# Country Operational Plan

# PEPFAR South Africa 2022

# Strategic Direction Summary

April 19, 2022

# Acronym List

| Acronym | Definition |
|---|---|
| ACC | Advanced Clinical Care |
| AGYW | Adolescent Girls and Young Women |
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Care |
| APR | Annual Program Results |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral (drug) |
| ASP | Above Site Portfolio |
| BAS | Basic Accounting System |
| BMGF | Bill & Melinda Gates Foundation |
| C/ALHIV | Children and Adolescents Living with HIV |
| CAPs | Corrective Action Plans |
| CBO | Community Based Organizations |
| CCM | Country Coordinating Mechanism |
| CCMDD | Central Chronic Medicine Disease Dispensing and Distribution Programme |
| CDC | U.S. Centers for Disease Control and Prevention |
| CFSW | Children of Female Sex Workers |
| CHAI | Clinton Health Access Initiative |
| CHW | Community Health Worker |
| CLHIV | Children Living with HIV |
| CODB | Cost of Doing Business |
| COP | Country Operational Plan (PEPFAR) |
| COP18 | 2018 Country Operational Plan |
| COP19 | 2019 Country Operational Plan |
| COP20 | 2020 Country Operational Plan |
| COP21 | 2021 Country Operation Plan |
| COVAX | Covid-19 Vaccines Global Access |
| CQI | Continuous Quality Improvement |
| CrAG | Cryptococcal Antigen |
| CSE | Comprehensive Sexuality Education |
| CSF | Civil Society Forum |
| DBE | Department of Basic Education |
| DDD | Decentralized Drug Distribution |
| DHIS2 | Digital Health Information Software 2 |
| DMOC | Differentiated Models of Care |
| DoH | Department of Health |
| DREAMS | Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe |
| DR | Drug Resistant |
| DSD | Direct Service Delivery |
| DSP | District Service Partner |
| DTG | Dolutegravir |
| EFV | Efavirenz |
| eGK | Electronic Gate Keeping (code) |
| EID | Early Infant Diagnosis |
| EQA | External Quality Assurance |

| | |
|---|---|
| FBO | Faith-Based Organizations |
| FSW | Female Sex Workers |
| FTE | Full-Time Equivalent |
| FY | Fiscal Year |
| G2G | Government to Government |
| GBV | Gender-Based Violence |
| GDP | Gross Domestic Product |
| GFATM | The Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GHSA | Global Health Security Agenda |
| GoSA | Government of South Africa |
| HAST | HIV/AIDS, STIs, and TB (Directorate) |
| HEI | HIV Exposed Infants |
| HIV | Human Immunodeficiency Virus |
| HIVSS | HIV Self Screening |
| HPRS | Health Patient Registration System |
| HMIS | Health Management Information Systems |
| HRH | Human Resources for Health |
| HRID | Human Resources Inventory Database |
| HRIS | Human Resources Information System |
| HROE | Human Resources Overseas Employment |
| HSRC | Human Sciences Research Council |
| HSS | Health Systems Strengthening |
| HTA | High Transmission Area |
| HTS | HIV Testing Services |
| IAS | International AIDS Society |
| I-ACT | Integrated Access to Care and Treatment |
| ICASS | Internal Continuous Assessment |
| IEC | Information Education Communication |
| IM | Implementing Mechanism |
| IP | Implementing Partner |
| IPC | Infection Prevention and Control |
| IPV | Intimate Partner Violence |
| ITS | Index Testing Services |
| KP | Key Populations |
| LAM | Lipoarabinomannan Assay |
| LES | Locally Employed Staff |
| LIVES | Listen, Inquire, Validate, Enhance Safety and Support (approach) |
| LGBTQI+ | Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex People |
| MDR | Multi-Drug Resistant |
| MER | Monitoring, Evaluation, and Reporting |
| MINA | For Men. For Health. “me” in the context of “my community” (Campaign) |
| MH | Mental Health |
| MMD | Multi-Month Dispensing |
| MSF | Medicines Sans Frontiers |
| M&O | Management and Operations |
| MLHIV | Men Living with HIV |
| MOU | Memorandum of Understanding |
| MPR | Minimum Program Requirements |

| | |
|---|---|
| MSM | Men Who Have Sex with Men |
| NDoH | National Department of Health |
| NGO | Non-Governmental Organization |
| NHLS | National Health Laboratory Service |
| NHI | National Health Insurance |
| NSP | South Africa National Strategic Plan for HIV, TB, and STIs, 2017-2022 |
| NVP | Nevirapine |
| OGAC | Office of Global AIDS Coordinator |
| OVC | Orphans and Vulnerable Children |
| PBFW | Pregnant and Breastfeeding Women |
| PCO | PEPFAR Coordination Office |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PEP | Post Exposure Prophylaxis for HIV |
| PI | Protease Inhibitor |
| PFIP | Partnership Framework Implementation Plan |
| PICT | Provider Initiated Counseling and Testing |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| PrEP | HIV Pre-exposure Prophylaxis |
| PT | Proficiency Testing |
| PWID | People Who Inject Drugs |
| POC | Point-Of-Care |
| POPI | Protection of Personal Information (act) |
| PPL | Program Planning Letter |
| PUP | Pick-up Point |
| RPCS | Repeat Prescription Collection Strategies |
| RFA | Results for Action |
| SA | South Africa |
| SAG | South African Government |
| SAHPRA | South Africa Health Products Regulatory Authority |
| SANAC | South African National AIDS Council |
| SFLA | Spaced and Fast-Lane Appointments |
| SI | Strategic Information |
| SID | Sustainability Index Dashboard |
| SIMS | Site Improvement Monitoring Systems |
| SMS | Short Message Service |
| SNU | Sub-National Unit |
| SOP | Standard Operating Procedures |
| SRH | Sexual and Reproductive Health |
| StatsSA | Statistics South Africa |
| STI | Sexually Transmitted Infections |
| SW | Sex Workers |
| SyNCH | Synchronized National Communication in Health |
| TAT | Turn Around Time |
| TB | Tuberculosis |
| TG | Transgender |
| TLD | Tenofovir/Lamivudine/Dolutegravir fixed-dose combination (ARV) |
| TEE | Tenofovir Disoproxil Fumarate/Emtricitabine/Efavirenz (ARV) |

| | |
|---|---|
| TPT | Tuberculosis Preventive Therapy |
| TVET | Technical and Vocational Education and Training College |
| TDY | Temporary Duty Travel |
| U.S. | United States |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNICEF | United Nations International Children's Emergency Fund |
| USAID | United States Agency for International Development |
| USD | U.S. Dollars |
| USDH | U.S. Direct Hire |
| USG | United States Government |
| USPSC | U.S. Personal Service Contract |
| U=U | Undetectable = Untransmittable |
| VL | Viral Load |
| VMMC | Voluntary Medical Male Circumcision |
| WHO | World Health Organization |
| ZAR | South African Rand |

# Contents

# 1.0 Vision and Goal Statement

Through the President's Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan 2022 (COP22), 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. In COP22, PEPFAR SA will continue its focus on providing substantial and targeted support to both facility- and community-based settings to close the treatment gap. The assurance of quality care will be the cornerstone of COP22 implementation. Therefore, priority activities for the treatment program will be tailored towards helping clients overcome barriers to facility-based treatment, improving client experiences with out-of-facility care, and cultivating community-based solutions.

COP22 will focus on linking and 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 and solutions; (2) Improving pediatric treatment and continuing to provide support for Orphans and Vulnerable Children (OVC); (3) Reducing HIV risk for adolescent girls and young women (AGYW) through the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program; (4) Saturating voluntary medical male circumcision (VMMC) for men aged 15 years and older; (5) Providing high-quality, comprehensive and KP-sensitive services for Key Populations, including those tailored for sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prisons; (6) Further enhancing collaboration with the Department of Health (DoH) across all levels, as well as with other stakeholders; and (7) Continuing to improve partner management through improved data use and accountability.

COP22 will seek to build on COVID-19 mitigation efforts for HIV and TB services underway in COP21 and further expand best practices and innovations resulting during this pandemic. To achieve these goals, PEPFAR SA will work with the GoSA to accelerate achievements by responding to 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 further integrated into this process. PEPFAR SA will continue to work closely with Civil Society through stakeholder engagement sessions, People's Country Operation Plan (People's COP) Activities, Civil Society Forum Meetings, Provincial AIDS Council Meetings, and continued community-led monitoring efforts.

PEPFAR SA will focus heavily on improving case finding approaches, returning clients to care, linkage and retention on ART, and viral suppression through expanding access to patient-centered retention strategies, including improved appointment systems and decanting stable patients to adherence clubs, external pick-up points, and facility pick-up points. In addition, PEPFAR SA will continue to support patient-centered interventions such as case management for all patients with unsuppressed viral loads, differentiated models of care (DMoC) for clients re-engaging in care, and overall accelerated access to DMoC to support sustained retention. PEPFAR SA will support implementation of 3-month dispensing for all stable clients (including shifting all stable clients still receiving a 2-month supply to a minimum of a 3-month supply) and the national restart of the 6-Month Multi-Month Dispensing (MMD) pilot. Pediatric

focused approaches will include scale-up of postnatal and adolescent clubs, pediatric case management, implementation of 3-month supply for all stable pediatric and adolescent clients, expanded DMOC for children, and optimization of pediatric ART regimens.

