FY17-20_20191220_v2_I_South Africa.txt

Figure 2.1.7 Epidemiologic Trends and Program Response for South Africa

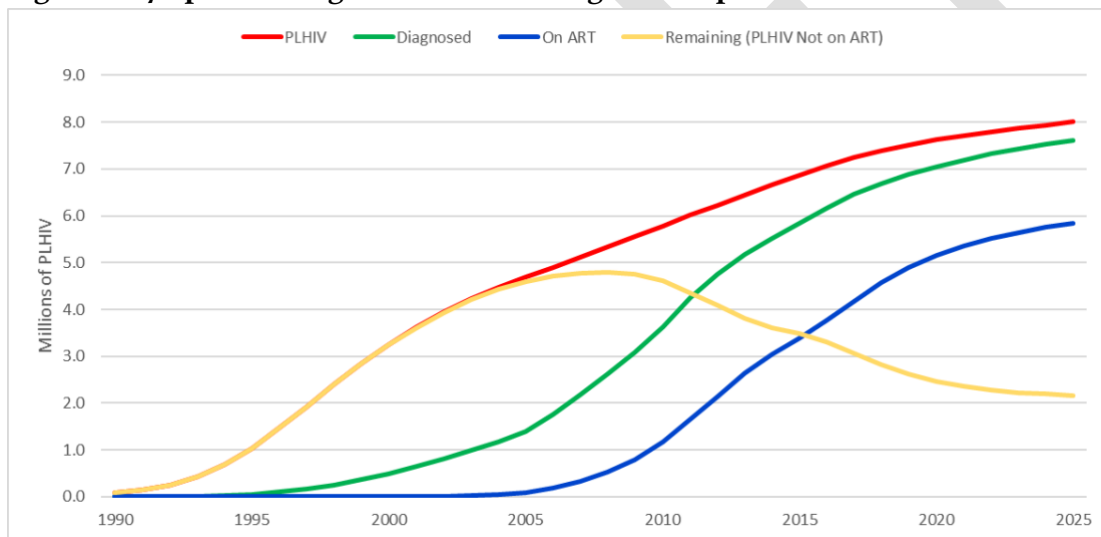
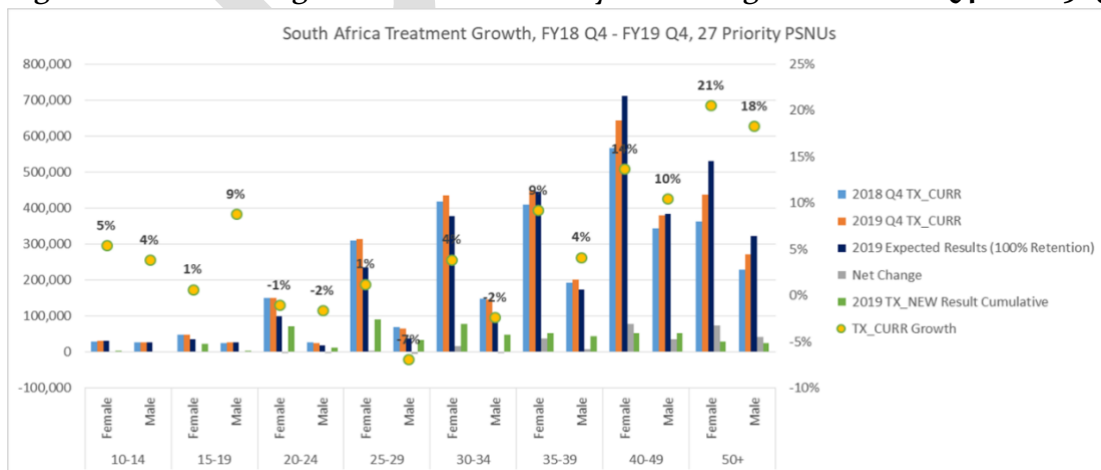


Figure 2.1.8 Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4



2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention

The COP20 approach focuses on the districts with the greatest need. Districts have been categorized into retention-focused districts and continued direct service delivery districts based on their past performance and projected COP19 achievement. Retention-focused districts are those that will reach >81% coverage by the end of COP20 with aggressive growth in COP19 and passive growth in COP20. Targets in these districts were set assuming 95% retention and a passive-growth trajectory in COP20. Continued DSD districts are those that will need to continue aggressive growth in COP19 and COP20 to ensure 81% coverage at the district level. Targets in these districts assumed 95% retention and additional case finding efforts to close remaining ART coverage gaps in COP20.

PEPFAR SA will continue to provide substantial support to facility- and community-level human resource investments to enable HIV testing, same-day initiation, extended service hours, patient navigation, active linkage, case management, adherence and retention tracking and tracing, and differentiated care in districts that have the greatest ART coverage gap to 90–90–90. It is anticipated that retention-focused districts will have more roving staff (who rove between sites) focused on providing technical assistance and mentorship to their DoH counterparts with less staff providing direct service delivery. Meanwhile, the continued DSD districts will retain their DSD staff compliments (who are fixed or seconded to specific sites) and primarily provide direct services (and less technical assistance and mentorship).

In line with the success of the Siyenza/Phuthuma efforts, PEPFAR SA will expand its intensive partner management and support in COP20. Using developed Standard Operating Procedures (SOP) and tools, PEPFAR SA staff will work closely with NDOH to accelerate the Phuthuma approach at both national and provincial levels through setting up daily data-review and facility management hubs attended by technical leads from PEPFAR, NDOH, and civil society. In addition, facility-based acknowledgements rewarding high-performing facilities will be used to further bolster the NDOH-PEPFAR collaboration at the site-level.

Treatment Program Growth - Case Finding and New Initiations

In COP20, PEPFAR will increase direct facility and community linkage to achieve >95% linkage in all PEPFAR supported districts. Strategies to improve linkage and treatment initiation in COP20 include same-day ART initiation through the handshake model (escorting HIV positive patients directly from testing to the ART initiation room/officer), provision of adherence counseling for PLHIV newly initiated on ART by lay counselors, community ART initiation, the welcome back campaign (to welcome back clients who defaulted from care back into the care and treatment program, including intensified adherence counselling), and through direct service delivery staffing and mentoring of DoH cadres. In COP20, the PEPFAR team intends to continue to support direct placement of lay counselors, nurses, and linkage officers to focus on case finding and ART initiation in DSD districts.

PEPFAR will prioritize patient literacy on the importance of ART initiation upon HIV diagnosis. Additionally, better and more efficacious treatment options will be scaled-up to improve treatment initiation and maintenance on treatment. The PEPFAR team will aim to ensure that ART initiations are being done by all Nurse Initiated Management of Anti-Retroviral Therapy (NIMART) trained staff. Also, the PEPFAR team will continue to scale up peer-led support groups in PEPFAR supported sites and ensure that newly diagnosed PLHIV, PLHIV returning to care, or PLHIV struggling with adherence are provided with the option to be linked to these support groups. This will be especially important in retention districts where the PEPFAR staff footprint will be reduced and support will be provided through a mix of technical assistance, mentorship and direct service delivery.

Retention of all Clients Over Time – Reducing loss to follow-up and case management

In COP19, all PEPFAR-supported districts scaled-up case management and the aggregate proxy retention rate from FY19Q1 to FY20Q1 was 98.2%. Retention on ART has improved since FY2018 but remains a significant challenge for the national HIV program given the size of the cohort of individuals on treatment in South Africa and the mobility of its population. In COP20, the case management approach will gain further efficiencies through the enhanced use of technology for continued peer-to-peer support. Population-focused approaches to strengthen retention will include continuing to scale-up postnatal clubs and pediatric focused case management. A specific strategic marketing strategy aimed at increasing male engagement in their health (the MINA campaign) is being developed and rolled-out in COP19. It is expected that this program will continue to be in place and will improve uptake of treatment and retention on ART among men in COP20.

Overall, retention among stable HIV patients who have been down-referred to differentiated service delivery models (e.g. decanted) is high in SA, yet it is estimated that only 53% of eligible clients are currently decanted. Demand creation for decanting is being implemented in COP19 and the PEPFAR team will aim to increase the total proportion of eligible patients decanted to 85% in COP20. Differentiated Service Delivery models include fast lane, Adherence Clubs (both facility and community based), and external pick-up points. There will be quarterly reporting on the number of clients transitioned to these models. PEPFAR partners will continue to support fast lane pick-ups with no need for client attendance elsewhere (e.g. registry, collecting files, checking vitals, clinician). PEPFAR will continue to support CCMDD implementation, which includes supporting CCMDD service providers and support to the NDOH related to stock provisions. In addition, the PEPFAR team will work with the NDoH to support national roll out of MMD (moving from the current 6-month visits with dispensing of 2-month supply to dispensing the full 6-month supply).

PEPFAR Monitoring, Evaluation, and Reporting (MER) and Siyenza data have shown a significant decline in the number of missing patients since the introduction of strategies to trace and track missing patients. Historically, the PEPFAR program has focused on finding patients who dropped out of care and relinking them to ART. During the second half of COP19 and during COP20, in addition to tracking patients disengaging from care, PEPFAR SA will focus on preventing defaulting by better understanding the individual characteristics and reasons for disengaging from care and focusing on improving patient experience during clinic

visits. Key strategies to do this include reducing queues, decanting stable patients, expanding hours of operation including weekends, offering scheduled visits with appointment times, re-training and sensitizing providers on friendly/compassionate services, ensuring organized/up-to-date/available patient records, and providing population-specific services like Men's Corner (e.g. specific spaces to provide services to male clients) and Youth-friendly services after school hours. PEPFAR SA will also continue to reduce the number of clients disengaging from care through tracking missed appointment lists from TIER.Net.

PEPFAR will also provide enhanced support through text message (e.g. Short Message Service - SMS) reminders and through early assignment of case managers to patients initiating therapy, as part of client centered services provision. Tracking patients will begin from the time an individual miss an appointment (e.g. same day). We will also strengthen patients' health literacy (U=U), and access to mental health services for patients initiating therapy and for those with unsuppressed HIV VL.

During COP18/19 PEPFAR SA in collaboration with the NDoH completed the development of the Advanced Clinical Care (ACC) curriculum. The roll-out of the ACC training is planned for COP 19/20 with other stakeholders. The profile of clients with advanced disease has changed and the training will focus on management of clients presenting with advanced disease prior to ART initiation or for those re-engaging in care (including TB-LAM and GeneXpert testing for TB at primary facilities and outpatient settings and CrAg screening), Drug Resistant (DR) HIV, Drug Resistant TB, management of an adult client failing a DTG regimen or PI regimen based. The training will strengthen advanced clinical management of HIV and TB to build capacity at all levels. Patients with advanced HIV disease will have easier access to providers trained on advanced clinical care (ACC) and the PEPFAR team will provide virtual support to ensure health care workers have access to specialist regarding the management of advanced disease.

TLD

In COP20, PEPFAR SA will continue to support the NDoH to rapidly roll out and monitor the transition to TLD in South Africa. A greater focus will be placed on ensuring that all patients are offered TLD within the context of informed choice, by expanding the availability of patient education materials and healthcare worker job-aids that clarify the risks (NTDs, weight gain) and benefits (smaller, more palatable Fixed Dose Combination, decreased side effect profile, more rapid viral suppression) of the drug. PEPFAR SA will support pharmacovigilance efforts to track side effects and support on-going training of health care workers, including side effect monitoring and appropriate regimen switch, in alignment with National guidelines. Although VL suppression rates are high among those currently on ARVs, the roll-out of TLD and Dolutegravir based regimens during COP19 and COP20 is expected to further improve retention and VL suppression.

TB/HIV

In COP20, PEPFAR SA will support the GoSA to ensure that individuals with TB know their HIV status, to effectively link HIV-infected TB patients to appropriate HIV treatment, and to scale up TB prevention and treatment among PLHIV. Priorities include ensuring

implementation of universal TB screening at all PEPFAR-supported facilities, increased HIV testing among individuals with presumptive TB, and ensuring rapid ART initiation for TB/HIV co-infected individuals. Ensuring data quality for reporting on the TB cascade will be key. In addition, with PEPFAR SA's dedicated TB funding, partners will be expected to further scale-up TB preventive therapy including among those currently on treatment who have not previously received Tuberculosis Preventative Therapy (TPT). A greater focus will be placed on ensuring TPT completion (currently 58%) through the roll-out of 3HP (Rifapentine and Isoniazid) and provision of dedicated adherence support focused on TB prevention and TB treatment. Site-level staff will be expected to have a greater focus on TB in COP20 than in prior years. DSP's will additionally be expected to ensure appropriate implementation of infection prevention and control practices and support rapid quality-improvement cycle to ensure that programmatic and facility implementation barriers are resolved rapidly for improved performance. PEPFAR SA will utilize feedback from community-led monitoring and our own site visits to target facilities that need to improve implementation of core infection control activities. Newly placed TB champions will further strengthen implementation of these activities during COP20.

At the above-site level, TB funding will go to support limited procurement of 3HP to complement the Global Fund investment (\$14M), pharmacovigilance and an evaluation of TPT adherence in the context of the roll-out of 3HP, and advanced clinical care to support the roll-out of TB-LAM (accessible as a POC test at primary facilities in both inpatient and outpatient settings) and Multi-drug Resistant (MDR) TB treatment.

Population Specific Interventions

In addition to these broad national and site-level strategies, PEPFAR SA continues to focus on specific populations which are further described in Section 4.0 as follows:

- AGYW and OVC: Sections 4.3.1
- Children / PMTCT: Section 4.3.2
- Key Populations: Section 4.3.3
- Men / VMMC: Sections 4.1.1 and 4.3.4

2.3 Investment Profile

The national HIV response in SA is funded primarily by the GoSA through domestic public revenue, with additional funding from external development partners (donors) such as PEPFAR and the Global Fund, as well as the private sector. Donor funding focuses on complementing government resources and piloting innovative interventions. Despite a constrained fiscal environment in recent years (i.e. considerable deficits and a growing debt-to-GDP ratio), SA's financial commitment to HIV programs continues to grow. Funding for HIV has grown more than the overall health budget over the last nine years, with the GoSA nearly tripling its domestic budget for HIV treatment to more than \$1 billion. PEPFAR continues to work closely with the GoSA and development partners to ensure sustainability and continuity (further described in Section 2.4).

In 2018/2019¹⁴, the total GoSA budget on HIV and HIV/TB was ZAR 23 billion (USD 1.76 billion). In terms of the relative domestic and donor contributions, the most recent study was the 2016/17 National AIDS Spending Assessments, which shows the GoSA's HIV investment comprising more than 71% of all investments (Table 2.2.1). According to the NSP 2017–2022, insurance costs for private ART patients are estimated to be ZAR 1.6billion in 2017/18.

Within the GoSA's response, the NDoH is the largest spender on HIV services, primarily via the HIV/TB Conditional Grant mechanism (ZAR 20.5 billion in 2018/19), followed by the Department of Social Development (ZAR 1.8 billion for 2018/19). An additional ZAR 1.9 billion has been allocated in 2017/18 and 2018/19 to support implementation of the HIV and TB Investment Case and the new NSP including the continued expansion of ART to PLHIV.¹⁵

Due to South Africa'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. The continued rollout of Tenofovir/Lamivudine/Dolutegravir fixed-dose combination (TLD) is expected to partially offset these increases. South Africa requires a steadily increasing investment in HIV programs to reach 90–90–90. Given SA's constrained economy, the GoSA has leveled funding for many services, and future rising HIV and TB treatment costs are projected to consume an increasing share of the health budget.

Table 2.3.1 Annual Investment Profile by Program Area [1]

Table 2.3.1 Annual Investment Profile by Program Area (COP18)				
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%
General Notes: <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. 				
^a The 45% attributed to GoSA is an underestimate as it does not include ARVs, HTS or full estimates of staff time.				
^b The GoSA investment in key population prevention includes costs for interventions in high-transmission areas.				
^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.				

¹⁴ The GoSA fiscal year is April-March, and is referenced as two calendar years (e.g. FY2018/19 for the period April 2018-March 2019). The USG fiscal year is October to September, and is referenced in relation to the latter calendar year (e.g. FY2019 for the period October 2018-September 2019).

¹⁵ Using the March 2018 Exchange Rate of ZAR12.0:USD1.

Table 2.3.2 Annual Procurement Profile for Key Commodities

Table 2.3.2 Annual Procurement Profile for Key Commodities					
Commodity Category	Total Expenditure	PEPFAR	GF	Host Country	Other
ARVs	\$399.62 million	\$8.79 million (PrEP)	\$15 million (treatment) \$830,000 (PrEP)	\$375 million	
Rapid test kits	\$7.9 million	\$3,439,973		\$3.4 million	
Other drugs	\$7,000,000		\$7,000,000 (3HP)		
Lab reagents	\$188 million			\$188 million	
Condoms	\$35 million			\$35 million	
Viral Load commodities	o				
VMMC kits	\$5.9 million	\$5,927,980			
MAT					
Other commodities	\$4.9 million	\$4,999,995			
Total	\$648.32 million	\$23,157,948	\$22,000,000	\$601,400,000	

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration.