Within PEPFAR SA-supported districts, overall viral load (VL) suppression was reported at 65% by the end of Fiscal Year (FY) 2021, and it is expected the program will achieve 95% VL suppression across all populations/sex bands by the end of COP22.[1] The roll-out of Tenofovir Lamivudine Dolutegravir (TLD) will continue to scale during COP22, with a focus on informed choice and patient literacy, 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) beyond 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 the results can be used to prioritize tracing of partners of persons with recent infection. HIV prevention efforts will continue through DREAMS support to 24 districts, increasing focus on VMMC coverage among males aged >15 years, and scaling up pre-exposure prophylaxis (PrEP) services.

All interventions will be aligned with the 2017-2022 South Africa National Strategic Plan (NSP) for HIV (which has been extended to 2023), Tuberculosis (TB) and Sexually Transmitted Infections (STIs); the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95–95–95 goals; World Health Organization (WHO) guidelines and global best practices; and with the PEPFAR Strategy for Accelerating HIV/AIDS Epidemic Control (2021–2024) and in close collaboration with GoSA and other stakeholders.

PEPFAR SA has focused for impact both geographically and programmatically. During COP22, PEPFAR SA will continue to co-invest in South Africa's 27 highest HIV burden districts—accounting for 82% of PLHIV. Within these districts, COP22 will further focus on the four largest metropolitan districts (accounting for 35% of PLHIV) and populations with the 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 achieve these goals. PEPFAR SA is particularly committed to working closely with GoSA and Civil Society to ensure high-quality, client-centered HIV services.

[1] Viral suppression rate is the proportion of total viral load tests done with a result of less than 1,000 copies/mL, as reported by National Health Laboratory Service

# 2.0 Epidemic, Response, and Program Context

### 2.1 Summary statistics, disease burden and country profile

South Africa is an upper-middle income country with a gross national income per capita of $6,010 in 2020.[2] In 2022, the country had an estimated population size of 60.8 million, of which approximately 51% (31.1 million) were female (Table 2.1.1).[3] Life expectancy at birth was estimated to be 64.6 years for females (71.3 without HIV/AIDS) and 59.3 years for males (64.8 without HIV/AIDS), and the infant mortality rate was estimated at 24.1 per 1,000 live births.[4]

In 2022, South Africa's HIV disease burden was an estimated 8,110,600 PLHIV, of which more than 4.7 million were women over the age of 25 years (Table 2.1.2).[5] The estimated number of new infections declined by 64% from 2001 to 2022, yet incidence remained high, with an estimated 194,185 new infections in 2022 (Table 2.1.1).[6]

The HIV epidemic in South Africa 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.

South Africa manages the largest national treatment program in the world, and the National Department of Health (NDoH) and the DoHs at provincial and district levels lead the public-sector HIV treatment and biomedical prevention efforts to achieve epidemic control. As of 2022, there were over 5.6 million people on ART in SA, including 126,274 children (<15 years) and 5,533,940 adults (Table 2.1.2).[7] Overall, treatment coverage among PLHIV in SA was 70%.[8] In 2022, ART coverage was higher among adult females (≥25 years, 75%) compared to adult males (≥25 year, 65%), but was comparable among adolescent girls and young women (15–24 years, 52%) and adolescent boys (15-24 years, 55%) (Table 2.1.2).[9] Relative to adults, ART coverage among children (<15 years) was substantially lower at 54% (Table 2.1.2).

[2] PEPFAR SA. 2022. South Africa HIV Resource Alignment Tool, March 2022.
[3] Statistics South Africa [StatsSA], Mid-year population estimates report table, 2021 Statistical Release P0302, Statistics South Africa: Pretoria Accessed March 14, 2022 at http://www.statssa.gov.za/publications/P0302/P03022021.pdf
[4] PEPFAR SA (n 2)
[5] Johnson LF, Dorrington RE (2022) Thembisa 4.4: A model for estimating the impact of HIV/AIDS in South Africa.
[6] StatsSA (n 3)
[7] StatsSA (n 3)
[8] StatsSA (n 3)
[9] StatsSA (n 3)

HIV prevalence and incidence vary significantly across geographic areas; half of PLHIV and nearly half of new HIV infections are concentrated in the Gauteng and KwaZulu-Natal provinces.10 In 2022, the HIV prevalence in KwaZulu-Natal (17%) was more than double that of the Western Cape (8%) and incidence rates ranged from 2.7 per 1,000 population in the Western Cape to 4.6 per 1,000 population in the Eastern Cape.11 Tables 2.1.1 and 2.1.2 below summarize key HIV epidemiological data and provide a national view of the 95–95–95 cascade.

In 2018, the SA Human Sciences Research Council (HSRC) issued results of the Fifth South Africa National HIV Prevalence, Incidence, Behavior and Communications Survey (SABSSM V).12 Overall, the survey demonstrated a marked decrease in new infections from 2012 to 2017, with a 42% decline among women of reproductive age. Incidence was higher for women than men, and in the important age group of 15–24 years, 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, SA had reached 85–71–88 toward the UNAIDS 95–95–95 targets.

South Africa has continued to make considerable progress toward testing and identifying PLHIV since the HSRC 2017 survey. An estimated 93% of HIV-positive South Africans were aware of their status in 2022.[13] Despite high awareness and implementation of universal ART eligibility, still only 75% of individuals diagnosed with HIV were estimated to be on ART, highlighting continued gaps in reaching diagnosed PLHIV with HIV treatment.[14]

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.[15] The GoSA and PEPFAR SA developed a treatment surge plan, and the roll-out began in COP18 with substantial PEPFAR SA investments in direct service delivery (DSD) in the 27 priority districts that account for the majority of the HIV burden in SA. The plan also included high-impact technical assistance and above-site interventions that support the national ART program.

In March 2019, PEPFAR SA 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 isiZulu). Siyenza has since been absorbed by the NDoH "Operation Phuthuma" initiative. The Siyenza approach is based on repeated site visits by PEPFAR SA, DoH, and implementing partner staff, with the goal of using quality improvement strategies to ensure full implementation of HIV testing and treatment policies with a focus on improving ART coverage

[10] ibid.
[11] ibid.
[12] Simbayi LC, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, Mabaso M, Ramlagan S, North A, van Zyl J, Mohlabane N, Dietrich C, Naidoo I and the SABSSMV Team (2019) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. Cape Town: HSRC Press
[13] StatsSA (n 3)
[14] ibid.
[15] State of the Nation Address by the President of the Republic of South Africa [2018], available at: https://www.gov.za/speeches/president-cyril-ramaphosa-2018-state-nation-address-16-feb-2018-0000

and retention on ART. Guided by the Minister of Health's 10-point plan[16] that defined and outlined performance standards and expectations for DoH staff, facility staff and managers. These included working to ensure that PLHIV are linked to care; PLHIV who miss appointments are immediately called and/or visited and brought back to care; and PLHIV who have dropped out of care are identified and welcomed back into facilities for care. The plan 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 reduce the number of patients disengaging from care. The NDoH's Operation Phuthuma forum launched a revised Operation Phuthuma Handbook in COP21 to guide provinces, districts, and health facilities in targeted HIV/TB quality improvement program management for the attainment of 95-95-95. PEPFAR SA is supporting the roll-out of the new handbook and guidance at all levels of the health system. This support will also include the rebranding of "Siyenza" to "PEPFAR Operation Phuthuma Support" (POPS) which will continue implementation of intense, site level support with key programmatic focus areas.

With the end of the USD 500 million two-year Surge funding (COPs 18 and 19) and continued strain of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) epidemic on the health system, PEPFAR SA must work closely with the GoSA and maximize USG support to maintain those on treatment. Like other countries in the region, SA has been battling coronavirus disease 2019 (COVID-19).[17] Accounting for over 45% of all SARS-CoV-2 cases in Africa, South Africa has the greatest burden of COVID-19 in Africa.18 The GoSA and PEPFAR SA's local partners need to work together closely to develop strategies for long term maintenance of people receiving ART particularly in the COVID-19 era where disruptions to routine health services may occur, 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 continues to require close collaboration with local Civil Society organizations to be highly effective with the available resources. Aligned with PEPFAR's person-centered focus, the GoSA has recently revived discussions around universal roll out of three-month dispensing (3MD) and the implementation of six-month ART dispensing (6MD) pilot.

[16] NDoH. 2019. Ten point plan: Toward HIV Epidemic Control: Lessons from Research to Practice Satellite Session SA AIDS Conference Durban ICC [2019], available at https://za.usembassy.gov/wp-content/uploads/sites/19/NDOH-10-point-plan_11Jun19_Yogan-Pillay-NDoH.pdf

[17] World Health Organization. COVID-19 (WHO African region) dashboard. Accessed Mar 17 2022. Available from https://who.maps.arcgis.com/apps/dashboards/0c9b3a8b68d0437a8cf28581e9c063a9

[18] ibid.

## Standard Table 2.1.1 Host Country Government Results

| Table 2.1.1 Host Country Government Results | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | <15 | | | | 15-24 | | | | 25+ | | | | |
| | Total | | Female | | Male | | Female | | Male | | Female | | Male | | |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | *Source, Year* |
| Total Population | 60,811,629 | 100% | 8,419,395 | 13.85% | 8,634,290 | 14.20% | 4,866,611 | 8.00% | 4,921,515 | 8.09% | 17,805,380 | 29.28% | 16,164,438 | 26.58% | Statistics South Africa (StatsSA), 2022 estimate from Mid-year population estimates, 2021 [1] |
| HIV Prevalence (%) | | 13.40% | 1.38% (sex non-specific) | | | | | 9.56% | | 3.98% | | HIV prevalence 25-49 yrs =31.6% | | HIV prevalence 25-49 yrs =16.41% | Thembisa 4.4 2022 estimate [2] |
| AIDS Deaths (per year) | 64,399 | | 2,479 (sex non-specific) | | | | N/A | | N/A | | AIDS deaths in female adults ≥15= 24,267 | | AIDS deaths in male adults ≥15= 37,653 | | Thembisa 4.4 2022 estimate [2] |
| # PLHIV | 8,110,600 | | 231,882 (sex non-specific) | | | | 459,267 | | 192,502 | | 4,723,023 | | 2,503,918 | | Thembisa 4.4 2022 estimate [2] |
| Incidence Rate (Yr) | | 0.37% | 0.07% (sex non-specific) | | | | | 1.19% | | 0.32% | | HIV incidence 25-49 yrs =0.71% | | HIV incidence 25-49 yrs =0.42% | Thembisa 4.4 2022 estimate [2] |
| New Infections (Yr) | 194,185 | | 11496 (sex non-specific) | | | | 51,704 | | 14,649 | | 68,367 | | 47,971 | | Thembisa 4.4 2022 estimate [2] |
| Annual births | 1,166,304 | 100% | | | | | | | | | | | | | Statistics South Africa (StatsSA), 2021 estimate from Mid-year population estimates, 2021 [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%). | | | | | | | | | | | | Demographic Health Survey, 2016 [3] |
| Pregnant women living with HIV on ART | | 98% | | | | | | | | | | | | | DHIS, December 2021 [4] |
| Orphans (maternal, | 2,602,602 (maternal | | N/A | | N/A | | N/A | | N/A | | N/A | | N/A | | General Household |

| Table 2.1.1 Host Country Government Results | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | <15 | | | | 15-24 | | | | 25+ | | | | |
| | Total | | Female | | Male | | Female | | Male | | Female | | Male | | |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | *Source, Year* |
| paternal, double) | 5,60,282, paternal 1,626,626, double 433,767) | | | | | | | | | | | | | | Survey, 2019 [5] StatsSA, 2021 [1] |
| Notified TB cases (Yr) | 208,032 | | N/A | | N/A | | N/A | | N/A | | N/A | | N/A | | WHO, 2020 [6] |
| % of TB cases that are HIV infected | 89,767 with known status who are HIV-positive | 71% among those with known status of total new and relapsed cases | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | WHO, 2020 [6] |
| % of Males Circumcised | 4,330,000 (medical; 15+) | 61.65% (all) | | | 1,064,835 | 13.4% (all) | | | 1,773,689 | 70.2 % (all) | | | 6,948,082 | 59.9% (all) | SABSSM V, 2017 [7] |
| Estimated Population Size of MSM | 357,876 | 1.4-2.2% | | | | | | | | | | | | | UCSF, 2020 [8] |
| MSM HIV Prevalence | | 29%% | | | | | | | | | | | | | Thembisa 4.4 2022 estimate [2] |
| Estimated Population Size of FSW | 127,190 | 0.5 - 1.0% | | | | | | | | | | | | | UCSF, 2020 [8] |
| FSW HIV Prevalence | | 61%% | | | | | | | | | | | | | Thembisa 4.4 2022 estimate [2] |
| Estimated Population Size of PWID | 82,500 | | | | | | | | | | | | | | UNAIDS, 2020 [9] |
| PWID HIV Prevalence | | 14% | | | | | | | | | | | | | Scheibe, 2015 [10] |
| Estimated Size of Priority Populations : Black African Females 15-34 years | 8,651,222 | | | | | | | | | | | | | | Statistics South Africa (StatsSA), 2022 estimate from Mid-year population estimates, 2021 [1] |

| Table 2.1.1 Host Country Government Results | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | <15 | | | | 15-24 | | | | 25+ | | | | |
| | Total | | Female | | Male | | Female | | Male | | Female | | Male | | |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | ***Source, Year*** |
| Estimated Size of Priority Populations : Black African Males 25-49 years | 9,630,136 | | | | | | | | | | | | | | Statistics South Africa (StatsSA), 2022 estimate from Mid-year population estimates, 2021 [1] |
| [1] 2021 and 2022 estimates from publication Statistics South Africa [StatsSA], Mid-year population estimates report table, 2021 Statistical Release P0302, Statistics South Africa: Pretoria Accessed March 14, 2022 at http://www.statssa.gov.za/publications/P0302/P03022021.pdf | | | | | | | | | | | | | | | |
| [2] Johnson LF, May MT, Dorrington RE, Cornell M, Boulle A, Egger M and Davies MA. (2017) Estimating the impact of antiretroviral treatment on adult mortality trends in South Africa: a mathematical modelling study. PLoS Medicine. 14(12): e1002468. Thembisa 2022 estimates reflect mid-year 2022 for point estimates (like prevalence) and mid-year 2022 to mid-year 2023 for flow estimates (like number of new infections). | | | | | | | | | | | | | | | |
| [3] National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC), and ICF. 2019. South Africa Demographic and Health Survey 2016. Pretoria, South Africa, and Rockville, Maryland, USA: NDoH, Stats SA, SAMRC, and ICF. | | | | | | | | | | | | | | | |
| [4] NDoH DHIS data, December 2021. Results presented represent ANC already on ART at 1st visit + ANC start on ART / ANC already on ART at 1st visit + ANC HIV 1st test positive + ANC HIV re-test positive + ANC known HIV positive but NOT on ART at 1st visit from Oct2020-Sept2021. | | | | | | | | | | | | | | | |
| [5] Statistics South Africa [StatsSA], General Household Survey, 2019. Statistical Release P0318, Statistics South Africa: Pretoria. | | | | | | | | | | | | | | | |
| [6] Global tuberculosis report 2020. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0IGO.Tuberculosis Country Profiles (South Africa 2020). Accessed Mar 14, 2022 at https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&lan=%22EN%22&iso2=%22ZA%22 | | | | | | | | | | | | | | | |
| [7] Simbayi LC, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, Mabaso M, Ramlagan S, North A, van Zyl J, Mohlabane N, Dietrich C, Naidoo I and the SABSSMV Team (2019) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. Cape Town: HSRC Press | | | | | | | | | | | | | | | |
| [8] University of California, San Francisco. (2020). Consensus Cascades. [Dataset] | | | | | | | | | | | | | | | |
| [9] UNAIDS Key Populations Atlas [2020], https://kpatlas.unaids.org/ | | | | | | | | | | | | | | | |
| [10] Scheibe, A, Brown, B, dos Santos, M, Final Report: Rapid assessment of HIV prevalence and HIV-related risks among people who inject drugs in five South African cities, February 2015. | | | | | | | | | | | | | | | |