Table 2.3.3 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 (USD)	PEPFAR COP Co-Funding Contribution (USD)	Objectives
USAID Maternal and Child Health	N/A	N/A	N/A	N/A	N/A
USAID TB	12,000,000	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	125,000,000 ^a	N/A	N/A	N/A	To advance health objectives
Centers for Disease Control and Prevention (CDC) - Global Health Security	540,425	N/A	N/A	N/A	Provide Global Health Security technical assistance and support to the South African Government.
Peace Corps	2,764,500	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
Other (specify)	N/A	N/A	N/A	N/A	N/A
Total	119,304,925				

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

^b IM: Implementing Mechanism

2.4 National Sustainability Profile Update

The second round of PEPFAR SA's National Sustainability Profile was completed in November 2019 using the Sustainability Index and Dashboard (SID) 4.0. The engagement process was led by the South African National AIDS Council (SANAC), GoSA, UNAIDS, and PEPFAR SA, and invited 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 17 critical sustainability elements.

The SA SID 4.0 demonstrated a high level of sustainability (score of 7.5/10) in 11 of the 17 critical elements, and a score of 9 or higher in an additional four elements. Five elements were identified with vulnerabilities to sustainability: civil society engagement; human resources for health; quality management; epidemiological and health data; and data for decision-making ecosystem (new element).

Since completing the SID in 2019, there has been progress made that reduces the vulnerabilities within these elements. For example, in the area 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. These investments contribute to improving sustainability of the national HIV program by optimizing the value of these important community resources. Specifically, the area of health data is also a priority and PEPFAR anticipates substantial progress in health data systems is underway to improve the quality, availability and use of data to inform effective program investments.

As noted in Section 2.3 (Investment Profile), the GoSA funds the vast majority of the HIV response in the country, with PEPFAR the next largest contributor with about 26% of the overall investment. In COP20, PEPFAR SA will continue to invest in the five program elements with the weakest sustainability scores, consistent with the NDoH/PEPFAR HIV Treatment Surge Plan.

The Global Fund for AIDS, TB and Malaria (GFATM) has also made specific commitments in each of these priority areas in the new funding covering the period April 2019–March 2022. In terms of service delivery, the GFATM funds important programming for vulnerable populations, in particular layered, comprehensive prevention programs for AGYW and key populations. In the area of Human Resources for Health (HRH), GFATM funding will support community 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.

PEPFAR SA continues to work closely through the bilateral work streams to ensure that COP investments both leverage and complement the investments of the GoSA and other donors. In particular, PEPFAR SA continues to work closely with the GFATM management committee

and Fund Portfolio Manager to strengthen the alignment of COP20 with the activities financed in the GFATM funding (April 2019–March 2022). 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 SA. Sustainability of investments and their impact is a significant consideration for all program investments made, including collaboration with the Department of Treasury to ensure alignment.

2.5 Alignment of PEPFAR investments geographically to disease burden

In COP20, PEPFAR SA continues to prioritize the 27 districts that account for approximately 80% of the national HIV burden, which are the same 27 focus-for-impact districts in the NSP. To further focus the PEPFAR SA investment, COP20 resources are targeted in the four largest metropolitan districts (Johannesburg, eThekweni, Ekurhuleni, Tshwane), which account for approximately 30% 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 continued to provide targeted support to these facilities, and in COP20 will further focus investments on the highest burden sites where PEPFAR SA investments will have the biggest impact on epidemic control.

PEPFAR remains committed to reach the 90–90–90 goal, as set out in the World Health Organization (WHO) guidelines and global best practices, and with the PEPFAR Strategy for Accelerating HIV/AIDS Epidemic Control (2017–2020). Targeting in the 27 Districts for COP 20 remains aligned with this long-term goal of epidemic control in South Africa but has shifted its targeting approach for districts to take into account the change from surge to maintenance of HIV care. The following three categories of districts have been identified:

1. **Retention-focused districts:**
 - Twelve districts that will be >81% coverage by the end of FY21 with aggressive growth in FY20 and more modest growth (5%) in FY21 (Amathole, Chris Hani, Alfred Nzo, Lejweleputswa, Thabo Mofutsanyane, Sedibeng, Harry Gwala, King Cetshwayo, Ugu, Zululand, Mopani, Ehlanzeni)
2. **Continued DSD districts:**
 - Ten districts that will need to continue aggressive growth trajectories to ensure 81% coverage at the district level (Buffalo City, Oliver Tambo, uMgungundlovu, Uthukela, Capricorn, Nkangala, Bojanala Platinum, Dr Kenneth Kuanda, Ngaka Modiri Molema, and Gert Sibande)
3. **Districts of high-unmet need**
 - Top 5 districts by unmet need: City of Johannesburg, City of Tshwane, Ekurhuleni, eThekweni, City of Cape Town

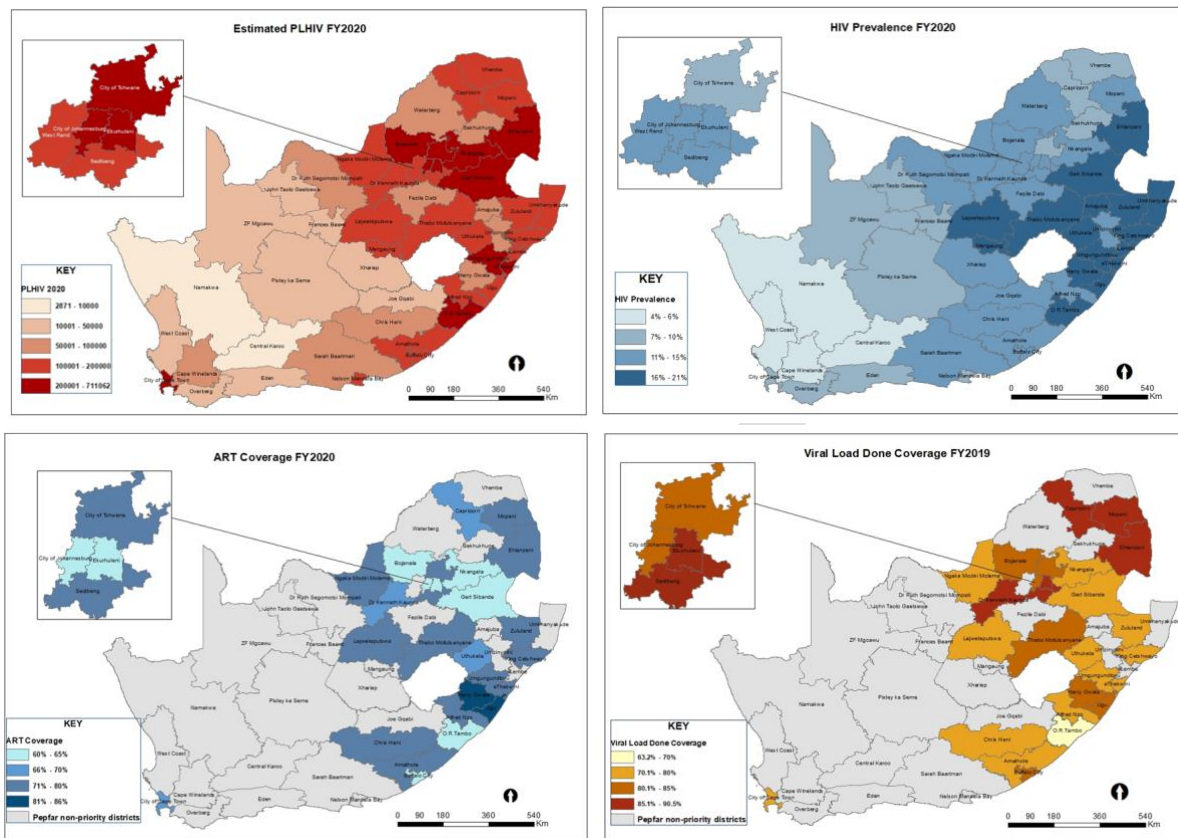
The aim of this shift is to ensure that by the end of COP20/FY21 PEPFARSA achieves 81% ART coverage across all 27 districts, with the three-categories scale allowing for different growth rates and retention rates to transition the program to maintenance.

PEPFAR SA will provide targeted support to facilities, with support linked to facility HIV burden and growth needed to reach 81% ART coverage. In COP20, PEPFAR SA plans to continue intense facility support to high-volume facilities. Once facilities achieve performance standards in ART coverage, PEPFAR SA will adjust direct service delivery support strategically to maintain 81% ART coverage and improve focus on sites remaining that have not yet reached 81% ART Coverage.

PEPFAR SA will not be setting individual facility level targets in COP 20, instead opting for a partner performance management approach to ensure districts achieve their rolled up targets to reach 81% ART coverage, allowing for a more agile response to the unique needs of facilities to reach ART coverage and maintenance thereof.

DREAMS programing in COP20 will focus on AGYW and their communities in 24 districts. Among these, 4 districts are historic and 20 more are added to the program: 6 priority population districts, and 14 new districts based on high UNAIDS incidence and overall PLHIV burden. Based on existing data, historical presence/successes, (including in COP 19) and requests from provinces and districts, PEPFAR SA will be expanding DREAMS to King Cetshwayo (KCD), Ehlanzeni, Gert Sibande, City of Tshwane, Bojanala, and City of Cape Town. These districts have been selected to remain additive to already existing prevention programs and aligned with work currently being undertaken and planned for by Global Fund.

Figure 2.5.1 PLHIV, HIV Prevalence, ART coverage, and Viral Suppression, by District



2.6 Stakeholder Engagement

In addition to a close collaboration with the GoSA, PEPFAR SA engages with a large cross-section of stakeholders. PEPFAR SA maintains a close relationship with other donors and multilateral organizations, including the Global Fund, UNAIDS, World Health Organization (WHO), the Clinton Health Access Initiative (CHAI), the Gates Foundation, the International AIDS Society (IAS), Medicine Sans Frontiers, among others. Quarterly and even more frequent meetings are held with those organizations across which areas of funding and focus are similar, in particular the Global Fund, to ensure alignment and synergy of activities. PEPFAR SA representatives sit on the various working groups of the CCM. Additionally, PEPFAR SA representatives are actively engaged with the technical working groups of SANAC.

PEPFAR SA engages with the PLHIV sector and Civil Society Forum (CSF), a broad-spectrum platform of 18 organized sectors of society, including women, men, lesbian, gay, bisexual, transgender and intersex people (LGBTI), youth, NGOs, labor, people with disabilities, PLHIV, and other representatives.

The PEPFAR SA team facilitated several meetings with civil society in COP18 to work collaboratively toward a strengthened relationship and community involvement to address the HIV/AIDS epidemic. These meetings resulted in the following:

- Quarterly reporting of implementing partners' progress to CSF and PLHIV sector
- Increased collaboration with other stakeholders (e.g., Departments of Health, Education and Social Development);

- Community-led site level monitoring; and
- Engagement on COP20, which includes inputs into the People's COP 20.

Civil society identified areas for improvement, which were included in the People's COP 20. These following recommendations were carefully considered and integrated into COP20 planning.

- Roll out of multi-month dispensing, including six-month dispensing
- Establish and scale up adherence clubs and support groups
- Develop a comprehensive approach to medical and psychosocial support to improve ART retention
- Ensure index testing does not lead to intimate partner violence
- Fund an expansion of high-quality treatment literacy information
- Ensure that PLHIV clients are informed and offered the option for TB prevention therapy
- Ensure men have access to male-friendly services
- Support youth-friendly services and youth clubs
- Maintain the Ritshidze (community-led monitoring) project (see section 4.3)
- Eradicate barriers towards accessing HIV, TB, and Sexually Transmitted Infections (STI) medications
- Other sector inputs to COP20 include activities to support and strengthen youth, Key Populations (KPs) and CS broadly.

Private Sector

The private sector was consulted in the planning of COP2. The PEPFAR team targeted workplaces that employ populations affected by HIV and their communities. These include engagements with the mining sector, agricultural sector, pharmaceutical manufacturers, pharmacies, and logistics providers.

In addition, the PEPFAR team works to integrate innovative private sector approaches to improve access to life-saving medicine and increase access to treatment. A priority is to target the uninsured sectors of the South Africa workforce living with HIV. In COP20, PEPFAR will continue its formal partnership with groups like the Cipla Foundation to place container-based pharmacy units in places with limited healthcare infrastructure. PEPFAR South Africa will also continue strengthening their relationships with US-based firms such as Johnson and Johnson, Gilead, and Coca-Cola into COP20.

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 consistently contain approximately 80% of PLHIV. During COP19, an increased emphasis was placed on the four metropolitan districts with the highest unmet need (Johannesburg, eThekweni, Ekurhuleni, and Tshwane). For COP20, the focus districts have been divided into three categories namely; High-burden metros (four priority metros + Cape Town), which have the most unmet need; Continued DSD districts (districts that will need to continue aggressive growth trajectories to ensure 81% coverage at the district level); and

Retention-focused districts (districts that will be >81% coverage by the end of FY21 with aggressive growth in FY20 and slower growth (5%) that can be sustained by the NDOH in FY21. The standard for all PEPFAR-supported sites is 95% retention and continued growth in TX_CURR to close the ART gap to 90–90–90. The projected ART coverage in COP20 is projected to be 84%, 81%, and 91% in High-burden metros, Continued DSD districts, and Retention districts, respectively.

Given the requirement to set targets by fine age/sex disaggregations within each district this year, PEPFAR SA completed additional modeling (the Naomi model) to estimate PLHIV and ART coverage within each of these sub-populations. These revised PLHIV estimates were agreed on with both NDoH and the Office of Global AIDS Coordination (OGAC). PEPFAR SA's program will be focused on closing treatment gaps in each of these populations and thus targets were set to reflect the most aggressive increases in the number of patients on treatment in the sub-populations/districts with the highest unmet need. With a focus on sustaining the gains from our treatment surge and closing any remaining gaps, COP20 targets aim to reach 90–90–90 in all districts and all age/sex bands except men aged 20–34. This equates to over 5 million persons on treatment and 86% coverage overall within the 27 in PEPFAR-supported districts by September 2021.

Consistent with COP19, 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 above (Section 2.2) have been specifically designed to improve identification of HIV-positive men, adolescents and children, and to link and retain them in treatment.

The MINA campaign is being designed to significantly increase demand for and retention on ART among men. In alignment with the NDOH's national strategy on reaching men, PEPFAR SA will additionally provide support to strengthen linkages between Voluntary Male Medical Circumcision (VMMC) and treatment programs, with a focus in incorporating knowledge of HIV status and adherence to ART as part of a broader self-care approach. In the latter part of COP19 the national VMMC program reviewed and assessed saturation levels across all 27 priority districts and utilized this information to more strategically set COP 20 targets. In contrast to COP19, in COP20 the PEPFAR team will exclusively target men age ≥15 years old, who are at highest risk for HIV acquisition, for VMMC services.

Service quality and retention strengthening 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. To close the treatment gap among children, PEPFAR-funded direct service delivery staff will continue to support dedicated pediatric case management to improve pediatric case finding and retention and to improve bilateral referrals between facilities and PEPFAR SA OVC programs. This is expected to increase the percent of Children Living with HIV (CLHIV) receiving these crucial wrap-around services and improve overall retention through late childhood and adolescence.

Priority populations for prevention were identified based on HIV risk profiles, with the greatest focus being on AGYW and OVC. DREAMS programming in COP20 will focus on AGYW and their communities in 24 districts including 4 historic DREAMS districts, 6 historic priority population districts, and 14 new districts based on high UNAIDS incidence and overall PLHIV burden. OVC services will be provided in 31 priority districts: 24 from COP19, adding Lejweleputswa and including six Peace Corps and Community Grants districts.

KPs are characterized by high HIV prevalence with social marginalization and stigmatization contributing to high infections; KPs include female sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prisons. Focus districts for KP are selected based on KP populations size estimations, in careful coordination with Global Fund to ensure national coverage of KP programs with no program overlap. By reaching saturation of treatment and prevention interventions among key and priority populations in the highest burden districts, SA 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 (Nov FY2019) [2,3]	# of Districts FY2020 (COP19)	# of Districts FY2021 (COP20)
Attained	-	-	-	-
Scale-up Saturation	2,317,765 (30%)	1,337,884	4	4
Scale-up Aggressive	3,808,462 (50%)	2,362,283	23	23
Sustained	-	-	-	-
Central Support	1,566,153 (20%)	1,019,306	25	25
[1] Eaton, J & Johnson, L. Unpublished Document – NAOMI 2020 District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)				
[2] NDoH Program data (DHIS), November 2019.				
[3] DATIM FY19Q4 APR Results.				

4. Client Centered Program Activities for Epidemic Control

4.1 Finding the missing and getting them on treatment

In COP20, 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. PICT optimization will be the focus to ensure the routinization of offering HIV testing within the other care provision and testing provided at a clinic, to ensure de-stigmatization and increase HIV testing for those who are eligible to be tested. Screening tools will be used to identify those likely at risk of undiagnosed HIV infection to ensure that only the truly eligible will be offered routine HIV testing. 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 with a special focus on men including: (1) Patients in the queues waiting to consult clinicians, (2) distribution channels such as the workplaces and transport hubs, and (3) partners of pregnant and breastfeeding women. In COP20, the targets for self-screening as a targeted testing modality will increase more than three-fold to maximize reaching the partners of index clients, community testing, as well as assisted self-screening at facilities.