## Standard Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression

| Table 2.1.2 95-95-95 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 | HIV Prevalence | Estimated Total PLHIV | PLHIV diagnosed (#) | On ART | ART Coverage (%) | Viral Suppression (%) | Tested for HIV** | Diagnosed HIV Positive** | Initiated on ART |
| | (#) [1] | (%) [2] | (#) [2] | (#) [2] | (#) [2] | (%) [2] | (%) [3] | (#) [4] | (#) [4] | (#) [4] |
| Total population | 60,811,629 | 13.40% | 8,110,600 | 7,564,173 | 5,660,732 | 70% | 65% | 12,749,081 | 463,104 | 411,506 |
| Population <15 years | 17,053,685 | 1.38% | 231,882 | 174,295 | 126,274 | 54% | 38% | 1,040,268 | 7,656 | 8,898 |
| Men 15-24 years* | 4,921,515 | 3.98% | 192,502 | 158,413 | 105,633 | 55% | 70% | 782,353 | 14,655 | 10,220 |
| Men 25+ years* | 16,164,438 | 15.70% | 2,503,919 | 2,326,380 | 1,628,579 | 65% | 86% | 2,572,292 | 143,811 | 134,469 |
| Women 15-24 years* | 4,866,611 | 9.56% | 459,267 | 374,948 | 240,412 | 52% | 76% | 3,058,120 | 76,307 | 62,516 |
| Women 25+ years* | 17,805,380 | 26.93% | 4,723,020 | 4,529,952 | 3,559,316 | 75% | 89% | 5,283,026 | 219,752 | 195,402 |
| | | | | | | | | | | |
| MSM | 357,876 [5] | 29% [2,5] | 103,856 [2,5] | 82,960 [2,5] | 47,774 [2,5] | 46% [2] | 93% [4] | 43,130 | 3,394 | 3,439 |
| FSW | 127,190 [5] | 61% [2,5] | 77,192 [2,5] | 72,051 [2,5] | 54,034 [2,5] | 70% [2] | 90% [4] | 27,320 | 3,858 | 3,464 |
| PWID | 82,500 [8] | 14% [9] | 10,598 [8,9] | 8,457 [8] | 4,292 [8,9] | 41% [8] | 67% [4] | 1,522 | 677 | 537 |
| People in prison & other closed settings | 155,069 [7] | 19.6% [6,7] | 30,394 [6,7] | 24,011 [6,7] | 15,505 [4] | 51% [4,6,7] | 93% [4] | 39,548 | 4,526 | 4,992 |
| **PLHIV estimates represent Thembisa 4.4 national-estimates; diagnosed, on ART, and viral suppression estimates represent Thembisa 4.4 age-specific estimates*<br>***Disaggregations do not sum to the totals due to unknown age in some HIV testing records* | | | | | | | | | | |
| [1] 2022 estimate from publication Statistics South Africa [StatsSA], Mid-year population estimates report table, 2021 Statistical Release P0302, Statistics South Africa: Pretoria Accessed March 14, 2022 at http://www.statssa.gov.za/publications/P0302/P03022021.pdf | | | | | | | | | | |
| [2] Johnson LF, Dorrington RE (2022) Thembisa 4.4: A model for estimating the impact of HIV/AIDS in South Africa. | | | | | | | | | | |
| [3] Viral suppression rate is the proportion of total viral load tests done with a result of less than 1,000 copies/mL, as reported by National Health Laboratory Service | | | | | | | | | | |
| [4] PEPFAR reported data (FY21). 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. | | | | | | | | | | |
| [5] University of California, San Francisco. (2020). Consensus Cascades. [Dataset] | | | | | | | | | | |
| [6] 19.6% of People in Prison LHIV were Diagnosed, pulled from Situational analysis of factors associated with HIV and viral hepatitis infection in two South African Correctional Centres: Final Report, 27 Feb 2022 | | | | | | | | | | |
| [7] Department of Correctional Services Annual Report 2020/2021<br>http://www.dcs.gov.za/wp-content/uploads/2021/11/DCS-AR-202021-FINAL-SIGNED.pdf | | | | | | | | | | |
| [8] UNAIDS Key Populations Atlas [2020], https://kpatlas.unaids.org/ | | | | | | | | | | |
| [9] Scheibe, A, Brown, B, dos Santos, M, Final Report: Rapid assessment of HIV prevalence and HIV-related risks among people who inject drugs in five South African cities, February 2015. | | | | | | | | | | |