Facility-based index testing will be fully implemented, targeting all new HIV positive clients, clients that have unsuppressed viral loads, STI patients, and TB patients. The unsuppressed viral load patient focus is crucial, because these clients are at risk of transmitting to sexual partners and may also potentially be transmitting resistant strains of the virus. Therefore, contacts of index cases with acute infections or who have a high viral load will be prioritized for tracing. Other priority populations for index testing include pregnant and breastfeeding women, as well as adolescent girls. Screening and monitoring incidence of intimate partner violence (IPV) is a high priority for this testing modality. To ensure fidelity in the scale-up of index testing, including alignment with WHO Five C's of HIV Testing Services (HTS), the DoH supports ongoing trainings and refresher trainings for its staff on the correct implementation and monitoring of index testing. Similarly, PEPFAR-funded DSPs will implement ongoing trainings and mentorship for their staff. Additionally, with the help of adverse event monitoring tools, the fidelity of index testing will be scrutinized at every facility performing this work. Monthly analyses comparing site level acceptance rates and partner elicited acceptance rates against the average will be conducted to pick cases where coercion may be happening. PEPFAR SA will ensure that all referral options listed for adverse events will be of the highest quality, with proven track records. Index testing implementation reporting is part of the weekly nerve center meetings where clinical cascade performance is discussed at the sub-district level.

Community testing in COP20 will primarily be focused on tracking and tracing index test partners and enhanced case-finding among men, through focusing on the community hotspots that men frequent. These will include, but are not limited to, workplaces and travel hubs. PEPFAR SA testing partners in the community will be trained to also use self-screening as a way to reach men that are not utilizing testing services at facilities. PEPFAR will support mobile outreach services, as an extension of the existing healthcare system in order to encourage access and uptake of basic services such as HIV testing, family planning, STI screening and ART initiation and management closer to the community as a strategy to reach, initiate, and retain men. Low yield (2%–3.7%) is to be expected from community mobile testing that is conducted to reduce stigma for index contacts that are traced and offered testing in communities, as well as from DREAMS and OVC entry points as these are essentially prevention programs. Additionally, in COP20, DSPs will ensure coordination of smaller Community Based Organizations (CBO) to ensure the quality of counselling as well as ensuring those who test positive are escorted from testers to clinicians who initiate ART treatment. PEPFAR SA will scale up community self-screening to focus on patients not engaging in more traditional testing modalities and in coordination with the scale-up of index testing. Another testing modality that will be broadened is recency testing. In COP20, PEPFAR

SA will double recency targets. Based on the results of recency testing, community hotspots will be identified and targeted for enhanced testing and other prevention activities.

4.1.1 Population-Specific Interventions

In addition to these broad national- and site-level strategies, PEPFAR SA continues to focus efforts 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. Extended hours and male-friendly spaces that improve the experience of men will be strengthened. Linkage to treatment will be enhanced through further scale-up of community ART initiation and private sector innovations, 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 and AGYW, PEPFAR SA has received a significant increase in funding for the DREAMS program that will entail working with facility, community, faith-based and traditional structures 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 continue to 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. PEPFAR will use support of community-led monitoring partners to further identify facilities that are providing services in a manner that is not friendly to young people, in order to quickly target interventions to remediate the situation.

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 DoH to reach HIV-positive mothers with differentiated models of care that particularly respond to the needs of the mother-infant pair. Specific 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.

In line with the success of the Siyenza and Phuthuma campaigns, PEPFAR SA will expand its intensive partner management and support in COP20. Using developed SOPs and tools, many PEPFAR SA staff will continue spending a predominant part of their time providing direct support to facility personnel, sub-district, and district HIV leadership, and more direct oversight to DSPs. In districts that are designated DSD districts, PEPFAR SA will 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, adherence and retention tracking and tracing, and differentiated care.

4.1.2 Getting Them on Treatment

Strategies to improve linkage in COP20 include same-day ART initiation, community ART, and further scale-up of linkage officer/case manager support staff. Over the course of COP19, 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.

In all these efforts, PEPFAR SA is committed to continue support for public health facilities and 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 investments in supplemental staff at public health facilities and in community human resources provide direct support to these efforts.

4.2 Retaining clients on treatment and ensuring viral suppression

Retention on ART is now 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 COP19 and during COP20, PEPFAR SA will focus on preventing defaulting by better understanding the individual characteristics and reasons for individuals disengaging from care, improving patient experience during clinic visits (by reducing queues, decanting stable patients, expanding hours of operation, providing population-specific services such as Men's Corner or youth-friendly services after school hours), and providing enhanced support SMS reminders, and through "case managers"/"buddies" to patients initiating therapy. Although VL suppression rates are high among those currently on ARVs, the roll-out of TLD during COP19 and COP20 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.

In FY19, the retention gap was highest among the adolescents 15 – 19 years (32–34%) and young adults 20–34 years for both males (27–27%) and females (22–33%). In response to this challenge, there are specific activities planned for COP20 for each of these population groups.

For adolescents, PEPFAR SA will facilitate the provision of youth friendly services, enhance clinic-OVC program linkages, scale-up pediatric case management, implement peer support groups, and engage youth ambassadors. To increase retention among young men and women, PEPFAR SA will scale up of population friendly services namely male-friendly services for men, and support groups (I-ACT) and postnatal care clubs for women, community ART (both initiation and maintenance), active promotion and enrolment in differentiated care modalities including 6 months dispensing and increasing the number of external pick-up points. Although VL suppression rates are high among those currently on ARVs, the roll-out of TLD

and Dolutegravir based regimens during COP19 and COP20 are expected to have a significant impact. Priority populations for prevention were identified based on HIV risk profile, with the greatest focus being on AGYW and OVC. With the eLab platform, patients who are virally unsuppressed will be identified early and recalled for enhanced adherence counselling with the support of case managers.

4.3 Prevention, specifically detailing programs for priority programming:

4.3.1 HIV prevention and risk avoidance for AGYW and OVC

PEPFAR SA recognizes the crucial importance of slowing the high HIV incidence of AGYW to achieve epidemic control. Progress made with targeting AGYW with evidence-based, age-specific, multi-session, and layered prevention interventions using both comprehensive community platforms and school-based curricular and co-curricular interventions supporting AGYW will continue in COP20. DREAMS will accelerate programming in the 4 existing DREAMS districts of eThekweni and uMgungundlovu in KwaZulu-Natal, and Ekurhuleni and City of Johannesburg in Gauteng to achieve 100% saturation. In COP20, DREAMS has received a significant funding increase to \$90m, representing a three-fold increase in funding over previous years.

In line with the priorities for DREAMS listed in South Africa's COP20 PEPFAR Planning Letter, PEPFAR SA will implement the following:

- **Hire a DREAMS Coordinator and deputy within the PEPFAR Coordination Office.** These positions will ensure dedicated support for the PEPFAR SA DREAMS program coordination and liaison with key stakeholders, including OGAC; particularly given the planned expansion, discussed below.
- **Rapidly expand DREAMS to increase reach and depth of programming.** DREAMS will expand into 14 new districts identified as having either very high or extremely high incidence together with a high burden of PLHIV. In order to achieve the most cost-effective and maximum impact, the focus within these new districts will be on high-burden, high-population sub-districts. In addition to these 14 new districts and based on existing data, historical presence/successes, and requests from provinces and districts, PEPFAR SA will also expand DREAMS into six other districts, including King Cetshwayo (KCD), Ehlanzeni, Gert Sibande, Tshwane, Bojanala, and Cape Town. Expansion into these 6 additional districts will leverage existing PEPFAR programming to maximize efficiencies of services. This geographical expansion will increase the reach of DREAMS to a total of 24 districts. All expansion will be done in close collaboration with Global Fund and the South African Government to ensure against unnecessary duplication of efforts, as well as ensure that PEPFAR and Global Fund jointly work towards saturating the six additional proposed districts.
- **Expedite the implementation of the South Africa database to accurately track layering across all DREAMS partners.** PEPFAR SA will continue to improve its system for tracking layering of DREAMS services, including completed referrals to

other service providers, for all beneficiaries. Efforts towards completion of the phased approach to an online data management platform will continue and allow for more accurate reporting on the new AGYW_PREV MER indicator. PEPFAR will accelerate plans to engage fully with the SAG key departments of health, social development and education to ensure the alignment of the DREAMS cohort tracking system to SAG's systems.

- **Improve targeting of AGYW to ensure that those most vulnerable to HIV acquisition are systematically identified and engaged.** PEPFAR SA will refine its identification and risk assessment strategies, including those approaches used to identify AGYW in schools, and apply new PEPFAR guidance to refine risk and vulnerability assessment tools in DREAMS. Focus will be on strengthening points of entry into DREAMS by using Antenatal Care (ANC), HTS, STI, FP and other clinic service points in DREAMS districts, as well as identification through various community points and social networks. The aggressive application of the DREAMS Risk and Vulnerability Assessment will include working in collaboration with the key SAG departments of health, education and social development to ensure alignment of tools and criteria and ensure opportunities to provide a case management system for DREAMS beneficiaries.
- **Enhance the package of economic strengthening services, including skills training and employment opportunities, for AGYW tied directly to program implementation.** Given South Africa's very high rates of youth under-employment and economic marginalization which contributes to the HIV vulnerability of AGYW, PEPFAR SA will focus on creating stronger linkages to employment for DREAMS beneficiaries. In addition to current DREAMS programming to build financial literacy skills, COP20 will focus more directly on improving the marketability, job readiness, and entrepreneurial skills of AGYW 20–24 years in all focus DREAMS districts. With COP20 funding PEPFAR will explore focused bridge to employment opportunities in target sub-districts of the City of Johannesburg, Ekurhuleni, eThekweni, Sedibeng, and Buffalo City. Market assessments will be undertaken at local levels to identify potential private sector collaborations and opportunities to connect older DREAMS beneficiaries to jobs. The Youth Employment Service (YES), a business-led collaboration with SAG, will be leveraged to provide DREAMS beneficiaries bridge to employment opportunities. As part of the economic strengthening focus for DREAMS in COP20, DREAMS Ambassadors, where feasible, will be hired to co-ordinate and assist with promoting DREAMS in all 24 DREAMS districts. In collaboration with PEPFAR implementing partners, COP20 will continue to identify employment opportunities to train and hire DREAMS Ambassadors as data collectors and linkage officers especially between health, social services and schools, to increase access to health services.
- **Accelerate efforts to expand PrEP uptake.** Vigorous promotion of PrEP will continue with PrEP targets of 215,000 for AGYW 15–24 years in COP20. Work with NDoH to ensure all Provincial Steering Committees are established and functional to accelerate PrEP implementation including creating platforms to engage and educate

parents and communities to support PrEP uptake for AGYW. Efforts to ensure adherence and continuation/retention on PrEP will be strengthened.

- **Integrate STI screening and treatment.** AGYW 15–24 years identified in hotspots as most vulnerable in the four original DREAMS districts will be offered STI screening, diagnostic testing, and treatment at DREAMS and PrEP service points.

In addition to the COP20 PEPFAR Planning Letter priorities, PEPFAR SA will continue improving the tools to facilitate referral pathways and quality of services by all implementing partners. In COP20, PEPFAR will work with all partners to develop standard operating procedures to support layering, and bidirectional referrals. DREAMS will support the strengthening of the Integrated School Health Program to ensure that the departments of health, social development and basic education receive capacity to provide targeted sexual and reproductive health (SRH) services to AGYW, and for the DBE to implement its policy on HIV, STIs and TB. Among 9–14 year-old adolescent girls and boys, PEPFAR SA will continue to 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 will continue to 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, PEPFAR SA will continue to leverage higher education community and clinical platforms to prevent HIV by empowering young women, mobilizing communities, and linking young women to SRH, including PrEP.

The target for **Post Violence Care** in DREAMS is 32,644 for COP20. PEPFAR SA will continue to strengthen the violence prevention programming integrated into the DREAMS core package and improve access to quality post-violence care services. More focus will be on integration of the GBV response into the HIV clinical cascade of services. This will include training of care and treatment partners and DoH counterparts to mitigate impact of GBV on retention, training of index case testing providers to build capacity for appropriate response to disclosure and building capacity of GBV case managers to track post-exposure prophylaxis (PEP) and ART adherence.

4.3.2 Children / PMTCT

Strategies to reach epidemic control for CLHIV aged <15 years will include strengthening the use of HIV screening tools in all pediatric service points, including TB/HIV care; screening all children in OVC platforms; scaling-up index testing in MCH platforms, chronic and acute streams, and the use of family tree in facilities to increase coverage among OVC. Additional mentoring and support for pediatric case management, such as phlebotomy, dosing, viral load monitoring, increased responsiveness to high viral load and transitioning of children ≥ 20 kg to Dolutegravir-based regimens, will be strengthened.

The OVC Partners and the DSPs will intensify their efforts to find CLHIV by maximizing index testing for 100% of biological children of HIV+ mothers and fast-tracking linkage to HTS for all OVC at-risk per HIV risk assessment. PEPFAR-supported OVC and treatment-integrated interventions will build on the case management approach by placing paid, trained social auxiliary workers in high volume facilities and child and youth care workers at the community level, which will enable the bi-directional and active referrals necessary to improve retention and adherence of CLHIV and ensure a holistic care package for these children and adolescents. OVC IPs will continue to proactively trace patients missing appointments or otherwise disengaging from care. Joint case conferencing will address non-suppression through regimen optimization, treatment literacy, and enhanced socioeconomic support.

The OVC platform has ramped up enrollment of HIV+ children into OVC programs from 2.5% in APR 18 to 15% in APR 19, with a target of 20% by APR20 and 25% by APR21, respectively. By APR 20, the OVC program expects to achieve 80% coverage of TX_CURR for those <18 years of age in OVC districts and by APR21 90% coverage of TX_CURR for those <18 years of age in OVC districts. OVC programs will ensure high-functioning relationships with health facilities in their area. In FY20 and COP20, these relationships will be formalized through Memoranda of Understanding (MoU) and/or informal agreements between DSPs and the community partners to intensify case finding and provide supportive adherence once children have been enrolled or re-enrolled on ART. The OVC program has showcased robust case management to ensure quality clinical outcomes (on ART, viral load test completed, virally suppressed, and retained in care) which are systematically tracked via custom indicators. OVC IPs will deliver intensive case management for children/adolescents living with HIV (C/ALHIV) (focusing on those not virally suppressed); strengthen treatment literacy among families; and provide tailored adherence support.

For people infected and affected by the epidemic, HIV is not only a medical experience; it is also a social and emotional experience that profoundly affects their lives and their futures. Family-based approaches and family-centered care are critical to improving clinical, as well as socio-emotional outcomes among HIV-infected and affected children and their caregivers. In COP20, OVC IPs will scale up disclosure education sessions with caregivers, as well as expand psychosocial support packages and peer support for C/ALHIV (Vhutshilo 3, IACT, routine youth care clubs).

In COP20, the goal is improve the clinical cascade for the 10–15-year age band by strengthening the implementation of youth-friendly spaces/youth zones and having youth ambassadors recruit school going children from the age of 10 years and above. All Siyenza-supported sites have recruited youth ambassadors to scale up activities for the 10–24-year age band at community and facility levels.

For 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 transmission to below 2% at <2 months. PEPFAR SA will strengthen the technical support for family planning platforms and self-screening services for women and their partners to improve case finding and uptake of TLD. Despite the successful PMTCT

program, gaps still exist during the postnatal period that hampers the elimination of Mother to Child Transmission of HIV at 18 months (final outcome), PEPFAR IPs will support the districts in the implementation of universal testing of all children at 18 months. PEPFAR SA will support the DoH to reach HIV-positive mothers -especially adolescent girls and young women (AGYW) 15–24 years—to be enrolled in differentiated care models at high priority sites to improve linkage to care, adherence, retention, viral suppression, and family planning services to increase uptake of TLD; improve early infant diagnosis (EID) coverage at 18 months, immunizations, and infant feeding of HIV-exposed infants. All partners have selected sites to roll out the postnatal clubs in MCH platforms and intensive partner management has been initiated. This intervention will help to support viral suppression and adherence to treatment of breastfeeding HIV positive mothers. PEPFAR SA is fully committed to active partner management and accountability, engagement at all spheres of government, and mobilizing faith-based organizations, private sector, and all stakeholders to achieving these goals.

4.3.3 Key Populations

PEPFAR has shown remarkable success and improvements in 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. All key population programs are aligned with strong country strategic plans and informed by population-size estimations and bio-behavioral data. In 2016/2017, SANAC launched strategic plans for sex workers and LGBTI,¹⁶ aligned with the NSP 2017–2022. These plans demonstrate strong consensus on the strategic direction and confirm GoSA’s support. SANAC is also planning for a new National Sex Worker Plan 2019–2022.

The core of the COP20 program focuses on peer-led outreach and mobilization, targeted strategic communication and demand creation, and key population-friendly mobile and drop-in centers. These centers provide HIV testing and treatment; STI screening and treatment; TB screening and referral; PrEP; PEP; and other primary health services, including sexual and reproductive health. Additional targeted services, including hormone replacement therapy for transgender people and opioid substitution therapy for people who inject drugs, are also provided based on key population needs. In COP20, we will emphasize case identification to increase HTS yield, particularly in the MSM program, through Enhanced Peer Outreach Approach or social network strategy.

This core package of services is complemented by interventions focused on stigma reduction, community mobilization, and use of strategic information for program management. Resources from the final year of the Key Populations Implementation Fund are additive to COP20 investments and will include innovations to improve yield, linkages and retention across the prevention, care and treatment cascades.

¹⁶ The South African National Sex Worker HIV Plan 2016–2019, and the South African National LGBTI HIV Plan 2017–2022.

Above-site support for the GoSA's High Transmission Area program will be expanded in COP20, strengthening the national strategy to target and address the needs of the WHO-defined key population groups and building the long-term sustainability of the key population's response. Finally, key population sensitization modules that were developed in COP19 will be rolled out broadly in COP20, starting with Siyenza facilities to expand behavioral and biomedical understanding of key populations to NDoH facilities.

4.3.4 Voluntary Male Medical Circumcision (VMMC)

The VMMC program has strengthened each year, for the past 5 years, and has performed very well, conducting approximately 500,000 circumcisions per year. In FY19, the program achieved 102% of its annual target. However, the age pivot in South Africa has remained problematic, with over 40% of VMMCs done in the 10–14 year old age group. This has remained relatively constant over the past several years. PEPFAR does not and has never supported any active demand generation targeting the 10–14-year old age group. However, in many South African cultures, male circumcision (MC) is done as soon as boys 'come of age'. Parents often encourage MC prior to sexual debut or prior to traditional male initiation (TMI) as a safety consideration. Additionally, in many parts of the country the TMI process consistently attracts younger boys. As a result, many boys present for VMMC early and, as per national policy, are not turned away.

In FY19 the proportion of 10–14 year olds remained at 43%. However, some partners achieved progress and increased service delivery in the older, targeted age groups. For FY20 the VMMC program set out to reduce the proportion of VMMC in 10–14-year olds from greater than 40% to less than 20%. In FY20/Q1 the proportion of 10–14-year olds was 18%. Hence, the program is confident that it is moving away from conducting VMMCs in 10–14-year olds.

Therefore, the VMMC program will not set any VMMC targets in the 10–14-year-old group for COP20. After careful consideration and negotiation with the (NDoH, PEPFAR SA will not consider implementing Tanner staging and will not move to support the implementation of the Shang Ring, options delineated in the PEPFAR COP20 Technical Considerations.

For proposed target allocation in the remaining age groups, the program first considered VMMC coverage. SA has lacked reliable VMMC coverage data for some time; however, in COP18, the Human Sciences Research Council (HSRC) was contracted to triangulate its household survey (2017) findings with a number of other available data sources (surveys, models, and programmatic data) to calculate reliable VMMC coverage estimates by district. These new estimates show that, while variations exist across districts, the estimated coverage is low, with not a single district reporting >60% VMMC coverage in the 15–34-year-old age group. Therefore, we will target all 27 PEPFAR supported districts based on prior year performance with more targets being assigned to better performing districts to move towards >80% VMMC coverage more quickly. The proposed targets have been set within the 15–34-year-old age group, with a strong preference for the 15–19 and 20–24 year old age groups (~70%) as per the COP20 guidance.

For COP20, the main programmatic challenge will be to no longer circumcise any 10–14-year-old boys while the current national policy and VMMC program guidelines recommend VMMC from the age of 10 and services are provided accordingly. The PEPFAR team has engaged NDoH and discussed the new age pivot guidance. NDoH acknowledged the guidance, has reviewed and understood the rationale and evidence behind it, and has expressed willingness to consider policy changes in the near future. PEPFAR will actively encourage and support

such a process, but recognizes that policy changes, and subsequent implementation, tend to be slow.

The following principles will be followed, effective immediately as per guidance from OGAC.

- Where PEPFAR is providing services through General Practitioner (GP) private practices, non-DoH sites, and mobile services that do not fall under the direct purview of the DoH, the program will stop circumcision of 10–14-year-old boys.
- Where PEPFAR provides services in public health facilities, dictated by the current NDoH policy, PEPFAR has already embarked on a substantial effort to reduce the 10–14 year old proportion. The program will stop circumcising younger boys completely by the end of September 2020. To achieve this major program pivot, we will consider developing counselling messages to better inform the public of the increased VMMC risk in 10–14 year old boys and promote delay of circumcision until 15 years of age. The program is also in discussion with NDoH on how DoH will continue to provide VMMC service delivery for younger boys prior to policy change.
- Finally, PEPFAR will work to sustain the benefits of the recent integration of VMMC in the TMI process, which has been a major programmatic achievement. The implementation of TMI, including the age pivot, is dictated by the traditional structures and not by DoH. This may be advantageous for PEPFAR i.e., in Eastern Cape Province where initiates are required to be 18 years of age or above. However, in other provinces, such as Mpumalanga, TMI attracts boys starting from age 10. In those districts, the program will explore options with the traditional structures and leadership. Once again, the program is negotiating with NDoH on how this may be done through the DoH until the policy change is enacted.

In addition, in COP20, PEPFAR SA plans to increase the total number of circumcisions done in the target age group (15–24) and will continue to find cost efficiencies. PEPFAR SA will prioritize reaching saturation in 15–24 year olds in the best performing districts.

Finally, the VMMC program will support the upcoming NDoH Men’s Health Strategy by using the VMMC platform to offer a comprehensive package of health services for men (general health screening, HIV testing, ART initiation, STI screening and management).

4.4 Additional country-specific priorities listed in the planning level letter

4.4.1 Client and Family Centered Treatment Services

COP20 implementation will continue to thoroughly address the on-going challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, requires long-term, continuous ART for a population that is often young and asymptomatic – and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, time constraints, poor customer service, stigma and discrimination, and life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient to the lives of clients and that make it easy for patients on ART to continue treatment. PEPFAR SA IPs work with DOH to provide client- and family-centered HIV treatment services by implementing National Adherence Guidelines and individualized case management.

Strategies to improve linkage in COP20 include same-day ART initiation through the “handshake” model (i.e., escorting of a newly diagnosed HIV positive patient to the ART initiation room to ensure linkage), community ART, the Welcome Back campaign, and extended and further scale-up of linkage officer/case manager support staff. During COP19, partners, through both direct placement of staff and mentorship of NDoH staff, have supported implementation of same-day ART initiation across all PEPFAR-supported sites. Among PEPFAR supported Operation Phuthuma facilities, >80% of newly diagnosed patients are now initiated on ART the same day. A number of districts [11/27 (41%) for males and 6/27 (22%) for females] are now meeting the 95% linkage proxy threshold and in COP20, the focus will be to increase the direct facility and community linkage to the same level across all supported districts. Patient education on the importance of ART initiation on HIV diagnosis and the availability of better and more efficacious treatment options will be scaled up to increase same day initiations. Services will be expanded, whereby HIV initiation is not only provided at one point in the facility but at multiple entry points where a NIMART nurse is stationed.

In COP20, PEPFAR SA will continue to support the NDoH to roll out and monitor the transition to TLD in South Africa, including intensified patient education on rapid viral suppression and on the benefits of the drug being a smaller and more palatable fixed-dose combinations. Although VL suppression rates are high among those currently on ARVs, the roll-out of TLD and Dolutegravir based regimens during COP19 and COP20 is expected to have a significant impact on retention and community-level VL suppression rates.

4.4.2 Retention

In COP20 PEPFAR SA IPs will continue implementing retention strategies, including appointment systems and decanting stable patients to adherence clubs, external pick-up points, and spaced and fast-laned appointments. PEPFAR will continue advocating with NDoH for the national roll out of MMD from the current 2 months supply to 6 months supply (with support to the supply chain for stock forecasting). In COP19, districts that implemented case management retained over 90% of their patients on treatment. In COP20, case management will be scaled up through the use of technology and continued peer-to-peer support. Other modalities for retaining patients include continuing to scale-up postnatal clubs and pediatric focused case managers/facilitators.

In addition to tracking patients disengaging from care, during the second half of COP19 and into COP20, PEPFAR SA will focus on preventing defaulting by better understanding the individual characteristics and reasons for disengaging from care, improving patient experience during clinic visits (by reducing queues, decanting stable patients, expanding hours of operation including Saturdays, offering scheduled visits with appointment times, retraining and sensitizing providers on friendly/compassionate services, ensuring organized/up-to-date/available patient records, providing population-specific services like Men’s Corner or Youth-friendly services after school hours), providing enhanced support SMS reminders, and through “case managers”/ “buddies” to patients initiating therapy which is part of client centered services provision. Tracking patients will begin from the time they miss an appointment (early missed) before they become disengaged from care. We will also strengthen patients’ health literacy, including U=U, and access to mental health services for patients

initiating therapy and for those with unsuppressed HIV VL. COP20 will fund an aggressive expansion of treatment literacy across all PEPFAR supported districts involving communities living with HIV and key populations. This will include dissemination to 100% of PEPFAR supported sites, trainings on materials, social mobilisation and incorporation in health talks. It will also include a healthcare worker training component ensuring that community and facility-based health workers understand HIV and TB fully to offer up to date prevention and treatment literacy information — and offer HIV and TB education in facilities, adherence clubs and beyond.

4.4.3 Community-led Monitoring

The PEPFAR SA COP20 will continue with the COP19 NDOH endorsed community-led monitoring. Community-led monitoring will contribute to South Africa's HIV/AIDS and TB responses by empowering PLHIV to monitor facilities and hold authorities accountable for providing high-quality HIV and TB care and support. During August and September of 2019, the PLHIV sector, together with support from Health GAP, amfAR and the O'Neill Institute, piloted a set of tools and strategies for systematizing community monitoring at 23 clinics in Gauteng and KwaZulu-Natal. Known as Ritshidze—meaning “Saving our lives” in TshiVenda—the project started to be brought to full scale in October 2019. When at scale, it will take place across 27 districts in 8 provinces in South Africa, to be expanded to 400 facilities by the end of the project. Selected facilities cover nearly half of all PLHIV on treatment in the country, with a focus on sites with large treatment cohorts and where data shows poor linkage and retention rates. Forty-five community monitors and 20 district organizers have been hired to carry out facility and community monitoring on the ground. Using tablets and the CommCare app, they will carry out surveys on a quarterly basis to capture data. Using data collected, fieldworkers will analyze the findings in order to outline the state of the facility, capturing challenges and evidence-based solutions for addressing them. The findings of monitoring efforts reflecting the “state of the facility” will form the basis of regular engagement with facility staff, clinic committees, and implementing partners in order to raise challenges, identify solutions for facility staff and implementing partners to undertake, and to then monitor the implementation of these solutions. Where challenges cannot be addressed at a facility level, fieldworkers will escalate the issues through direct and regular participation and engagement in Operation Phuthuma. In the coming weeks, all data collected will be available on a public data dashboard searchable by province, district or site, as well as by thematic area.

Great progress has been made in testing and validating a number of monitoring tools and the CommCare app, recruiting and capacitating the team, procuring and capacitating people to use the equipment, liaising with government at national, provincial and district level to ensure access to sites (ongoing), and building the data systems including the online data dashboard. Data capture has begun at many sites, the analysis of which will take place in COP20.

4.4.4 Pre-Exposure Prophylaxis

As per the NDoH PrEP and Test and Treat Policy, priority groups for PrEP in COP20 remain individuals who tested negative in index testing but remain at increased risk of HIV acquisition by virtue of unprotected exposure to HIV, KP (including sex workers, men who have sex with men, transgender persons, and people who use drugs), AGYW, including

breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified sero-discordant couples.

4.4.5 TB Preventive Treatment (TPT)

NDoH is working with PEPFAR SA to rapidly scale up 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 (TST) 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 Prophylactic 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 IPs 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. IPs also report on IPT initiations weekly for Siyenza sites, allowing 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 MER 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 COP20, 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 COP20 TB_PREV target in the planning letter. NDoH plans to introduce 3HP (Rifapentine and Isoniazid) in a few demonstration sites and PEPFAR SA will support the roll-out of 3HP, covering 5% of the overall TPT initiations in COP20. NDoH is yet to make the final decision on the number of demonstration sites as well as the number of patients to be initiated on 3HP, but PEPFAR SA will be as ambitious as possible in its introduction of 3HP to help the NDOH administer the 3HP courses it has been guaranteed, given existing global supply constraints. 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.

4.4.6 DREAMS

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 additional sub-districts. In the City of Johannesburg DREAMS interventions will be expanded into Regions B, C and F. The inclusion of additional regions is based on large-scale migration patterns across the city; AGYW migrate between the regions for schooling, work, socializing, and convenient health and social services. The vast regions of the City of Johannesburg also include major transport networks, including expansive taxi ranks that bring in migrant and mobile populations from neighboring countries and from coastal regions and rural villages within SA.

In the 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 hyper-epidemic 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 operating procedures for the systematic identification, enrollment, and delivery of services to the most vulnerable AGYW. Furthermore, DREAMS will continue to track and strengthen the layering of prevention interventions (particularly between community and clinical partners) through the cohort tracking system 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 TB creates substantial opportunities to scale up effective CSE interventions, including HIV and violence prevention interventions in schools in the highest burden districts (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 DoH, schools implementing CSE interventions have been linked to local health facilities offering adolescent and youth friendly services (AYFS), working through PEPFAR SA clinical partners. These interventions are designed to increase the provision of biomedical 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 supported DoH 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 COP20.

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 (TVETs) and universities] and 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 COP20 is the rapid scale-up of PrEP for AGYW targets 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.

4.4.7 Orphans and Vulnerable Children (OVC)

In COP20, 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 IPs will identify the most vulnerable children (including AGYW) and provide one-on-one support empowering them to stay and progress in school; access health services and grants; be adherent and retained in HIV care services; reduce violence and abuse; and prevent HIV infection. In COP20, 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 ‘Impower’. 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 COP20, the OVC IPs 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 AYFS, 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.

4.4.8 Voluntary Male Medical Circumcision (VMMC)

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 shown that targeting this age group is the most cost-effective in terms of infections averted. In COP20, 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 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 also strengthen linkage to treatment for men with HIV. Finally, as per the revised VMMC guidance, surgical VMMC under the age of 15 years will only be conducted by the dorsal slit method and are able to provide full informed consent for the procedure.

4.4.9 PLHIV Stigma Index 2.0

In COP19, the HSRC in collaboration with SANAC is implementing the PLHIV Stigma Index 2.0 to measure the levels of stigma and discrimination experienced by PLHIV. The survey includes PLHIV aged 15 years and older who are linked to an organization, including those attending primary health care centers, home-based care organizations, CBOs and NGOs for accessing HIV-related support and/or care and treatment. This survey will be conducted in six districts across the provinces of KwaZulu-Natal (uMgungundlovu District Municipality and eThekweni Metropolitan Municipality), Mpumalanga (Ehlanzeni and Gert Sibande District Municipalities) and the Free State (Thabo Mofutsanyane and Mangaung District Municipalities). The survey protocol is currently in clearance (HSRC is addressing DGHT HQ review comments). It is expected that data collection will be completed by the end of COP19.

4.5 Commodities

The GoSA maintains an investment of approximately \$601 million for the procurement of HIV-related commodities in 2020/21. The Global Fund plans to invest \$15 million in ARVs for treatment and \$830,000 for PrEP (annual estimates based on new grant funding estimates). In COP19 PEPFAR SA will invest \$23.1 million for the procurement of PrEP, VMMC commodities, HIV tests (including HIV self-tests), and 3HP.

South Africa will transition more than half of all adult patients, including women of childbearing potential, to TLD by August 2020. Six-month, multi-month scripting will be expanded in a targeted manner, to allow the NDoH to closely monitor treatment outcomes and 3MMD will be expanded for those not decanted to the Central Chronic Medicines CCMDD program. The CCMDD program will continue to expand, including various pick up points such as private pharmacy and standalone sites. No funding gaps for commodities have been projected for the period covered under COP19. The potential impact of coronavirus disease 2019 (COVID-19) on the availability of commodities will be closely monitored, given limited buffer stocks. The NDoH is working closely with its suppliers regarding any anticipated supply issues for active pharmaceutical ingredients sourced from China. The South African Health Products Authority (SAHPRA) and NDoH are working closely together to understand how this may impact registration updates for critical products.