**Figure 2.1.3 Individuals Currently on Treatment in South Africa**

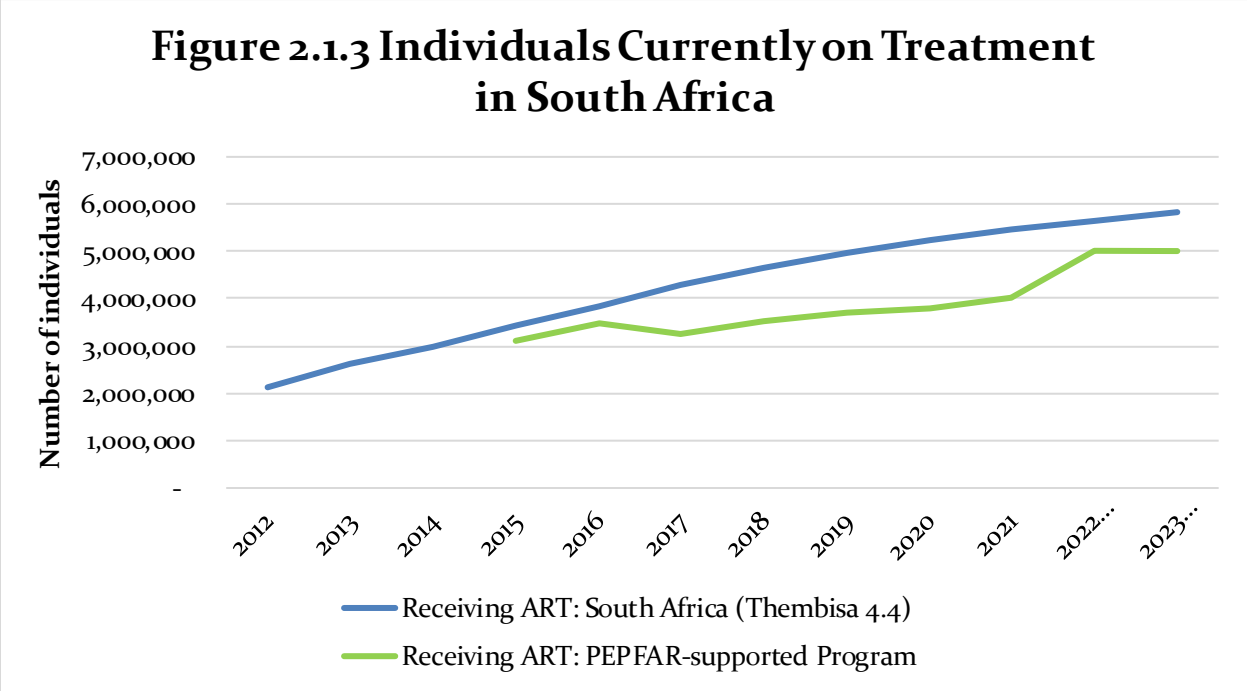



**Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV**

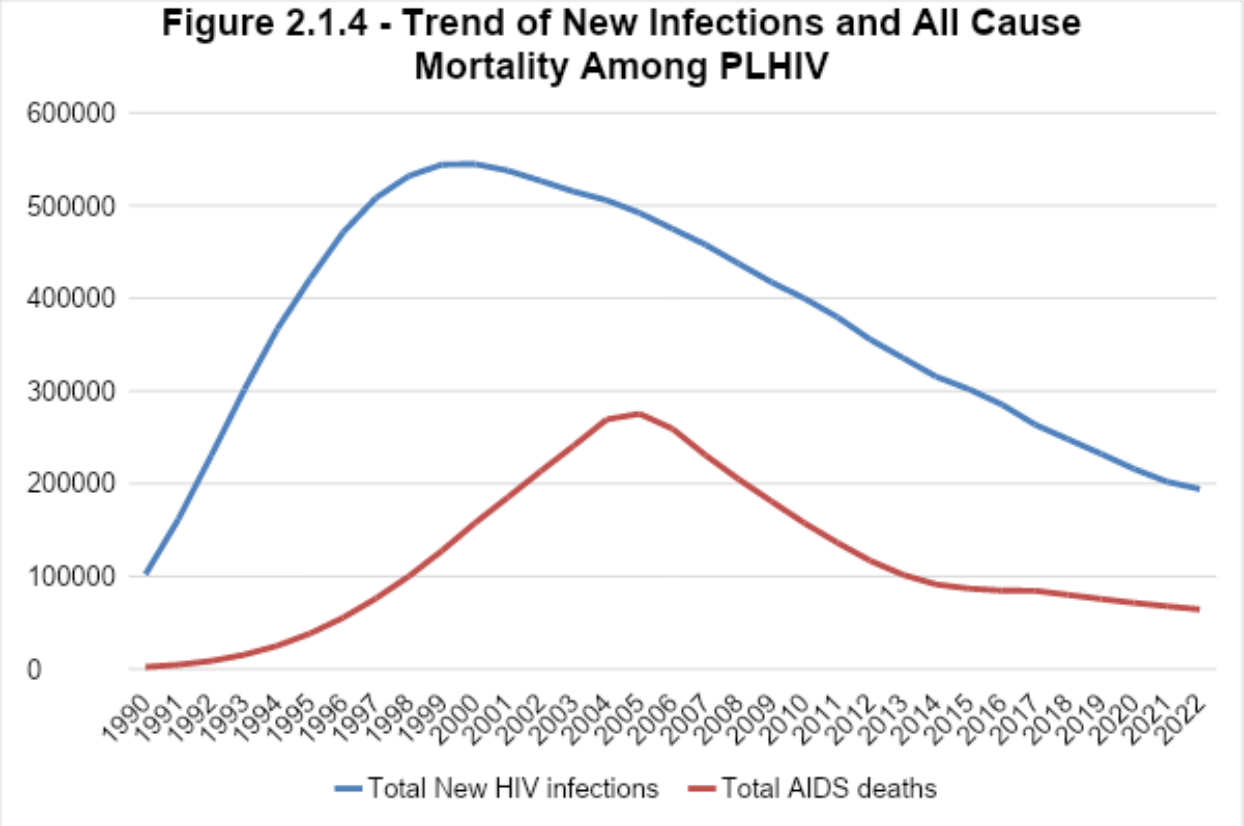


**Figure 2.1.5 Assessment of ART program growth in FY21**


**Figure 2.1.6a Clients Gained/Lost from ART by Age/Sex, FY21 Q4**

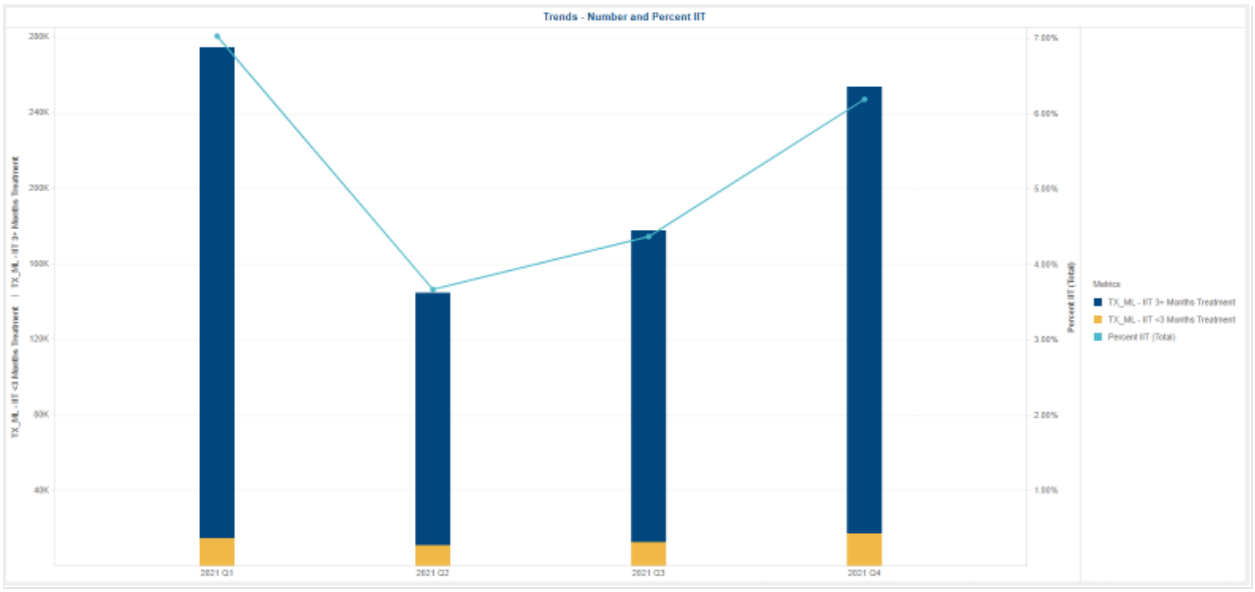


**Figure 2.1.6b Clients Gained/Lost from ART by Age/Sex, FY21 Q4**

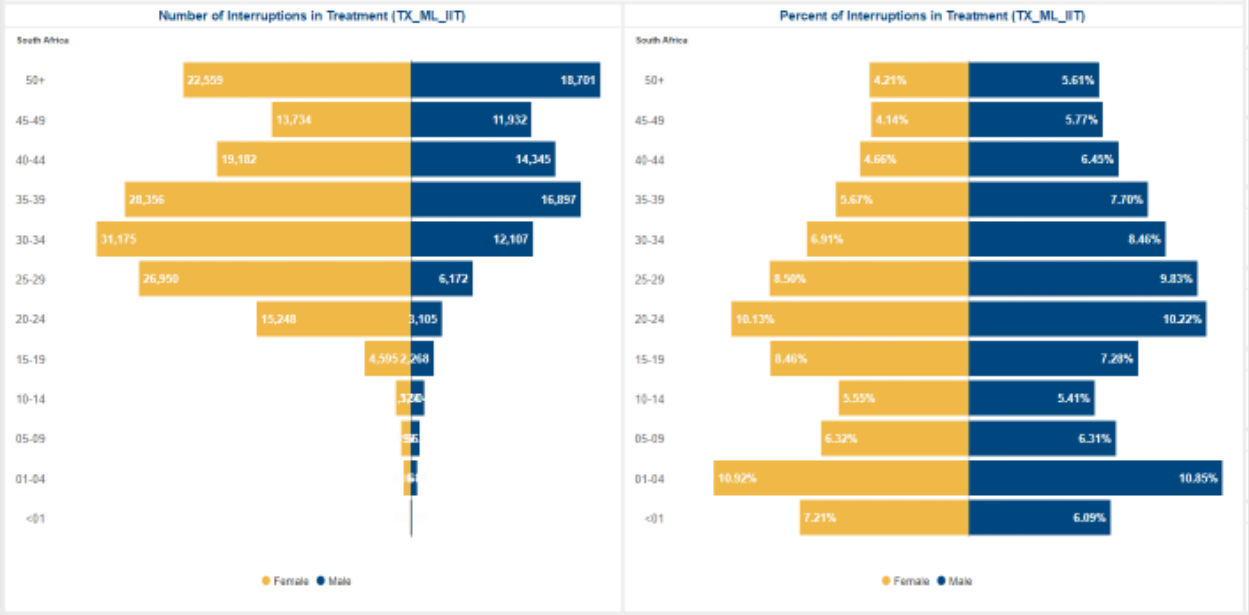



**Figure 2.1.7 Projected Epidemiologic Trends and Program Response for South Africa**

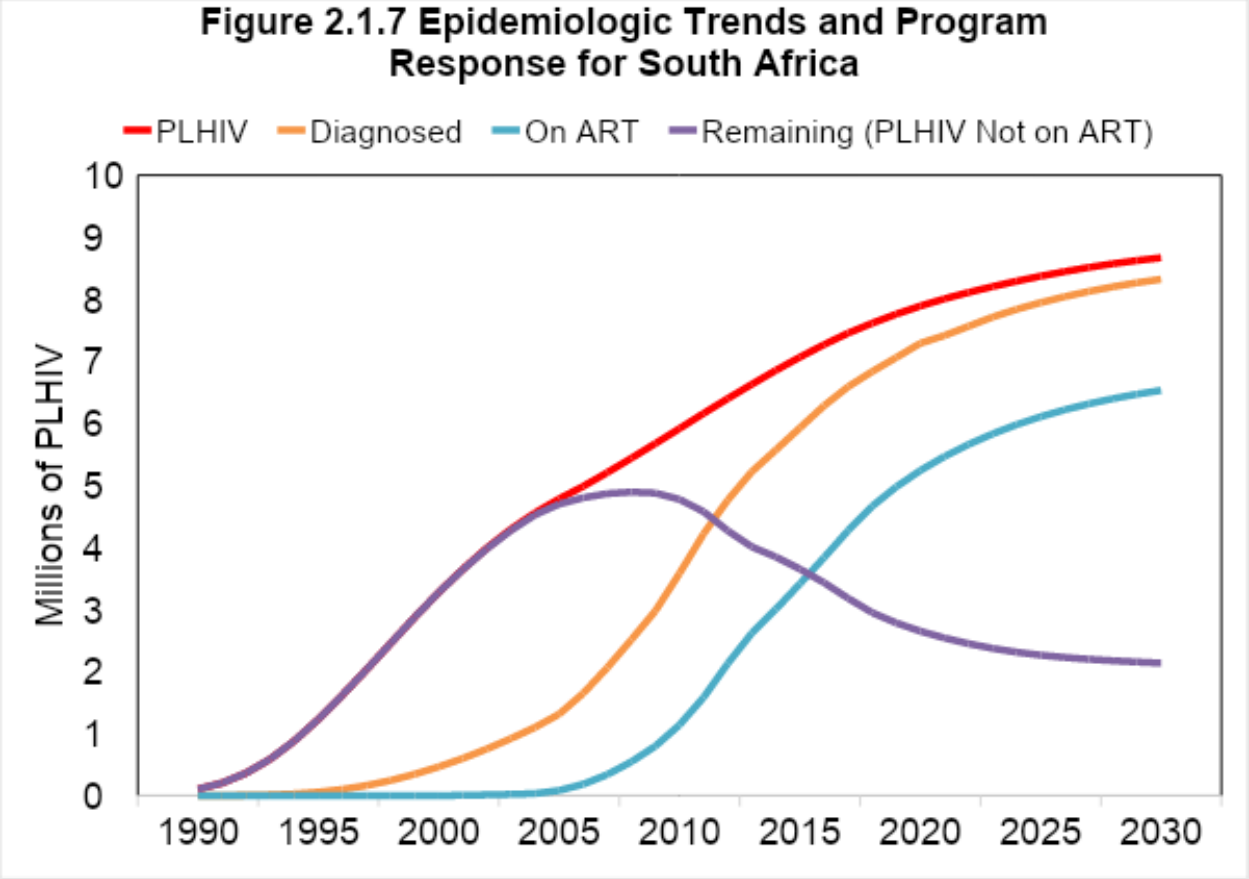
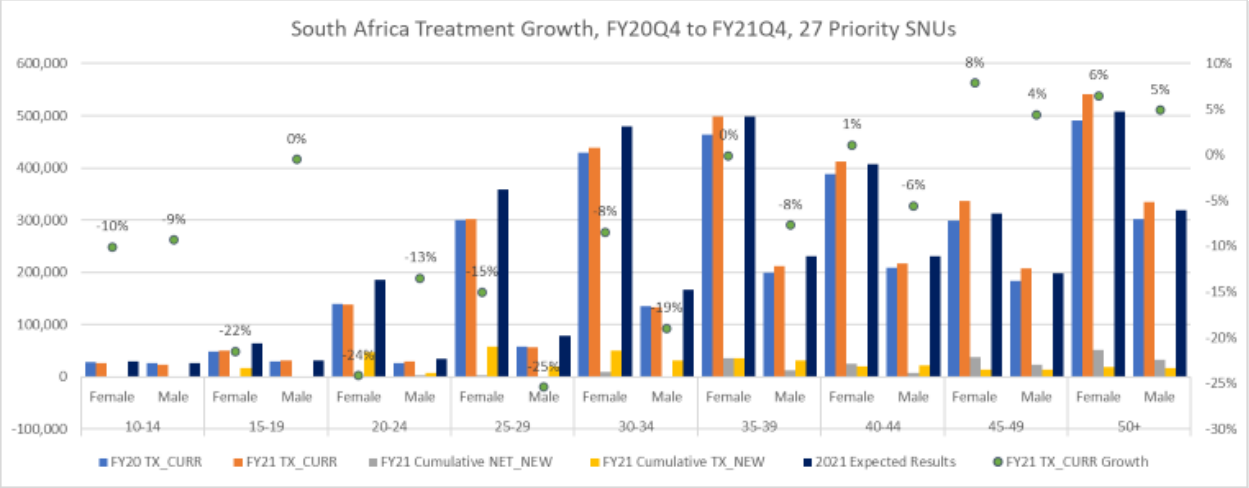