4.6 Collaboration, Integration and Monitoring

Throughout the past several years, substantial gaps have emerged in performance related to initiation and maintenance of PLHIV onto ART. Together with the NDoH, PEPFAR SA has consequently collaborated on specific approaches to improve these critical programs. The

progress identified in COP19 will continue into COP20, including reinforcing the intense, site-level support that PEPFAR SA and NDoH launched in February 2019, strengthening the commitment to Ministerial circular about interventions needed to reach 90–90–90 targets, building off of NDoH’s SOP for all HIV/AIDS, STI and TB (HAST) Managers, increasing commitments to HRH and VL result reporting, documenting and addressing facility-based challenges. Careful monitoring of the fidelity of the implementation of these interventions will help South Africa reach the 90–90–90 targets. Notable activities for collaboration, integration and monitoring include:

- PEPFAR SA and the NDoH began a focused site-level activity in February 2019, following the Minister’s 10-point Plan. NDoH initiated “Operation Phuthuma” (e.g. acceleration) to manage the implementation of the 10-point plan at identified high volume, poor performing sites. PEPFAR supported Operation Phuthuma sites in Phase 1 (February – July 2019) in 343 sites while Phase 2 (August 2019 – February 2020) it expanded to 419 sites. Between February 2019 and February 2020, PEPFAR staff conducted 3,873 in-person site visits to provide hands-on technical support and problem-solving in coordination with Provincial and district level-DOH facility and IP staff with a focus on improve HIV case finding, ART initiation, and retention. Through this surge support, Operation Phuthuma sites consistently increased TX_CURR over the last year.
- PEPFAR SA and IPs continue to support Operation Phuthuma at all levels of government. Through Operation Phuthuma and Siyenza, PEPFAR SA and NDoH established a new way of doing business that includes daily monitoring of key indicators, weekly reporting and data-driven decision-making, and achievement driven IPs that work with DoH to address site-level bottlenecks immediately. District and Provincial forums (E.g. Nerve Centers or Management Review Meetings) were initiated weekly and monthly to review performance, identify and address bottlenecks and continuous monitoring of implementation of action items to improve the quality of health services. These forums are providing a space for DoH to “own” their programs and drive performance in alignment with the NDoH circulars that were sent in COP19. PEPFAR SA COP19 and COP20 activities will continue to bolster these forums for optimal collaboration and coordination to effectively expedite the resolution of site-level challenges.
- In January 2020, NDoH activated a re-energized Operation Phuthuma initiative to manage interventions, monitor achievement against targets, coordinate communication among partners, districts and provinces, troubleshoot and implement immediate remedial actions and to leverage provincial support partners to tackle barriers. The new structure includes nine joint (NDoH, CDC, and UASID) working groups to address:
 - Data reporting and analytics
 - Troubleshooting and resolution
 - Communication
 - Nerve Centers/ Monitoring Response Units
 - Admin and logistics support
 - Strategy/ interventions
 - HRH – training, performance monitoring and incentives
 - Finance
 - Project Management

- To ensure IPs share accountability for their performance, IPs are reporting weekly and monthly data to PEPFAR SA. In COP20, PEPFAR SA will continue its focus on scaling up PLHIV newly initiated on treatment, while intensive efforts are placed on retention in care. PEPFAR SA has directed attention to improving IP capacities to retain PLHIV on treatment and to re-engage those who have defaulted treatment. IPs who are underperforming will be placed under Corrective Action Plans (CAPs) which are monitored closely by agency leads.
- COP19 will be the final year of PEPFAR SA surge support. In COP20, PEPFAR SA will identify which of the 27 districts require continued full direct service delivery support to reach epidemic control or retention maintenance support depending on ART coverage. Surge staff will transition to DoH where possible in the retention districts.
- PEPFAR SA and NDoH are committed to improving the use of unique identifiers across sites and programs in clinical settings. As noted in the Minister's circular, PEPFAR SA and NDoH will continue to monitor full implementation of HPRS as the unique identifier system to track patients across facilities and trace defaulting ART patients. Both PEPFAR SA and NDoH will work to strengthen the implementation and routine use of HPRS within South Africa.
- PEPFAR SA and NDoH will continue to hold high level weekly coordination meetings to evaluate program performance, the main gaps identified, and the need for additional support to the provinces, districts, and facilities. PEPFAR technical staff, in coordination with the NDoH, will support the development of any technical material, as needed.
- PEPFAR SA will continue to consolidate and analyze monthly data from the facilities using its Siyenza interagency dashboard that allows for joint decision-making to support program management. An effort will be made to continue adding more facilities (both Siyenza and non Siyenza) in some districts.
- PEPFAR SA is consolidating the gaps identified in the facilities that will require escalation to the NDoH, provincial or district level. The data will continue to be shared weekly to obtain NDoH guidance and action, as needed, to support improvements in specific districts and facilities.
- PEPFAR SA will consolidate and analyze timely facility data to identify interventions that successfully lead to improved program performance, that will be presented as a package in the form of "best practices" that will then be scaled up in the remaining Phuthuma facilities to accelerate performance improvement.
- PEPFAR SA's program has been strengthened in COP19 by increased collaboration with GFATM and CS. This collaboration has improved program planning, resulting in a more robust and comprehensive HIV response. This collaboration will increase in COP20, as PEPFAR SA will continue to benefit from community monitoring through PLHIV sector's Ritshidze, which will continue to monitor HIV services at PEPFAR-supported sites within the 27 priority districts. PEPFAR SA and CS will increase accountability by jointly monitoring facility-level adherence to guidelines, observing staff performance, and serving as an additional data source to increase facility-level improvement.

To optimize the PEPFAR SA investments in addressing these gaps, PEPFAR SA will continue to collaborate with GoSA, GFATM and other key 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, 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).

4.7 Targets by population

The targets for the following three tables should be generated from DATIM, a “COP2o Target Table Favorites” will be available:

Table 4.7.1 ART Targets by Prioritization for Epidemic Control

Table 4.7.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (APR FY20)	Addition al patients required for 80% ART coverage	Target current on ART (APR FY21) TX_CUR R	Newly initiated (APR FY21) TX_NEW	ART Coverage (APR 21)
Attained	N/A	N/A	N/A	N/A	N/A	N/A
Scale-Up Saturation	2,317,765	1,858,396	-4,184	1,745,537	170,574	81%
Scale-Up Aggressive	3,808,462	3,018,553	28,217	1,745,537	377,543	85%
Sustained	N/A	N/A	N/A	N/A	N/A	N/A
Central Support	1,566,153	1,182,000	70,922	1,337,487	N/A	81%
Private Sector		303,000				
Total	7,692,380	5,357,450	796,454	4,828,561	548,117	82%

[1] Eaton, J & Johnson, L. Unpublished Document – NAOMI 2020 District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)

Table 4.7.2 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* (FY2020 expected)	VMMC_CIRC (in FY2019)	VMMC_CIRC Target (in FY2020)	VMMC_CIRC Target (in FY2021)
ec Alfred Nzo District Municipality	15-34 year olds	119,175	34%	7,942	20,000	13,077
ec Amathole District Municipality	15-34 year olds	129,188	9%	9,070	20,000	17,079
ec Buffalo City Metropolitan Municipality	15-34 year olds	118,504	14%	20,738	20,000	30,133
ec Chris Hani District Municipality	15-34 year olds	114,123	5%	7,772	10,000	10,291
ec Oliver Tambo District Municipality	15-34 year olds	269,687	14%	5,153	10,000	148
fs Lejweleputswa District Municipality	15-34 year olds	111,091	58%	3,585	5,991	8,743
fs Thabo Mofutsanyane District Municipality	15-34 year olds	129,555	49%	6,339	10,000	2,441
gp City of Johannesburg Metropolitan Municipality	15-34 year olds	1,081,522	56%	18,474	37,601	3,923
gp City of Tshwane Metropolitan Municipality	15-34 year olds	699,889	53%	10,020	10,890	15,360
gp Ekurhuleni Metropolitan Municipality	15-34 year olds	762,648	42%	10,354	16,688	16,118
gp Sedibeng District Municipality	15-34 year olds	183,562	57%	4,942	9,600	5,896
kz eThekweni Metropolitan Municipality	15-34 year olds	735,557	53%	49,510	115,199	3,740
kz Harry Gwala District Municipality	15-34 year olds	85,555	57%	5,838	12,600	56,434
kz King Cetshwayo District Municipality	15-34 year olds	164,325	55%	11,393	20,441	5,603
kz Ugu District Municipality	15-34 year olds	153,333	38%	9,859	15,995	9,571

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

District	Target Populations	Population Size Estimate (FY2020)	Current Coverage* (FY2020 expected)	VMMC_CIRC (in FY2019)	VMMC_CIRC Target (in FY2020)	VMMC_CIRC Target (in FY2021)
kz uMgungundlovu District Municipality	15-34year olds	204,643	49%	9,187	15,000	9,598
kz Uthukela District Municipality	15-34year olds	121,530	47%	7,696	15,000	8,658
kz Zululand District Municipality	15-34year olds	144,959	45%	6,451	18,400	7,166
lp Capricorn District Municipality	15-34year olds	218,126	62%	5,310	9,699	3,923
lp Mopani District Municipality	15-34year olds	197,477	35%	6,866	5,599	5,386
mp Ehlanzeni District Municipality	15-34year olds	306,479	55%	10,303	16,487	7,304
mp Gert Sibande District Municipality	15-34year olds	233,563	61%	7,621	9,896	8,449
mp Nkangala District Municipality	15-34year olds	311,623	41%	18,594	35,358	20,707
nw Bojanala Platinum District Municipality	15-34year olds	352,299	44%	9,408	9,845	10,237
nw Dr Kenneth Kaunda District Municipality	15-34year olds	133,160	42%	4,856	6,941	3,168
nw Ngaka Modiri Molema District Municipality	15-34year olds	154,472	28%	11,192	20,340	13,248
wc City of Cape Town Metropolitan Municipality	15-34year olds	782,391	26%	7,732	22,134	11,153
TOTAL	15-34year olds	8,018,437	Not Available	286,205	519,704	307,554
<p>*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.</p>						
<p>SOURCE: VMMC coverage modelling estimates, DHIS and DATIM</p>						

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control.

DRAFT

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Districts	Population Size Estimate	FY20 Results (expected in FY20)	Coverage Goal (in FY20)	Coverage Goal (in FY21)	FY21 Target
AGYW [10–24 yrs] (PP_PREV)	ec Alfred Nzo District Municipality	141,181	3	0%	18%	25,826
	ec Amathole District Municipality	117,725	3	0%	11%	13,176
	ec Buffalo City Metropolitan Municipality	98,726	3	0%	19%	18,916
	ec Chris Hani District Municipality	103,396	3	0%	11%	11,856
	fs Lejweleputswa District Municipality	82,263	3	0%	20%	16,727
	fs Thabo Mofutsanyane District Municipality	106,907	3	0%	20%	21,138
	gp City of Johannesburg Metropolitan Municipality	594,018	86,487	15%	30%	179,701
	gp City of Tshwane Metropolitan Municipality	387,505	19,265	5%	13%	49,901
	gp Ekurhuleni Metropolitan Municipality	410,855	32,837	8%	21%	86,461
	gp Sedibeng District Municipality	101,708	3	0%	23%	23,438
	kz eThekweni Metropolitan Municipality	480,460	74,341	15%	19%	90,440
	kz King Cetshwayo District Municipality	148,948	6,169	4%	18%	27,324
	kz Ugu District Municipality	103,999	56	0%	19%	19,771
	kz uMgungundlovu District Municipality	153,733	52,910	34%	28%	43,620
	kz Uthukela District Municipality	108,946	3	0%	17%	18,061
	lp Capricorn District Municipality	179,615	446	0%	22%	39,823
	lp Mopani District Municipality	161,585	108	0%	21%	34,115
	mp Ehlanzeni District Municipality	266,626	9,623	4%	18%	48,194
	mp Gert Sibande District Municipality	174,352	18,071	10%	17%	29,986
	mp Nkangala District Municipality	208,160	4,119	2%	19%	38,744
	nw Bojanala Platinum District Municipality	202,937	1,726	1%	19%	37,923
nw Dr Kenneth Kaunda District Municipality	99,490	3	0%	11%	11,074	
nw Ngaka Modiri Molema District Municipality	122,923	3	0%	14%	17,619	

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Districts	Population Size Estimate	FY20 Results (expected in FY20)	Coverage Goal (in FY20)	Coverage Goal (in FY21)	FY21 Target
	<u>wc</u> City of Cape Town Metropolitan Municipality	524,607	51,511	10%	17%	91,173
AGYW [10–24 yrs] (PP_PREV) - subtotal*		5,080,665	357,699	-	-	995,007
Female Sex Workers (KP_PREV)	<u>ec</u> Chris Hani District Municipality	1,711		0%	80%	1,369
	<u>ec</u> Oliver Tambo District Municipality	2,835	2,328			2,768
	<u>gp</u> City of Johannesburg Metropolitan Municipality	7,697	13,580	176%	80%	6,158
	<u>gp</u> City of Tshwane Metropolitan Municipality	5,435	9,060	167%	80%	4,348
	<u>gp</u> Ekurhuleni Metropolitan Municipality	5,606	5,361	96%	80%	4,485
	<u>kz</u> eThekweni Metropolitan Municipality	9,323	4,128	44%	96%	8,958
	<u>kz</u> iLembe District Municipality	1,302				1,042
	<u>kz</u> uMgungundlovu District Municipality	2,339	1,854	79%	101%	2,371
	<u>kz</u> Uthukela District Municipality	1,416				1,133
	<u>lp</u> Vhembe District Municipality	2,883	2,205	76%	80%	2,307
	<u>mp</u> Ehlanzeni District Municipality	3,648	1,605	44%	101%	3,668
	<u>mp</u> Gert Sibande District Municipality	2,190	1,120	51%	98%	2,152
	<u>mp</u> Nkangala District Municipality	2,801	1,218	43%	93%	2,591
	<u>nw</u> Dr Kenneth Kaunda District Municipality	1,510	1,281	85%	100%	1,508
	<u>nw</u> Ngaka Modiri Molema District Municipality	1,753	1,012	58%	100%	1,752
	<u>wc</u> City of Cape Town Metropolitan Municipality	6,500	3,450	53%	80%	5,200
FSW (KP_PREV) - subtotal*		58,949	48,202	-	-	51,810
	<u>ec</u> Buffalo City Metropolitan Municipality	3,601	1,260	35%	45%	1,620

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Districts	Population Size Estimate	FY20 Results (expected in FY20)	Coverage Goal (in FY20)	Coverage Goal (in FY21)	FY21 Target
MSM (KP_PREV)	ec Nelson Mandela Bay Municipality	5,654	1,978	35%	45%	2,544
	gp City of Johannesburg Metropolitan Municipality	37,549	16,642	44%	45%	16,897
	gp City of Tshwane Metropolitan Municipality	24,466	5,116	21%	45%	11,010
	gp Ekurhuleni Metropolitan Municipality	27,238	2,405	9%	45%	12,257
	kz eThekweni Metropolitan Municipality	27,394	4,848	18%	45%	12,327
	kz uMgungundlovu District Municipality	4,758	2,190	46%	45%	2,141
	mp Ehlanzeni District Municipality	7,311	1,810	25%	45%	3,290
	wc City of Cape Town Metropolitan Municipality	29,901	10,465	35%	45%	13,455
MSM (KP_PREV) - subtotal*		167,872	46,714	-	-	75,541
TGW (KP_PREV) **	ec Buffalo City Metropolitan Municipality	830	414	50%	50%	415
	ec Nelson Mandela Bay Municipality	1,260	629	50%	50%	630
	gp City of Johannesburg Metropolitan Municipality	3,893	1,946	50%	50%	1,946
	wc City of Cape Town Metropolitan Municipality	2,413	1,206	50%	50%	1,206
TGW (KP_PREV) - subtotal*		8,396	4,195	-	-	4,197
People Who Inject Drugs (KP_PREV)***	gp City of Tshwane Metropolitan Municipality	4,514	2,169	48%	50%	2,257
	mp Ehlanzeni District Municipality	1,395	991	71%	50%	698
People Who Inject Drugs (KP_PREV) - subtotal*		5,909	3,160	-	-	2,955
Inmates (KP_PREV)	ec Amathole District Municipality	1,104	773	70%	70%	773
	ec Buffalo City Metropolitan Municipality	3,712	2,598	70%	70%	2,598

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Districts	Population Size Estimate	FY20 Results (expected in FY20)	Coverage Goal (in FY20)	Coverage Goal (in FY21)	FY21 Target
	ec Nelson Mandela Bay Municipality	2,855	1,999	70%	70%	1,999
	ec Oliver Tambo District Municipality	2,546	1,782	70%	70%	1,782
	ec Sarah Baartman District Municipality	1,651	684	41%	70%	1,156
	fs Fezile Dabi District Municipality	3,234	896	28%	70%	2,264
	fs Lejweleputswa District Municipality	2,014	995	49%	70%	1,410
	fs Thabo Mofutsanyane District Municipality	682		0%	70%	477
	fs Xhariep District Municipality	1,738	1,217			1,217
	gp City of Johannesburg Metropolitan Municipality	10,658	7,089	67%	70%	7,461
	gp City of Tshwane Metropolitan Municipality	10,390	7,273	70%	70%	7,273
	gp Ekurhuleni Metropolitan Municipality	8,074	5,258	65%	70%	5,652
	gp Sedibeng District Municipality	700		0%	70%	490
	kz Amajuba District Municipality	3,007	1,646			2,105
	kz eThekweni Metropolitan Municipality	3,500	3,150	90%	70%	2,450
	kz Harry Gwala District Municipality	1,562		0%	70%	1,093
	kz King Cetshwayo District Municipality	3,138	1,828			2,197
	kz Ugu District Municipality	884	619	70%	70%	619
	kz uMgungundlovu District Municipality	1,151	806	70%	70%	806
	kz Umzinyathi District Municipality	1,032	722	70%	70%	722
	kz Uthukela District Municipality	992	694	70%	70%	694
	kz Zululand District Municipality	2,864	1,545	54%	70%	2,005
	lp Capricorn District Municipality	1,308	916	70%	70%	916
	lp Vhembe District Municipality	4,697	2,870	61%	70%	3,288
	lp Waterberg District Municipality	502		0%	70%	351
	mp Ehlanzeni District Municipality	1,314	920			920

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Districts	Population Size Estimate	FY20 Results (expected in FY20)	Coverage Goal (in FY20)	Coverage Goal (in FY21)	FY21 Target
	<u>mp</u> Gert Sibande District Municipality	1,535	697	45%	70%	1,075
	<u>mp</u> Nkangala District Municipality	1,783	1,248	70%	70%	1,248
	<u>nc</u> Frances Baard District Municipality	3,810	2,667	70%	70%	2,667
	<u>nc</u> Zwelentlanga Fatman Mgcawu District Municipality	1,188	832	70%	70%	832
	<u>nw</u> Bojanala Platinum District Municipality	1,710	623	36%	70%	1,197
	<u>nw</u> Dr Kenneth Kaunda District Municipality	3,214	2,250	70%	70%	2,250
	<u>wc</u> Cape Winelands District Municipality	3,478		0%	70%	2,435
	<u>wc</u> City of Cape Town Metropolitan Municipality	6,526	4,568			4,568
	<u>wc</u> Garden Route District Municipality	1,698	801	47%	70%	1,189
	<u>wc</u> Overberg District Municipality	1,206	844	70%	70%	844
	<u>wc</u> West Coast District Municipality	3,427	2,036	59%	70%	2,399
Inmates (KP_PREV) - subtotal*		104,884	62,846	-	-	73,422
TOTAL*			522,816			1,202,932

**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

District	Estimated # of Orphans and Vulnerable Children	Target # of OVC (FY21 Target) (<18 years)	Target # of OVC (FY21 Target) (18+ years)	Target # of beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target)
		OVC_SERV	OVC_SERV	OVC_HIVSTAT [<18 ONLY]
ec Alfred Nzo District Municipality	53,226	15,104	16,504	15,104
ec Amathole District Municipality	83,519	6,880	8,000	6,880
ec Buffalo City Metropolitan Municipality	37,922	18,227	20,467	18,227
ec Chris Hani District Municipality	77,033	8,609	10,008	8,609
ec Oliver Tambo District Municipality	252,601	8,604	10,008	8,604
fs Lejweleputswa District Municipality	N/A	3,832	3,832	3,832
fs Thabo Mofutsanyane District Municipality	69,372	11,923	13,044	11,921
gp City of Johannesburg Metropolitan Municipality	154,382	159,268	171,655	159,269
gp City of Tshwane Metropolitan Municipality	90,469	33,973	40,998	33,969
gp Ekurhuleni Metropolitan Municipality	133,873	20,753	23,489	20,753
gp Sedibeng District Municipality	47,649	18,689	20,929	18,689
kz eThekweni Metropolitan Municipality	221,572	57,742	64,428	57,739
kz Harry Gwala District Municipality	55,785	8,710	10,110	8,710
kz King Cetshwayo District Municipality	99,107	15,003	16,403	15,003

Table 4.6.4 Targets for OVC and Linkages to HIV Services

District	Estimated # of Orphans and Vulnerable Children	Target # of OVC (FY21 Target) (<18 years)	Target # of OVC (FY21 Target) (18+ years)	Target # of beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target)
		OVC_SERV	OVC_SERV	OVC_HIVSTAT [<18 ONLY]
<u>kz</u> King Cetshwayo District Municipality	99,107	15,003	16,403	15,003
<u>kz</u> Ugu District Municipality	78,122	13,359	14,759	13,359
<u>kz</u> uMgungundlovu District Municipality	88,618	11,651	13,470	11,651
<u>kz</u> Uthukela District Municipality	75,420	7,019	8,138	7,018
<u>kz</u> Zululand District Municipality	104,278	6,885	8,006	6,885
<u>lp</u> Capricorn District Municipality	95,223	18,616	20,029	18,614
<u>lp</u> Mopani District Municipality	81,600	20,454	22,420	20,454
<u>mp</u> Ehlanzeni District Municipality	135,560	42,353	48,550	42,353
<u>mp</u> Gert Sibande District Municipality	88,571	28,737	32,988	28,737
<u>mp</u> Nkangala District Municipality	71,577	24,616	28,753	24,616
<u>nw</u> Bojanala Platinum District Municipality	77,076	8,591	9,991	8,591
<u>wc</u> City of Cape Town Metropolitan Municipality	96,687	39,151	44,025	39,151
TOTAL	2,369,242	608,749	681,004	608,738

Table 4.6.4 Targets for OVC and Linkages to HIV Services

District	Estimated # of Orphans and Vulnerable Children	Target # of OVC (FY21 Target) (<18 years) OVC_SERV	Target # of OVC (FY21 Target) (18+ years) OVC_SERV	Target # of beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC_HIVSTAT [<18 ONLY]
----------	--	---	---	---

Footnotes: Population size estimates for OVC assumed constant between 2019 and 2020. Data displayed for Priority districts only. Several districts (N=4) have OVC_SERV FY21 targets but were excluded due to location (Centrally Supported) or because beneficiaries targeted are not OVC but rather beneficiaries of HIV primary prevention programming aged 10–14. Excluded Districts: kz Amajuba District Municipality (Primary Prevention Targets) - <18 Target: 138, kz Umkhanyakude District Municipality (Primary Prevention Targets) -<18 Target: 167, lp Vhembe District Municipality (Primary Prevention Targets) - <18 Target: 125, lp Waterberg District Municipality (OVC Targets)-<18 Target:110, 18+ Target:3, wc West Coast District Municipality(Placeholder Targets)-<18 Target:4780, 18+ Target: 6692.

DRAFT

4.8 Cervical Cancer Program Plans

N/A

4.9 Viral Load and Early Infant Diagnosis Optimization

In SA, VL and EID testing is highly centralized, with a lab network of 16 VL labs (14 of which are SANAS accredited) and 9 EID accredited labs. All VL and EID labs are equipped with high throughput and medium-size testing platforms. The testing is run by the National Health Laboratory Services (NHLS), which has its own sample transport system and 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. In COP2018 (FY2019), PEPFAR funded a mapping of the NHLS sample transport network by NHLS, supported by HERO, to assess possibilities for further optimization that could lead to better patient care. The results showed that the network is largely well-optimized; however, some benefits were observed from a delay in specimen collection time at facilities from 2 p.m. to 3 p.m., and more frequent, shorter routes. This would result in more patients having access to same-day blood draw, and an improvement in laboratory processing and workflow. NHLS is currently working to implement these findings. PEPFAR has funded the eLABs system that is being used to improve turnaround times, reduce specimens' rejection rate and improve results usage to manage patients for VL.

Preliminary data from the CDC study, *Optimizing maternal viral load testing and infant HIV testing to improve postnatal PMTCT outcomes in HIV-infected women and their children in South Africa* (OPPTIM), showed that VL point-of-care (POC) testing is possible, allowing immediate and tailored clinical management of HIV in maternal populations. Once final data are available to share with NHLS, PEPFAR/SA will assess NHLS interest in using VL POC testing for the mothers and their baby infant pairs. An analysis of the capacity and location of GeneXpert analyzers to be utilized for EID, VL and TB testing in mother-infant pairs at delivery wards has been conducted by the Clinton Health Access Initiative, which is in discussions with NHLS on the implementation of the findings. The outcome of the discussions will determine the use of GeneXpert platforms for EID, VL and TB for infants and breastfeeding women in SA.

5.0 Program 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, and treatment health services. This is the focus of COP20. Systems investments implemented at the above-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 MER system, and intensive site improvement and monitoring (including Siyenza), and are linked to the SID scores. The investments are aligned with the GoSA and 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 upon 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).

COP20 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 and Need for Robust and Consistent Surveillance Data for Program Planning
4. Strategic Allocation of HIV Resources
5. Utilization of Civil Society Resources
6. Drugs and Commodities Planning
7. Utilization of the Private Sector
8. Strengthening Laboratory Infrastructure and Processes

Each of these barriers is presented below with a summary of the planned COP20 investments and expected outcomes of the investment. The COP20 minimum requirements (see Appendix D) related to the investment are also included below.

Key Systems Barrier 1: Human Resources for Health (HRH)

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 COP20 Above-Site Investments (HRH)	Expected Outcomes
<ul style="list-style-type: none"> • PEPFAR SA will support the implementation of information systems to collect and synthesize data on national human resources information system (HRIS) and the human resources inventory database (HRID) for PEPFAR supported staffing. • PEPFAR SA will second staff to the <u>NDoH</u> to provide essential HR support for condom and Key Populations programming. • PEPFAR SA will provide technical support at the national level towards strengthening HIV & TB related activities at the national and sub national levels. These include guideline development, training of trainers at provincial levels and lower level engagement in the 27 priority districts for ART linkage & initiation, pediatrics, VMMC, and HMIS coordination. • PEPFAR SA will improve implementation and generate use of cost-effective capacity-building program for health care workers to ensure adherence to latest standards and guidance. 	<p>HRH planning/ coordination and systematic capacity building for service delivery will result in an optimized health workforce to achieve epidemic control.</p> <p>Fully comprehensive and functional health workforce registry inclusive of all cadres across the public sector, integrated HRH and programmatic data to monitor site-level staff performance and utilized to optimize human resources planning.</p> <p>Improved engagement of the HIV cluster in <u>NDoH</u>.</p> <p>Ensure that at least 20,000 health workers use the Knowledge Hub platform to improve their skills and knowledge about latest standard operating procedures and ensure that the platform is linked to Nurse Connect, the <u>NDoH's</u> mobile platform to reach nurses.</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 COP20 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 COP20 Above-Site Investments (Patient Linkage and Retention)	Expected Outcome
<ul style="list-style-type: none"> • PEPFAR SA will disseminate newly developed, high transmission area (HTA) guidelines to provinces and districts to support best practices in delivering care to Key Populations. • PEPFAR SA will support the NDoH in revisiting the Ideal Clinic platform to reflect lessons learned from Operation Phuthuma on how to optimize HIV service delivery and other quality improvement initiatives. This will include aligning team-based facility incentive program (e.g. performance leader boards) to establish ideal clinic tools and processes. • PEPFAR SA will implement an Undetectable = Untransmissible campaign to improve linkage and retention across the program. The U=U campaign will be population appropriate and support the NDoH's Welcome Back strategies, involve both facility level communications interventions and mass media. In addition, PEPFAR SA will assess the effects of a strategic marketing (U=U) campaign on patient retention. 	<p>Strengthened guidelines and implementation accountability structures on linkage to care and differentiated service delivery will result in more efficient and effective HIV services.</p> <p>PEPFAR will disseminate recommendations to at least 9 provincial departments and to 52 districts about the HTA guidelines and KP care will be improved.</p> <p>The Ideal Clinic platform is revised to reflect lessons learned from Operation Phuthuma (Siyenza) on how to optimize HIV service delivery and other quality improvement initiatives.</p> <p>In response to the U=U campaign, proxy linkage and retention rates. It is expected that rates of patients disengaged from care reduced to below 15% in U=U campaign districts.</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 COP20 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 COP20 Above-Site Investments (Interoperable Patient Data Systems)	Expected Outcome
<ul style="list-style-type: none"> ● Improvement of the surveillance of priority public health events associated with: <ul style="list-style-type: none"> ○ Adverse events associated with different types of HIV treatment, including pregnant women and their perinates; ○ Tracking patients longitudinally from testing to viral suppression; ○ Tracking stigma and discrimination among people living with HIV in three provinces in South Africa; and ○ Strengthening the services delivered to adolescent girls and young women and other at-risk populations. ● PEPFAR/SA needs to strengthen the existing health information systems at all levels for quality patient-level data. The development of a patient-centered digital health information system is a core element of the South Africa National Digital Health Strategy (2020–2024). This includes support to key NDoH aggregate health information systems, including WebDHIS, to improve the timeliness and accuracy of reporting. ● Continuous system <u>support</u> the implementation of the Synchronized National Communication in Health (SyNCH) system for CCMD program monitoring and implementation. ● Finalization of information hub technology, Power BI analytics platform and longitudinal patient record. Transfer of sustainable solution to capacitated South African NDoH team. 	<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>Increased proportion of facilities with DHIS2; DHIS2 skills transfer activities continue; Dissemination and capacity building for 90–90–90 dashboards continue; dissemination of data quality reports continues.</p> <p>Improved <u>SyNCH</u> utilization rate.</p> <p>Solution for networked Tier developed in collaboration with NDoH in accordance with the national digital health strategy.</p> <p>Provincial information hubs able to be accessed by all levels of the Health System at all levels (i.e. facility, district, province). Routine quarterly data dissemination instituted as part of <u>Phuthuma</u> and able to account for longitudinal client record. Information Hub Solution transitioned to NDoH ownership.</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 COP20 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 financial and managerial capacity building for the HIV/AIDS conditional grant to 27 priority districts. Ensure the appropriate alignment with PEPFAR, prioritization, budgeting, and execution of budgets directed to national HIV/AIDS program. Transition down provincial level support for financial and managerial capacity building. • PEPFAR SA will design and institute pay-for-performance for health workers employed by DSPs. Deliver technical assistance to National Treasury and NDOH to institute outcomes-based payment system as part of HIV/AIDS conditional grant. • PEPFAR SA will support the GoSA to improve allocative and technical efficiency through evidence-based cost modeling and financial capacity building. 	<p>The GoSA will leverage domestic resources to more strategically invest to maximize HIV-related health outcomes at national, provincial, and district levels.</p> <p>27 districts receiving technical support on budgeting and budget execution to procure necessary equipment, supplies, and other expenditures essential to HIV service delivery. This involves 95% financial execution at district level of HIV conditional grant against budget planning tool.</p> <p>Pay-for-performance mechanisms implemented and improved after one year of execution across all PEPFAR priority districts, through the NDoH. Outcomes-based payment for the HIV conditional grant instituted in policy and payment implemented.</p> <p>Positive trend of resource commitments by host government as compared to previous year. Target of at least 10% increase in 2019/20 to 2020/2021 budget cycles.</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 COP20 Above-Site Investments (Civil Society)	Expected Outcomes
<ul style="list-style-type: none"> PEPFAR SA will assess the impact of policies and regulations on HIV. 	<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> <p>Updated estimates and cascades to inform program planning.</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 COP20 Minimum Requirements: Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens.

Summary of COP20 Above-Site Investments (Drugs and Commodities Planning)	Expected Outcome
<ul style="list-style-type: none"> PEPFAR SA will optimize supply chain predictability through continued support for demand and supply planning, creating end-to-end visibility and routinized commodities availability at national-level and based on district-level aggregate reporting of real-time supply chain and commodities data. PEPFAR SA will support the GoSA in evidence-based scale-up of multi-month dispensing of ARVs to include 6MD. PEPFAR SA will scale up the "informed push" system, based on body of evidence from pilot to inform national roll-out. This system automates the quantification of stock requisitions for health workers at facilities to save them time and improve accuracy. PEPFAR SA will support the GoSA Affordable Medicines Directorate in strategic HIV/TB control operations toward epidemic control, facilitating implementation of NDOH-PEPFAR interventions. 	<p>Routine integration and triangulation of Supply Chain National Surveillance Centre (NSC) and program data implemented for all PEPFAR supported sites. The aim is to have 95% facilities or more reporting into the NSC.</p> <p>27 districts implementing MMD; >95% availability of stock implementing MMD; zero stock-outs associated with implementation of MMD. Reductions in facility visits by patients to 2 per year.</p> <p>500 facilities managing stock through informed push system.</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 COP20 Above-Site Investments (Utilization of the Private Sector)	Expected Outcome
<ul style="list-style-type: none"> PEPFAR SA will support full sustainable transition of pick-up point (PuP) models to domestic resources and provide private sector engagement technical assistance to DSPs. PEPFAR will assist in business model design and strategies for differentiated models of care to promote retention. PEPFAR SA will support full sustainable transition of modular pharmacy container model to domestic resources. 	<p>A better integrated private-public health system will result in greater accessibility and population coverage of HIV services.</p> <p>All innovative external pick-up point models transitioned to domestic resources.</p> <p>50 Cipla Container pharmacies break-even and operationally sustainable.</p>

Key Systems Barrier 8: Strengthened laboratory infrastructure and processes

PEPFAR South Africa will prioritize ensuring the South Africa laboratory network is sufficient to ensure that all patients receive timely results, specifically for viral load testing and other priority diagnostic tools.

COP20 Associated Minimum Requirement: 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.