**Figure 2.1.8 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4**




## 2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Continuity

### 2.2.1 Overview

In COP22, PEPFAR SA will continue its focus on providing substantial and targeted support to both facility- and community-based settings to close the treatment gap. The assurance of quality care will be the cornerstone of COP22 implementation. Therefore, priority activities for the treatment program will be tailored towards helping clients overcome barriers to facility-based treatment, improving client experiences with out-of-facility care, and cultivating community-based solutions.

Key strategies for helping clients overcome barriers to facility-based treatment include leveraging the NDoH initiative, Operation Phuthuma. Through POPS, PEPFAR SA will strengthen client tracing, recall, and re-engagement in care. Other strategies will include implementing lessons learned from the SARS-CoV-2 response to improve HIV care and treatment; standardizing and scaling-up successful case management approaches; and linking mass media and facility-based campaigns to better reach sub-populations with the greatest ART gap.

Key strategies for improving client experiences with out-of-facility care include expanding decanting options through implementing additional external pick-up points and community adherence clubs to increase geographical coverage, mobile clinics, home delivery, and strengthening the supply chain; optimizing MMD; ensuring that providers are fully implementing policies; strengthening community ART service delivery through expansion and improved quality assurance of differentiated HIV/TB services based on need; expansion of nurses qualified to provide Nurse Initiated Management of Antiretroviral Therapy (NIMART); and counsellors and data capturers within NDoH's Primary Health Care community outreach services work to ensure clients receive the complete package of HIV services, including same-day initiation.

Community-based solutions will be cultivated through close collaboration with local community-based organizations to refine differentiated and holistic approaches to treatment and prevention, drawing from community-based models of the SARS-CoV-2 response, to address individual age, sex and geographic needs. PEPFAR SA's Community Grants Program will also work to align technical assistance, capacity-building, and above-site activities to fill those gaps. In COP22, PEPFAR SA will apply best practices from the Human Resources for Health (HRH) surge and work with district support partners to improve HRH planning to meet the HIV care and treatment needs of PLHIV. Additionally, in COP22, PEPFAR SA will continue to prioritize HIV case finding through targeted geographic interventions for specific populations using a focused and strategic mix of modalities (further detailed in section 4.1).

### 2.2.2 Linkage and Treatment Initiation

In COP22, PEPFAR SA will increase direct facility and community linkage to ART with the aim to achieve and sustain >95% proxy linkage in all PEPFAR SA supported districts. Strategies to improve linkage and treatment initiation will include same-day ART initiation in both facilities and communities, strengthening patient treatment literacy and adherence counseling for PLHIV newly initiated on ART, and scaling-up the NDoH welcome back campaign strategy to initiate clients who know their status but never initiated treatment or those who interrupted treatment but re-engaged in care. Case management as an overarching strategy will be peer-to-peer-based and will seek to provide motivational interviewing, support treatment initiation, continue treatment literacy, and ensure linkage to care of all PLHIV not on treatment.

PEPFAR SA will also enhance the integration of services to improve linkage through other clinical entry points (e.g., acute clinical services, TB, STIs, in-patient medical wards, etc.). The management and monitoring of clients awaiting ART will be improved, and clients will remain engaged in care through case management approaches until they initiate ART. Keeping clients in regular care will improve their overall health and reduce the risk of advanced disease and HIV transmission through prevention measures.

In FY21, young PLHIV had the highest linkage gap to ART initiation.19 To close this gap, PEPFAR SA will expand the "MINA. For Men. For Health." (MINA) Campaign to include provision of comprehensive male friendly services for young men and intensify the integration of HIV/TB services in the maternal, neonatal, and child health (MNCH) platforms for young women, with closer layering of DREAMS to reach adolescents, girls, and young women (AGYW), and develop women-focused campaigns to improve treatment literacy and access to ART for adolescents and young women.

### 2.2.3 Retention of all Clients Over Time – Reducing Interruption in Treatment

The South African HIV program has been negatively impacted by the SARS-CoV-2 pandemic. Although retention on ART has improved, it remains a significant challenge for the national HIV program. Some additional contributing factors include mobility of populations, unplanned facility closures due natural disasters and civil unrest, and continued data quality and completeness

19 PEPFAR. 2021. Data for Accountability, Transparency and Impact Monitoring (DATIM). FY2021 Dashboard.

challenges. To address some of these challenges, in COP22 PEPFAR SA will intensify community ART delivery in partnership with GoSA mobile clinics. Intensified data management will be provided in PEPFAR SA supported facilities through periodic in-service refresher training for all data capturers including NDoH staff, continuous data and file audits, and supporting government to improve and maintain the functionality of filing systems. As per updated 2020 Adherence Guidelines on repeat prescription collection strategies (RPCs), files will not be required for ART refill: For facility pick-up — PLHIV will go directly to the pick-up point in the facility to collect their ART refill.

To reduce treatment interruption, PEPFAR SA will continue to support the GoSA in implementing person-centered continuity of treatment strategies. The strategies will include optimizing decanting and DSD models, scaling up TLD uptake, case management, intensified welcome back campaigns to improved return to care and differentiated service delivery upon re-engagement, scaling up MMD (minimum of 3-month supply for all stable clients and aim to shift to 6-month supply), and expanding the MINA campaign to include women sub-groups with gaps in retention. In COP22, case management models will continue to be scaled up to ensure that newly diagnosed PLHIV, those returning to care, and those struggling with adherence are retained on treatment. Case management approaches will gain further efficiencies through the enhanced use of technology for continued peer-to-peer support. PEPFAR SA will also increase efforts to integrate mental health and substance abuse prevention interventions across the prevention and treatment portfolios.

Improving the quality of ART services will be prioritized to improve retention in care. ART sites identified to have quality of care concerns (e.g., long wait times, confidentiality and privacy challenges, poor staff attitude) through Ritshidze (a community-led monitoring (CLM) program) will be followed-up in collaboration with the DoH to identify specific challenges and implement tailored interventions. PEPFAR SA will continue to collaborate with GoSA to identify strategies to address vacancies at POPS facilities in the short term. DSP should work with facility and district to develop a plan to reduce total average waiting time at POPS sites that have been flagged as having longer waiting times than average. PEPFAR is committed to ensuring efficient and respectful service delivery, such as addressing factors that create long waiting times and barriers to receiving services

In COP 22, the PEPFAR SA team in collaboration with NDoH will endeavor to provide a minimum of 3-month ART refills to stable PLHIV and offered RPCSs options with the aim to increase the total proportion of eligible patients decanted to 85% with the majority (70%) decanted to external pick-up-points or community-based adherence clubs. PLHIV will be provided with options to choose the modality that suits their individual needs and preferences.