Summary of COP20 Above-Site Investments (Strengthening lab infrastructure and processes)	Expected Outcome
<ul style="list-style-type: none"> PEPFAR SA will maintain and monitor eLABs in 1,031 PEPFAR supported facilities; expand eLABs to 500 more PEPFAR supported facilities; scale up direct messaging to patients; Hire VL coordinators (3), Clinical trainers(3) and eLABs remote monitors(2); Support implementation of the lab network optimization results; Continuous monitoring of turnaround time from specimens' collection time to results return to the facilities, rejection rate, specimens' volume, instruments downtime for VL/labs; Develop and pilot the module to send VL results to patients' phones. PEPFAR SA will continue sending Results For Action (RFA) EID and Crypto LFA positive results and VL>1000 copies/ml to facilities and individuals that are receiving it in FY2020; Expand to 300 more PEPFAR supported facilities. PEPFAR SA will also support the NDoH in conducting post market surveillance for HIV rapid test kit quality assurance. PEPFAR SA will Support the NHLS External Quality Assurance (EQA) department to implement quality management systems to get EID, VL, TB and CD4 labs accredited and to maintain accreditation in the ones that are already accredited. PEPFAR will support the NHLS EQA department to prepare and distribute proficiency testing (PT) panels for viral load, and Early Infant Diagnosis (EID) laboratories. 	<p>Strengthened laboratory infrastructure and processes will ensure great VL monitoring to inform clinical service delivery and improve the rate of viral suppression.</p> <p>Continue to increase awareness of CrAg dashboard and promote registration and use of CrAg RFA reports, Monitor CrAg test discrepancies through inter-laboratory quality assessment.</p> <p>Reduce specimens' rejection rate to below 4% in the facilities accessing eLAB (should be 1,031 at end of FY2020). Expand eLAB to 400 more facilities (Total should be 1,431 at the end of FY2021); Reduced turnaround time (TAT) for VL specimens' processing in 1031 facilities that should have eLABs. eLabs will aim to reduce</p>

	<p>TAT in the hubs serving the 1,031 facilities that have <u>eLAB</u>.</p> <p>Expand RFA to 300 more PEPFAR supported facilities; (Total should be 1,367 PEPFAR supported facilities at the end of FY 2020).</p> <p>Get 3 more labs accredited (decreased budget) and maintain accreditation in the ones accredited in FY17 – FY2020.</p>
--	---

6.o USG Operations and Staffing Plan to Achieve Stated Goals

Peace Corps has committed to support the Interagency Team’s partners by growing the Peace Corps Response program; recruiting highly-skilled, short term Volunteers to support in the areas of capacity building, change management, monitoring and evaluation, programmatic support, and other high-impact areas.

CDC analyzed its COP18 and COP19 approved staffing with an eye towards optimizing footprint to maintain surge gains in COP19, support technical assistance needs for DSP during the transition period into retention, fully support NDoH Operation Phuthuma, and meet Ambassador Marks’ top priorities for epidemic control. CDC staff are 100% PEPFAR-funded and aligned to priority program areas as approved in COP19 and proposed in COP20. [REDACTED]

USAID proposed COP20 staffing fulfills the COP19 mandate to increase human resources to effectively manage partners and have boots on the ground to support Phuthuma/Siyenza and to ensure implementation fidelity. While the overall CODB budget will be reduced by [REDACTED], CODB will be shifted toward hiring local expertise to carry out this mission. [REDACTED]

Peace Corps has no long-term vacancies. The PC Small Grants manager position was vacated in March 2019, and the HIV Coordinator position vacated in December 2019. [REDACTED]

CDC has two positions that have been vacant for more than six months. Twelve other positions have been vacant for less than six months. [REDACTED]

USAID has one long-term vacancy in the Health Office, a medical officer position that has been advertised.

Peace Corps proposes one new position to bring communications expertise to its PEPFAR program, [REDACTED]. This broadened awareness will also assist in the recruitment of highly qualified Volunteers to the South Africa program.

PEPFAR Coordination office proposes three new positions as follows: A DREAMS Coordinator, DREAMS Deputy Coordinator and a communications expert. The DREAMS related positions will provide additional coordination to ensure expansion of DREAMS is successful and aligns to existing priorities.

CDC requests three new positions that do not increase approved footprint and which have been vetted in the interagency COP20 process. These positions will replace COP19 positions that are not being filled. [REDACTED]

USAID proposes 24 new positions to fulfill to continue the intensified partner management and site-level oversight scaled under the Phuthuma/Siyenza initiative, including placing 10 staff at Consulates. [REDACTED]

The Cost Of Doing Business (CODB) for Peace Corps has remained [REDACTED] over the past four COP years. [REDACTED]

CDC plans cost reductions in three main categories: Locally Recruited Staff, Program Travel, and Institutional Contractors. [REDACTED] CDC CODB is aligned with COP20 strategy support needs.

Updates to individual USAID CODB lines for COP20 are derived from improved data on the cost implications of Siyenza/Phuthuma, as well as a detailed review of accounting data and individual personnel cost estimates. [REDACTED]

[REDACTED] Per the PLL requirement, the PEPFAR Coordination Office (PCO) will hire a DREAMS Coordinator Position [REDACTED] and a Deputy DREAMS Coordinator [REDACTED].

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1 PEPFAR Priority Treatment Coverage for 27 Focus Districts by Age, Sex and District, by District Prioritization (fine age bands) Children <15 Years [1]

[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									
					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		
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	APR19	reported	---	35%		36%	---	30%		33%	33%	48%
	COP 19	Scale-Up Saturation	APR 20	expected	51%	58%	70%	73%	51%	57%	69%	72%	69%	78%
	COP 20	Scale-Up Saturation	APR 21	expected	136%	82%	82%	82%	100%	82%	82%	82%	82%	78%
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	APR19	reported	88%	42%		46%	69%	37%		42%	43%	56%
	COP 19	Scale-Up Saturation	APR 20	expected	43%	56%	67%	68%	43%	56%	67%	67%	65%	83%
	COP 20	Scale-Up Saturation	APR 21	expected	99%	87%	87%	87%	89%	77%	82%	87%	85%	81%
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	APR19	reported	66%	36%		39%	49%	32%		36%	36%	48%
	COP 19	Scale-Up Saturation	APR 20	expected	42%	60%	68%	67%	42%	60%	67%	67%	65%	77%
	COP 20	Scale-Up Saturation	APR 21	expected	100%	74%	81%	81%	85%	69%	73%	81%	78%	77%

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									
					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		
kg 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	APR19	reported	118%	49%		51%	79%	45%		46%	48%	57%
	COP 19	Scale-Up Saturation	APR 20	expected	48%	78%	79%	75%	48%	78%	79%	74%	76%	83%
	COP 20	Scale-Up Saturation	APR 21	expected	119%	87%	87%	87%	98%	83%	83%	81%	85%	82%
gc 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	APR19	reported	88%	35%		34%	70%	32%		30%	33%	53%
	COP 19	Scale-Up Aggressive	APR 20	expected	32%	88%	91%	73%	32%	87%	90%	71%	79%	80%
	COP 20	Scale-Up Aggressive	APR 21	expected	88%	89%	95%	89%	90%	89%	90%	84%	89%	87%
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	APR19	reported	1080%	72%		27%	877%	67%		19%	54%	55%
	COP 19	Scale-Up Aggressive	APR 20	expected	45%	88%	88%	86%	44%	78%	88%	78%	83%	84%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	88%	88%	88%	80%	78%	88%	78%	84%	83%
gc 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	APR19	reported	78%	37%		43%	54%	30%		39%	37%	40%
	COP 19	Scale-Up Aggressive	APR 20	expected	33%	55%	60%	47%	33%	55%	60%	46%	52%	75%
	COP 20	Scale-Up Aggressive	APR 21	expected	85%	81%	84%	84%	36%	70%	84%	80%	82%	79%
gc 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%

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									
					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		
	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	40%	72%	77%	60%	39%	71%	76%	60%	66%	88%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	88%	88%	88%	50%	85%	88%	75%	84%	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	APR19	reported	77%	28%		32%	39%	23%		26%	27%	51%
	COP 19	Scale-Up Aggressive	APR 20	expected	14%	82%	81%	66%	13%	67%	81%	65%	71%	79%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	82%	83%	83%	83%	67%	83%	69%	78%	79%
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	APR19	reported	104%	45%		60%	72%	46%		59%	53%	53%
	COP 19	Scale-Up Aggressive	APR 20	expected	57%	84%	76%	73%	57%	83%	74%	72%	75%	83%
	COP 20	Scale-Up Aggressive	APR 21	expected	89%	86%	91%	91%	74%	91%	91%	91%	91%	86%
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	APR19	reported	68%	41%		49%	35%	41%		45%	44%	59%
	COP 19	Scale-Up Aggressive	APR 20	expected	26%	86%	72%	74%	25%	73%	71%	74%	73%	92%
	COP 20	Scale-Up Aggressive	APR 21	expected	27%	89%	85%	95%	27%	73%	89%	95%	90%	92%
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	APR19	reported	---	38%		49%	---	36%		44%	41%	61%
	COP 19	Scale-Up Aggressive	APR 20	expected	47%	63%	86%	86%	50%	56%	82%	82%	80%	82%

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									
					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		
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	63%	86%	86%	71%	57%	82%	82%	80%	78%
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%	65%
	COP 18	Scale-Up Aggressive	APR19	reported	77%	45%		42%	30%	44%		38%	42%	63%
	COP 19	Scale-Up Aggressive	APR 20	expected	74%	99%	99%	94%	73%	99%	99%	92%	95%	96%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	99%	99%	99%	100%	99%	99%	99%		
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	APR19	reported	104%	44%		40%	79%	38%		37%	40%	59%
	COP 19	Scale-Up Aggressive	APR 20	expected	51%	88%	88%	85%	50%	88%	88%	83%	85%	84%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	88%	88%	88%	89%	88%	88%	88%	99%	95%
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	APR19	reported	116%	50%		52%	72%	47%		53%	51%	71%
	COP 19	Scale-Up Aggressive	APR 20	expected	55%	97%	93%	84%	54%	94%	92%	82%	87%	96%
	COP 20	Scale-Up Aggressive	APR 21	expected	112%	97%	97%	97%	85%	94%	97%	97%	97%	93%
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	APR19	reported	65%	42%		45%	52%	35%		44%	42%	53%
	COP 19	Scale-Up Aggressive	APR 20	expected	39%	78%	81%	78%	39%	76%	81%	75%	78%	81%
	COP 20	Scale-Up Aggressive	APR 21	expected	126%	84%	84%	84%	110%	84%	84%	84%		
	COP 16	Scale-Up Aggressive	APR 17	reported	51%				32%				41%	52%

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			
kz Uthukela District Municipality	COP 17	Scale-Up Aggressive	APR 18	reported	103%	47%		41%	100%	47%		35%	43%	62%	
	COP 18	Scale-Up Aggressive	APR19	reported	89%	41%		39%	53%	36%		33%	37%	58%	
	COP 19	Scale-Up Aggressive	APR 20	expected	22%	82%	79%	73%	21%	82%	78%	72%	75%	85%	
	COP 20	Scale-Up Aggressive	APR 21	expected	75%	88%	88%	88%	75%	88%	88%	77%	85%	80%	
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	APR19	reported	80%	43%		39%	66%	39%		37%	40%	59%	
	COP 19	Scale-Up Aggressive	APR 20	expected	21%	88%	85%	80%	20%	88%	85%	78%	81%	87%	
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	88%	88%	88%	88%	88%	88%	88%	88%	85%	
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	APR19	reported	---	41%		43%	---	36%		42%	40%	55%	
	COP 19	Scale-Up Aggressive	APR 20	expected	47%	82%	81%	79%	46%	81%	81%	79%	80%	78%	
	COP 20	Scale-Up Aggressive	APR 21	expected	88%	82%	82%	82%	63%	82%	82%	82%	82%	77%	
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	APR19	reported	---	43%		51%	---	38%		50%	45%	57%	
	COP 19	Scale-Up Aggressive	APR 20	expected	34%	83%	84%	80%	34%	82%	84%	81%	82%	84%	
	COP 20	Scale-Up Aggressive	APR 21	expected	111%	84%	84%	84%	95%	84%	84%	84%	85%	81%	
mp Ehlanzeni District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	52%				53%				53%	60%	
	COP 17	Scale-Up Aggressive	APR 18	reported	129%	46%		54%	127%	46%		54%	51%	66%	
	COP 18	Scale-Up Aggressive	APR19	reported	115%	45%		53%	72%	40%		52%	48%	63%	

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									
					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		
	COP 19	Scale-Up Aggressive	APR 20	expected	50%	91%	95%	88%	49%	90%	94%	86%	89%	86%
	COP 20	Scale-Up Aggressive	APR 21	expected	96%	96%	96%	96%	76%	96%	96%	96%	96%	92%
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	APR19	reported	61%	32%		41%	58%	30%		40%	36%	49%
	COP 19	Scale-Up Aggressive	APR 20	expected	42%	77%	81%	77%	42%	76%	80%	76%	77%	78%
	COP 20	Scale-Up Aggressive	APR 21	expected	90%	84%	84%	84%	96%	79%	84%	84%	84%	80%
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	APR19	reported	80%	33%		42%	63%	28%		39%	62%	72%
	COP 19	Scale-Up Aggressive	APR 20	expected	48%	62%	65%	62%	48%	61%	65%	61%	44%	72%
	COP 20	Scale-Up Aggressive	APR 21	expected	105%	85%	85%	92%	93%	85%	85%	85%	87%	82%
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	APR19	reported	84%	37%		47%	62%	36%		44%	41%	49%
	COP 19	Scale-Up Aggressive	APR 20	expected	24%	61%	65%	66%	23%	59%	64%	64%	63%	75%
	COP 20	Scale-Up Aggressive	APR 21	expected	107%	80%	81%	81%	92%	76%	78%	81%	81%	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	APR19	reported	56%	28%		33%	48%	27%		29%	30%	46%
	COP 19	Scale-Up Aggressive	APR 20	expected	13%	62%	61%	65%	13%	61%	62%	68%	79%	79%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	81%	84%	84%	84%	80%	84%	84%	84%	80%

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		
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%	42%	55%	43%	42%	43%	52%	
	COP 18	Scale-Up Aggressive	APR19	reported	71%	40%	41%	41%	48%	38%	40%	40%	50%	
	COP 19	Scale-Up Aggressive	APR 20	expected	93%	73%	71%	77%	82%	72%	70%	74%	83%	
	COP 20	Scale-Up Aggressive	APR 21	expected	91%	74%	87%	87%	83%	77%	87%	87%	85%	
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%	64%	113%	39%	50%	48%	60%	
	COP 18	Scale-Up Aggressive	APR19	reported	103%	41%	55%	55%	42%	33%	46%	43%	57%	
	COP 19	Scale-Up Aggressive	APR 20	expected	38%	65%	67%	58%	37%	65%	64%	58%	80%	
	COP 20	Scale-Up Aggressive	APR 21	expected	113%	80%	80%	83%	84%	65%	64%	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.

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

Table A.2 PEPFAR Priority Treatment Coverage Centrally Supported Districts

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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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

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)
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A

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)
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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
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
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 17	Central Support	APR 18	reported	N/A: No target required	38%

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)
nc John Taolo Gaetsewe District Municipality	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
nc Zwelentlana 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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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

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)
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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
	COP 20	Central Support	APR 21	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.

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

APPENDIX B – Budget Profile and Resource Projections

B1. COP20 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP20 Budget by Program Area

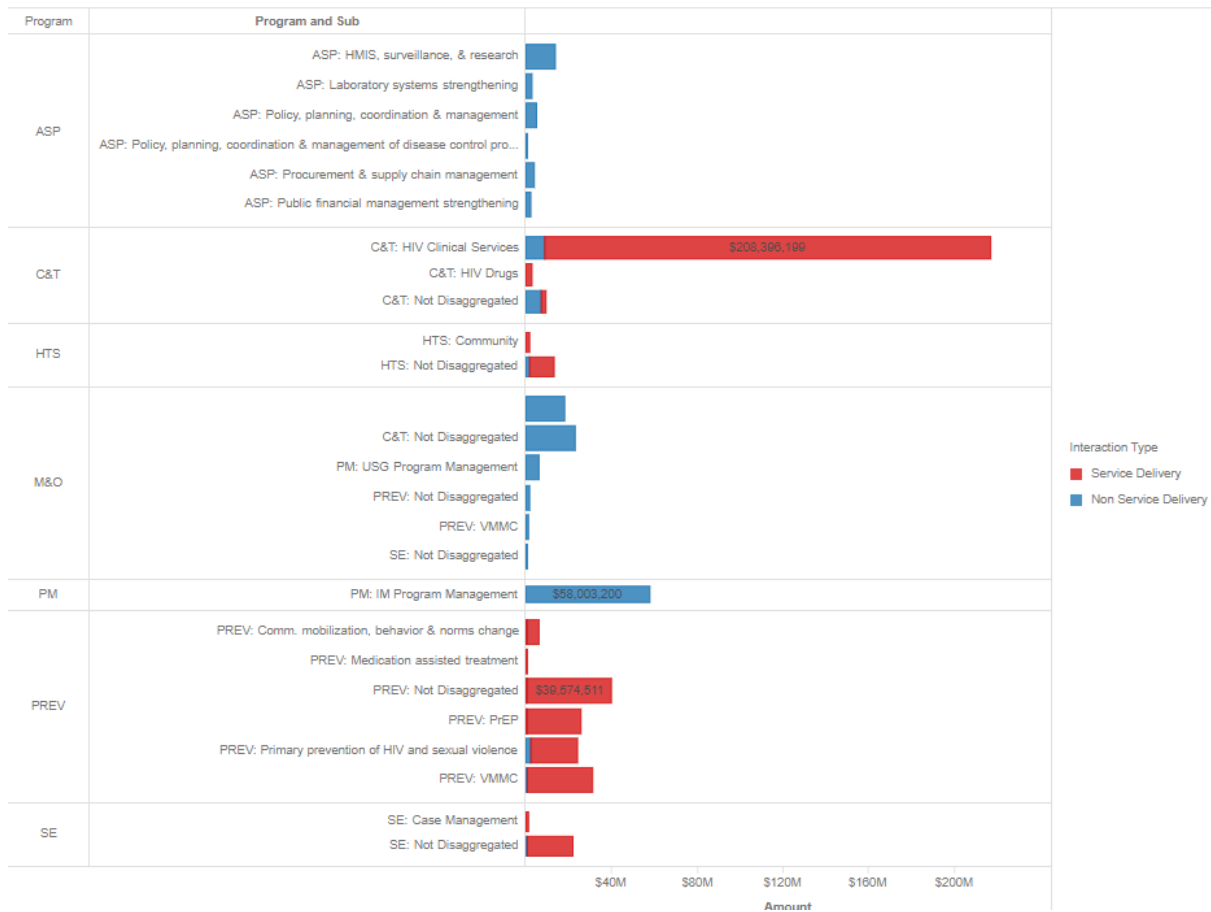


Table B.1.2 COP20 Total Planning Level

Table B.1.2 COP20 Total Planning Level		
Applied Pipeline	New Funding	Total Spend
\$US61,077,141	\$US467,832,915	\$US528,910,056

*Data included in Table B.1.2 should match FACTS Info records and total applied pipeline amount required in PLL guidance.

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
Applied Pipeline		\$61,077,141
MTCT	Mother to Child Transmission	\$4,518,944
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	\$16,660,287
HVOP	Other Sexual Prevention	\$64,481,488
IDUP	Injecting and Non-Injecting Drug Use	\$736,917
HMBL	Blood Safety	\$0
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$23,581,053
HVCT	Counseling and Testing	\$5,234,432
HBHC	Adult Care and Support	\$0
PDCS	Pediatric Care and Support	\$0
HKID	Orphans and Vulnerable Children	\$39,462,784
HTXS	Adult Treatment	\$262,993,907
HTXD	ARV Drugs	\$34,590
PDTX	Pediatric Treatment	\$0
HVTB	TB/HIV Care	\$34,708,792
HLAB	Lab	\$3,000,215
HVSI	Strategic Information	\$3,452,790
OHSS	Health Systems Strengthening	\$2,292,121
HVMS	Management and Operations	\$6,674,601
TOTAL		\$528,910,062

*Estimated PEPFAR budget code data included in Table B.2.2 is generated by PEPFAR Panorama

B.2 Resource Projections

B.2 Resource Projections

All COP20 budget planning was completed using the Funding Allocation to Strategy Tool. The overall funding envelope reflects a return to pre-HIV Surge investment levels. Within the portfolio, significant shifts are planned to focus on sustaining momentum toward 90–90–90 and 95–95–95 HIV treatment coverage levels, while tripling investments in DREAMS and related prevention activities to address continued new infections among adolescent girls and young

women. Above site programming was further prioritized, and now accounts for only 5% of total PEPFAR South Africa programming.

Resource projections were made using estimated service package costs for service delivery activities and activity-based budgeting for above-site activities. Treatment budget cost estimates were formulated for two broad packages of programming - (1) continued scale up districts; and (2) retention-focused districts (i.e. those projected to reach or exceed 90-90-90 during FY20) - using a detailed HRH analysis among other inputs available from the Expenditure Reporting and Human Resource Information (HRID) data sets. DREAMS, PrEP, Key Population and OVC programming followed a similar approach carrying forward agreed interagency methodology from previous COPs.

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

Table 6 Snapshot

Funding Agency	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Pregnant & breastfeeding Women: Not	Surveillance	Epidemiology PEPFAR Minimum	COP19	COP22	Data collection in progress but not
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Epidemiology PEPFAR Minimum	COP19	COP20	Data collection completed. Analysis and
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	Surveillance	Epidemiology PEPFAR Minimum	COP18	COP22	Data analysis. Final report submitted to
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Epidemiology PEPFAR Minimum	COP18	COP22	Phased implementation of case based
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Epidemiology PEPFAR Minimum	COP17	COP20	Final datasets available for District level
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Pregnant & breastfeeding Women: Not	Surveillance	Epidemiology PEPFAR Minimum	COP19	COP21	Analysis and writing completed. Final
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Epidemiology PEPFAR Minimum	COP19	COP21	Data collection completed. Analysis and
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Epidemiology PEPFAR Minimum	COP16	COP20	Increased proportion of facilities with
HHS/CDC	ASP-Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	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	Disseminate recommendations to at least 9 provincial departments and to 52 districts
HHS/CDC	ASP-Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Clinical guidelines, policies for service delivery	HRH Key Systems Barrier: Health workforce is	COP19	COP20	Functional staffing
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	HMIS systems	Epidemiology PEPFAR Minimum	COP17	COP21	80% of PEPFAR supported health facilities
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Epidemiology PEPFAR Minimum	COP20	COP22	Solution for networked Tier developed in
HHS/CDC	ASP-Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Lab PEPFAR Minimum Requirement:	COP17	COP22	Reduce specimens' rejection rate to
HHS/CDC	ASP-Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Lab PEPFAR Minimum Requirement:	COP17	COP22	Expand BFA to 300 more PEPFAR
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Epidemiology PEPFAR Minimum	COP19	COP20	Data collection completed. Analysis and
HHS/CDC	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Epidemiology PEPFAR Minimum	COP19	COP20	Data collection completed. Analysis and
USAID	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Epidemiology PEPFAR Minimum	COP18	COP20	Analytics platform, able to be accessed by
USAID	ASP-Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Training in public financial management strengthening	Resource Mobilization PEPFAR Minimum	COP19	COP21	11/27 districts receiving technical support
USAID	ASP-Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Administrative and financial systems	Resource Mobilization PEPFAR Minimum	COP19	COP20	11 Pay-for-performance mechanisms
USAID	ASP-Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Technical and allocative efficiencies	Resource Mobilization PEPFAR Minimum	COP19	COP21	11 Positive trend of resource
USAID	ASP-Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Internal controls and accounting standards	Policy Minimum Requirement: Direct and	COP20	COP21	The Ideal Clinic platform is revised to
USAID	ASP-Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Commodity PEPFAR Minimum Requirement:	COP18	COP21	11 95% facilities reporting
USAID	ASP-Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Commodity PEPFAR Minimum Requirement:	COP19	COP20	11/27 districts implementing MMS
USAID	ASP-Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Commodity PEPFAR Minimum Requirement:	COP18	COP21	1000 facilities managing stock through
USAID	ASP-Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Commodity PEPFAR Minimum Requirement:	COP19	COP20	MMS change management successfully
USAID	ASP-Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Private sector engagement	Private Sector Key Systems Barrier: The private sector is underutilized in the HIV	COP20	COP20	50 Cipla Container pharmacies break-even and operationally sustainable
USAID	ASP-HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	HRH Key Systems Barrier: Health workforce is	COP20	COP20	20,000 health workers use the knowledge
USAID	ASP-HMIS, surveillance, & research-NSD	DVC: Not disaggregated	Program and data quality management	Epidemiology PEPFAR Minimum	COP18	COP21	1) Ongoing tracking of DVC cohorts and
USAID	ASP-HMIS, surveillance, & research-NSD	Females: Young women & adolescent females	Program and data quality management	Epidemiology PEPFAR Minimum	COP18	COP21	Completion of data collection and

Table 6 Summary of Systems Investments, COP2o

Type of Investment	COP2o Activity Description	Expected Timeline for Achievement of Outcome
Surveillance	Establishing a National Pregnancy Exposure Registry (NPER) for Pregnant Women to monitor adverse pregnancy outcomes and birth defects from ARV exposure in pregnancy.	4 years
Surveillance	Support the National Department of Health (NDoH) Pharmacovigilance (PV) Center's need to strengthen and/or establish PV surveillance nationally. This will improve on surveillance of adverse events associated with different types of HIV treatment.	2 years
Surveillance	Surveillance of HIV drug resistance in adult patients through routine ARV program monitoring in South Africa	5 years
Surveillance	Establish Case Based Surveillance (CBS) using a longitudinal database with unique identifiers aimed at tracking patients from HIV testing to viral suppression; to monitor 90/90/90 and WHO indicators/sentinel events along the continuum of care	5 years
Program and data quality management	Support for epidemiological estimations and modelling of HIV in South Africa including sub-national estimations to generate HIV burden estimates for PEPFAR South Africa COP planning (datapack).	4 years

Type of Investment	COP20 Activity Description	Expected Timeline for Achievement of Outcome
Surveillance	Conduct enhanced HIV sentinel site survey among antenatal care attendees in South Africa	3 years
Surveillance	Demonstration of the use of Rapid Recency Assay to distinguish recent from long-term HIV infection	3 years
Surveillance	The Sixth South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2021 (SABSSM VI)	4 years
Research	Population survey using the PLHIV Stigma index to measure stigma and discrimination experienced by people living with HIV in three provinces in South Africa	2 years
Surveillance	Improve ascertainment of mortality and causes of deaths; assess the feasibility of using verbal autopsy for improved identification of HIV/TB, and all-cause mortality in SA.	3 years
Research	Determine best practices for improving linkage among AGYW and men	3 years
Research	Determine the impact of presumptive TB on delayed ART initiation	3 years
Research	Assess adherence to TB prophylactic treatment (TPT); Identify non-adherence and design patient-centered interventions to improve outcomes of TPT	3 years
Research	Strengthen evidence for interventions for GBV and mental health in selected at-risk populations	2 years
Research	Assessment of perceptions related to PREP among groups at higher risk of HIV acquisition to inform targeted messaging	2 years
Research	Assessment of barriers to care and opportunities for linkage for individuals with HIV-positive status and not on ART	3 years
Lab quality improvement and assurance	Monitor the impact of Cryptococcal Meningitis screening on morbidity and mortality	6 years
HMIS systems	Support to key National Department of Health aggregate health information systems, including WebDHIS, to improve the timeliness and accuracy of reporting	5 years

Type of Investment	COP20 Activity Description	Expected Timeline for Achievement of Outcome
National strategic plans, operational plans and budgets	Assessing impact of policies and regulations on HIV	4 years
Oversight, technical assistance, and supervision to subnational levels	Dissemination of newly developed high transmission area (HTA) guidelines to provinces and districts	2 years
Clinical guidelines, policies for service delivery	Secondment to NDOH to provide essential HR support for condom and key populations programming	2 years
HMIS systems	Continuous system support for the implementation of the Synchronized National Communication in Health (SynCH) system for CCMDD program monitoring and implementation	5 years
HMIS systems	Support for the development of a patient-centered digital health information system in accordance with the South Africa National Digital Health Strategy (2020–2024).	3 years
Laboratory infrastructure	Maintain, monitor, and expand eLABs; Support implementation of the lab network optimization results; Continuous monitoring of turnaround time from specimens' collection time to results return to the facilities, rejection rate, specimens' volume, instruments downtime for VL/labs.	6 years
Laboratory infrastructure	Continue sending Results <u>For</u> Action (RFA) EID and Crypto LFA positive results and VL>1000 copies/ml to facilities and individuals that are receiving it in FY2020; Expand to 300 more PEPFAR supported facilities	6 years
Lab quality improvement and assurance	Post market surveillance for HIV rapid test kit quality assurance	6 years
Lab accreditation	Support the NHLS External Quality Assurance (EQA) department to implement quality management systems to get EID, VL, TB and CD4 labs accredited and to maintain accreditation in the ones that are already accredited; Support the NHLS EQA department to prepare and distribute proficiency testing (PT) panels for viral load, and Early Infant Diagnosis (EID) laboratories; Support the NHLS EQA department to prepare and distribute PT and IQC to 4,600 clinics and 242 correctional department facilities; Cover the cost of the Lab PT data management software	6 years

Type of Investment	COP20 Activity Description	Expected Timeline for Achievement of Outcome
	Support NHLS to use ECHO to provide training to NHLS interns and pathologists	
HMIS systems	Implementation support for the national Human Resources Information System (HRIS) and the Human Resources Inventory Database (HRID) for PEPFAR supported staffing data	4 years
Clinical guidelines, policies for service delivery	Provide technical support at the national level towards strengthening HIV & TB related activities at the national and sub national levels. These include guideline development, training of trainers at provincial levels and lower level engagement in the 27 priority districts for ART linkage & initiation, pediatrics, VMMC, and HMIS coordination	7 years
Surveillance	Demonstration of the use of Rapid Recency Assay to distinguish recent from long-term HIV infection	2 years
Surveillance	Demonstration of the use of Rapid Recency Assay to distinguish recent from long-term HIV infection	2 years
HMIS systems	Finalization of information hub technology, Power BI analytics platform and longitudinal patient record. Transfer of sustainable solution to capacitated South African NDoH team	3 years
Training in public financial management strengthening	Provide financial and managerial capacity building for the HIV/AIDS conditional grant to 27 priority districts. Ensure the appropriate alignment with PEPFAR, prioritization, budgeting, and execution of budgets directed to national HIV/AIDS program.	3 years
Administrative and financial systems	Design and institute pay-for-performance for health workers employed by DSPs. Deliver technical assistance to National Treasury and NDOH to institute outcomes-based payment system as part of HIV/AIDS conditional grant.	2 years
Technical and allocative efficiencies	Support the Government of South Africa (GoSA) to improve allocative and technical efficiency through evidence-based cost modeling and financial capacity building.	3 years
Internal controls and accounting standards	Revise the Ideal Clinic platform to reflect lessons learned from Operation Phuthuma on how to optimize HIV service delivery and other quality improvement initiatives.	2 years

Type of Investment	COP20 Activity Description	Expected Timeline for Achievement of Outcome
Forecasting, supply chain plan, budget, and implementation	Optimize supply chain predictability through continued support for demand and supply planning, creating end-to-end visibility and routinized commodities availability at national-level and based on district-level aggregate reporting of real-time supply chain and commodities data.	4 years
Forecasting, supply chain plan, budget, and implementation	Support the NDOH in evidence-based scale-up of multi-month dispensing of ARVs to include 6MD.	2 years
Forecasting, supply chain plan, budget, and implementation	Scale up of "informed push" system, based on body of evidence from pilot to inform national roll-out. This system automates the quantification of stock requisitions for health workers at facilities to save them time and improve accuracy.	4 years
Forecasting, supply chain plan, budget, and implementation	Support the NDOH Affordable Medicines Directorate in strategic HIV/TB control operations toward epidemic control, facilitating implementation of NDOH-PEPFAR interventions.	2 years
Product selection, registration, and quality monitoring	Support full sustainable transition of PPR models to domestic resources and provide private sector engagement technical assistance to DSPs. Assist in business model design and strategies for differentiated models of care to promote retention.	2 years
Private sector engagement	Support full sustainable transition of Cipla Foundation container model to domestic resources.	1 year
Civil society engagement	Implementation of Undetectable = Untransmissible campaign to improve linkage and retention at sites. Align U=U campaign with facility Welcome Back strategies. Will involve both facility level communications interventions and mass media.	2 years
HMIS systems	Improve implementation and generate use of cost-effective capacity-building program for health care workers to ensure adherence to latest standards and guidance.	1 year
Program and data quality management	Track OVC cohorts over three years to examine changes in HIV risk factors and behaviors over three years (provide combination of evidence-based interventions to OVC to remain HIV negative/link HIV+ to Care and Treatment).	4 years
Program and data quality management	Measure layering in DREAMS through the tracking of cohorts.	4 years
Research	Assess the effects of a strategic marketing (U=U) campaign on patient retention.	2 years

APPENDIX D– Minimum Program Requirements

Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. ¹⁷	The PEPFAR-SA Program is meeting this minimum program requirement
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens. ¹⁸	The PEPFAR-SA Program is partially meeting this minimum program requirement
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents. ¹⁹	The PEPFAR-SA Program is preparing to meet this minimum program requirement
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. ²⁰	The PEPFAR-SA Program is partially meeting this minimum program requirement
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	The PEPFAR-SA Program is partially meeting this minimum program requirement
Case Finding	Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV. ²¹	The PEPFAR-SA Program is partially meeting this minimum program requirement

Prevention and OVC	Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) ²²	The PEPFAR-SA Program is meeting this minimum program requirement
	Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year old girls and boys in regard to primary prevention of sexual violence and HIV.	The PEPFAR-SA Program is meeting this minimum program requirement
Policy & Public Health Systems Support	Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention. ²³	The PEPFAR-SA Program is meeting this minimum program requirement
	OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. ²⁴	The PEPFAR-SA Program is meeting this minimum program requirement
	Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	The PEPFAR-SA Program is preparing to meet this minimum program requirement
	Clear evidence of agency progress toward local, indigenous partner direct funding.	The PEPFAR-SA Program is meeting this minimum program requirement
	Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	The PEPFAR-SA Program is meeting this minimum

		program requirement
	Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	The PEPFAR-SA Program is partially meeting this minimum program requirement
	Scale-up of case-based surveillance and unique identifiers for patients across all sites.	The PEPFAR-SA Program is preparing to meet this minimum program requirement

Site level MPRs related to linkage and retention: During FY 2020 (COP19 implementation), all OUs are expected to fully implement retention-related PEPFAR Minimum Program Requirements at every PEPFAR-supported site, as these have a known impact on continuity of ART. Site level implementation of these 4 elements must be assessed to inform COP20 planning. In addition, an effective tracking and tracing system must be in place at each site.

Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	The PEPFAR-SA Program is partially meeting this minimum program requirement
--	---