An additional COP22 priority will be expanding external pick-up points and restarting facility- and community-based adherence clubs, PEPFAR SA in collaboration with GoSA will work to engage PLHIV in the facilitation of the clubs. PEPFAR SA will continue efforts to increase the number of patients decanted into RPCS, including through the national Central Chronic Medicine Dispending and Distribution (CCMDD) program service providers and support GoSA in ARV stock quantification and ART provision to facilitate decanting. RPCS include facility-based pick-up points (previously called spaced appointment and fast lane (SFLA), facility- and

community-based adherence clubs (used as pick-up-points during COVID-19 lockdown), and external pick-up points (such as private pharmacies or community-based organization (CBO)-run points). In COP22, PEPFAR SA in collaboration with GoSA and civil society will work to improve the enrollment and retention of patients in RPCS, ensure that >90% of patients enrolled in RPCS are active (and not overdue for rescript) on the program. PEPFAR SA will monitor and support facilities to report on patients enrolled in RPCS that are more than 28 days late for rescripting.

Overall, retention among people established on treatment who have been decanted (enrolled into any of the RPCS) is high in SA; at least 1.5million ART clients were decanted by the end of FY21.[20] Demand creation for RPCS was implemented in COP21 through the Daplapmed campaign, and PEPFAR SA will continue to monitor reporting on the number of clients decanted to these models on a quarterly basis. To improve retention, PEPFAR SA will not only work with the GoSA to scale up CCMDD, but also the national roll out of MMD with full scale roll-out of 3MD across all districts and planning for 6MD, ensuring that CCMDD and Synchronized National Communication in Health (SyNCH) processes support this. To prevent loss- to-follow-up, implementing partners will continue to support facilities to track missed appointments. Extended hours for clients who are working or at school (including early morning from 5am, evening to 7pm, and weekend hours) will be expanded for drug pick-up. More convenient places (e.g., decentralized drug distribution, facility extensions into the community) and procedures that support expedited ARV refills, and community mobile ART deliveries will also be improved. Client satisfaction will be monitored regularly and independently validated by PLWHIV, Key Populations (KP), and Community Service Organization (CSO) groups.

In line with the success of the Siyenza/Phuthuma efforts, PEPFAR SA will continue to expand its intensive partner management and support in COP22. Using developed Standard Operating Procedures (SOP) and tools, PEPFAR SA will work closely with GoSA for the POPS approach at both national and provincial levels through setting up daily data-review and facility management hubs attended by technical leads from PEPFAR, GoSA, and Civil Society. In addition, facility-based acknowledgements rewarding high-performing facilities will be used to further bolster the NDoH-PEPFAR SA collaboration at the site-level.

Finally, PEPFAR SA will work to ensure adequate infection, prevention, and control (IPC) for SARS-CoV-2 in facilities.

### 2.2.4 Treatment Optimization

The PEPFAR SA team supported the GoSA to scale up Tenofovir –Lamivudine Dolutegravir (TLD) in the latter part of COP19 and by the end of COP20 at least 17 of the 27 PEPFAR focused districts had over 50% of patients on ART receiving TLD. In COP22, PEPFAR SA will continue to support GoSA to further expand and monitor TLD access in South Africa. Optimization of ART will be done through accelerating the transition to TLD and other dolutegravir (DTG)-based regimens to improve treatment initiation, retention in care, and overall optimal treatment outcomes. This will be achieved by assigning aggressive TLD initiation and transition targets and monitoring TLD stock at different levels.

[20] NDoH. 2021. CCMDD report Sept 2021.

To identify the barriers in TLD update, PEPFAR SA in collaboration with GoSA will conduct a rapid assessment at ART sites in COP 21 to obtain data for programming. The focus areas in the assessment will include clinician capacity and knowledge of the benefits of TLD, clinician hesitancy to transition patients, reasons for patient refusals to be transitioned, efforts to promote TLD transition (e.g., among CCMDD clients, patient education), supply chain management and reporting, and monitoring of TLD transitions and side effects.

In COP22 PEPFAR SA will support GoSA in implementing interventions directed at addressing identified bottlenecks. A greater focus will be placed on ensuring that all patients are offered TLD with informed choice, by expanding the availability of patient educational materials, capacity building interventions to address healthcare worker hesitancy, and healthcare worker job-aids, as needed. PEPFAR SA will also support DTG-related pharmacovigilance and active surveillance efforts to track side-effects and adverse outcomes, and support on-going training of healthcare workers, including side-effect monitoring and appropriate regimen switch, in line with national guidelines.

### 2.2.5 Pediatric Surge

PEPFAR SA is implementing a surge to substantially improve the pediatric cascade in COP21-22, focusing on five key program areas: case finding, linkage, case management, providing health services tailored to the needs of Children and Adolescents Living with HIV (C/ALHIV), and optimizing treatment.

Activities under the 1st 95 for the pediatric surge include scaling up the offering of index testing; demand creation among PLHIV for testing of their children; testing in key entry points including acute care, well baby clinics, TB clinics, inpatient wards, youth zones; and improving the community and Integrated School Health Policy referral pathway.

Linkage has been improving for children aged 0-9 years over the last few quarters; we plan to continue to strengthen community-facility linkages and enable children to be initiated in the community. Use of the Results for Action (RfA) datasheets developed by the National Institute for Communicable Diseases (NICD) to improve linkage to treatment especially for children younger than 18 months is ongoing. The eLABS platform and the RfA datasheets are also being used to facilitate more rapid identification of C/ALHIV with unsuppressed viral loads and optimize their regimens. PEPFAR SA partners continue to provide mentorship and training to the NDoH staff in facilities to empower them to initiate children on ART. PEPFAR will work with GoSA to provide stable pediatrics and adolescents with a minimum of 3-month ART refill, offering enrollment on RPCs (specifically options aimed at pediatrics and adolescents), and ensuring alignment with caregiver appointments. The OVC program will also be used to strengthen community outreach for CALHIV who have not been linked to ART. For the C/ALHIV aged 10-19 years, key barriers to linkage include access to adolescent and youth friendly services (AYFS), gaps in treatment literacy, and need for psychosocial support including for disclosure. PEPFAR SA partners are working with their NDoH counterparts to provide training and support to facilities to implement AYFS and peer-led support groups, which would provide treatment literacy and disclosure support to the caregivers and C/ALHIV. Taking advantage of the success of the MINA men's campaign, we plan to include messaging that reinforces the benefits of ART for adolescent boys to improve their linkage and retention on ART.

Partners will continue conducting file audits to identify gaps and interventions to improve time to action viral load results and transition of CALHIV to Dolutegravir (DTG)-based regimens. TLD transition has not occurred at the optimal rate as expected over FY21; however, with close monitoring, we strive to improve those rates. With expected approval of pediatric DTG at the end of April 2022, PEPFAR SA will aim to start transitioning children in FY22Q4 and complete the transition by the end of FY23.

Access of C/ALHIV to 3MD and to RPCS will continue to be supported in COP22 through inclusion of the pediatric formulary in SyNCH an information system that facilitates online patient registration in the country's decanting system, as well as mentorship of facility staff. This will help to improve retention on treatment, as well as viral load suppression.

### 2.2.6 TB/HIV

SA has the largest HIV epidemic globally, compounded by a high TB/HIV coinfection burden and rising drug-resistant TB cases. The SARS-CoV-2 pandemic has had devastating effects on the TB/HIV program, reversing the progress made in case detection, linkage to treatment, and treatment success in the last decade.

South Africa pioneered the implementation of WHO TB/HIV policy on collaborative TB/HIV activities, which provides a framework on actions to decrease the dual burden of TB and HIV. Despite the early roll out of the NDoH policy and guidelines recommending TB and HIV care integration, its suboptimal implementation has resulted in TB remaining as one of the major causes of death among PLHIV. PEPFAR SA will continue to put in effort to improve TB/HIV program implementation, embrace progressive and innovative approaches to adapt to different contexts, and where appropriate, leverage the COVID-19 response to deliver better care for coinfected patients. In COP22, PEPFAR SA will focus on the following three key strategies to reduce new TB infections and TB-associated deaths:

**Improving TB Case Finding Among PLHIV**

South Africa has made significant progress in adopting and scaling up rapid molecular diagnostics for TB. The current policy prioritizes PLHIV among high-risk groups for intensified TB case finding. A success toward improving TB diagnosis was the NDoH and the National TB Think Tank's development of a package of interventions to improve TB screening and testing and developing the revised national systematic TB screening and investigation SOP. The first National TB prevalence survey indicated that subclinical TB was underestimated and that the use of chest x-ray as part of the diagnostic work-up package would improve the TB diagnostic yield. However, there remains a performance gap in case detection as evidenced by a declining positive TB screening rate, low presumptive TB rate, and sub-optimal use of GeneXpert as the initial diagnostic test.

To address these gaps and improve the quality of TB case finding, PEPFAR SA will focus on addressing operational issues to ensure consistent implementation of key interventions with fidelity. The following evidence-based interventions will be scaled up (1) Targeted Universal Testing for TB (TUTT) for PLHIV, (2) strengthen the implementation of GeneXpert algorithm for PLHIV starting on ART, (3) support the routine use of digital chest x-rays in addition to symptomatic screening for PLHIV, (4) create awareness and monitor use of the self-screening

app, and (5) continue supporting the use of TB-Lipoarabinomannan Assay (LAM) in primary health care clinics and community health centers. We will further leverage community-based Integrated Service Delivery Models to fully integrate TB/HIV services. Specific interventions to improve TB case finding among children will include refresher training for clinicians in health facilities on identification of TB in children with a medical doctor and chest x-ray on site.

**Increasing HIV Testing Services (HTS) Coverage Among TB patients**

HIV Testing Services (HTS) is an integral part of the services provided to presumptive and confirmed TB cases. While HTS is routinely provided to TB patients, reported data does not accurately reflect the coverage of HTS, and can be an underestimate. Real time monitoring at the site-level and follow-up of patients diagnosed at hospitals and down referred to primary health care facilities is required for a more accurate picture of provision of HTS. While the overall HTS coverage among TB patients remains above 90%, PEPFAR SA will intensify support to clinicians to improve HTS for children <15 years, in whom coverage is below 90%.

To address programmatic and data quality issues and make progress toward achieving 100% HTS coverage in both adults and children, PEPFAR SA will assign TB Champions using existing cadres to (1) follow up on HTS results for TB patients diagnosed in hospital, (2) optimize HTS in TB patients through the scale-up of HIV-SS and index testing, (3) improve follow-up of down referred patients, (4) improve linkage to care, (5) find the missing TB cases, and (6) improve documentation of TB/HIV information, especially for patients collecting TB treatment and ART in different facilities.

**Starting and Maintaining TB/HIV Clients on ART and TB Preventive Treatment (TPT)**

Antiretroviral therapy has dramatically decreased HIV-associated morbidity and mortality in high-and low-income countries with a corresponding reduction in TB incidence; however, the epidemic of HIV-associated TB continues to rage in South Africa. Aligned with the national TB recovery plan and provincial TB catch-up plans, PEPFAR SA will cultivate lessons from the COVID-19 response and focus on optimizing TB/HIV integration in differentiated care models across all PEPFAR SA supported district with a goal to achieve 99% TB_ART coverage. Our interventions will focus on sustaining mechanisms for collaboration between TB and HIV programs, infection control in health care and congregate settings, HIV testing of TB patients, ART for PLHIV to reduce illness and mortality, and adopt HIV case management best practices to improve linkage to treatment. The outcome of our key activities will be ensuring that (1) HIV-positive TB patients are identified and treated effectively, (2) ART is initiated early once TB treatment is tolerated, (3) TB infection is prevented among HIV-positive individuals, (4) program monitoring is intensified, and (5) data quality is improved.

TB preventive treatment (TPT) is an instrumental component of HIV care because it has a synergistic effect with ART and independently lowers the risk of TB disease among PLHIV. PEPFAR SA has been at the forefront of scaling up TPT provision, with over 3 million PLHIV who received TPT through program support. Although the number of TPT initiations have increased substantially over time, patient adherence and completion rates remain low, in large part related to the South African TPT guidelines' stipulation of a longer, 12-month, course of isoniazid preventive treatment (IPT) for adults living with HIV. However, the roll-out of 3HP

proclaims the new era of shorter TPT regimens in South Africa. PEPFAR SA envisages that 3HP's introduction will address some of the barriers to implementing IPT because of its reduced hepatotoxicity, better adherence, and shorter course with higher treatment completion rates compared with that of isoniazid. PEPFAR SA will support GoSA to expedite the adoption of LTBI Guidelines. All PEPFAR-supported districts will support the introduction of short-course single-dose and fixed-dose combination (FDC) 3HP (i.e. a short-course TPT regimen that combines two antibiotics) therapies.

PEPFAR SA will scale up the provision of TPT among eligible PLHIV without active TB (i.e., 95% of PLHIV new on ART and 5% of PLHIV already on ART). All eligible PLHIV and all eligible contacts of a person with pulmonary TB, including children and adolescents, should be traced and initiated on TPT. All people considered for TPT should undergo clinical evaluation (symptom check and physical examination) and be tested with GeneXpert, even without having any symptoms. To achieve an 85% completion rate, PEPFAR SA will (1) continue to advocate for the NDoH approval of the revised TPT guidelines to improve implementation, (2) continue engaging NDoH to align PEPFAR SA TPT targets, (3) obtain buy-in from the Provincial DoH, (4) develop tailor-made interventions to improve TPT uptake in CLHIV and adults living with HIV, (5) support 3HP scale-up and advocate for other shorter TPT regimens such as 1HP, and (6) collaborate with District DoH and local stakeholders to enforce TPT scale-up in differentiated care models, improve TPT documentation, stock monitoring at the facility-level to ensure sufficient supplies required to scale-up TPT, strengthen patient adherence education and TPT demand creation activities, conduct joint TPT monitoring activities, address TPT interruptions, and improve TPT completions.

**Advanced HIV Disease (AHD)**

In COP22, PEPFAR will continue to leverage lay providers to support re-engagement strategies including linkage and down-referral of people with AHD from hospitals to clinics. PEPFAR SA will strengthen re-engagement of people with AHD through phone calls and physical tracing for those who disengage from care.

PEPFAR SA will continue to engage the GoSA on future provision and/or scale-up of point of care CD4 testing among PLHIV in PEPFAR-supported sites and appropriate timely management. PEPFAR SA will continue to support the GoSA to correctly implement guidelines for AHD including appropriate management of PLHIV with cryptococcal meningitis in PEPFAR-supported health facilities.

Together with other partners, PEPFAR SA is supporting the NDoH to develop a national Monitoring, Evaluation and Reporting Plan (MERP) for AHD. On completion and endorsement by NDoH, this framework will support reporting and monitoring of AHD including cryptococcal meningitis. This will, for example, provide national data on the number of patients with AHD, the number of cryptococcal antigen tests (CrAg) conducted and number of positive cryptococcal antigen tests (CrAg).

## 2.3 Investment Profile

According to the most recent National HIV/AIDS Spending Assessment (NASA), the national HIV response in SA is funded primarily by the GoSA (69%, USD $1.7B) through domestic public

revenue, with additional funding from external development partners (donors) such as PEPFAR SA (24%) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) (2%), as well as the private sector.[21] Government resources fund the majority of HRH and critical commodities such as ARVs and laboratory reagents. Donor funding complements and partners with government resources to address critical resource gaps and focuses on developing innovative interventions and solutions.

The country has faced a constrained fiscal environment in recent years with a growing debt-to-gross domestic product (GDP) ratio, which has been exacerbated by the Sars-CoV-2 pandemic. Many public sector programs have experienced budget cuts during the 2020/21 budget year, with national baseline budget cuts totaling ZAR308 billion (roughly USD20 billion) over the medium term.[22] Despite these conditions, the GoSA's financial commitment to HIV programs during local financial year 2020/21 remained relatively consistent with prior year funding, and in 2021/22, programs are anticipated to see a slight nominal increase in budget levels. Despite some short-term stagnation due to SARS-CoV-2, GoSA's financial commitments for the national HIV/AIDS response have continued to grow over the last decade.

Due to South Africa's high HIV burden and the large and growing number of patients on treatment, HIV program costs are expected to continue to increase over time, primarily driven by expanding ART service delivery. However, the continued expansion of cost-effective innovations such as: increasing TLD coverage and the optimization of HRH may partially offset these increases. Given SA's constrained economy, the GoSA has leveled funding for many services, and future rising HIV and TB resource needs are projected to consume an increasing share of the health budget. PEPFAR SA will continue to work closely with the GoSA and development partners to ensure sustainability and continuity of service provision despite anticipated broader domestic funding cuts.

Additionally, in an effort to maximize the utility of constrained resources, the GoSA identified efficiency in the management of public human resources—which represent 35%[23] of total national public expenditure—as a major priority to achieve national economic and social objectives. Last year, the GoSA implemented a three-year salary freeze for public servants within a framework of fiscal austerity. Within the HIV/AIDS related health sector, HRH represented 33% (USD900 million) of total expenditures in 2019/20.[24] Identifying efficiencies and approaches to maximize the utility of HRH is essential for South Africa to sustainably achieve epidemic control.

[21] South African National AIDS Council. 2021. National AIDS Spending Assessment 2017/18-2019/20.

[22] South Africa National Treasury. 2021 Budget Review
[23] National Treasury Medium Term Budget and Policy Statement 2021
[24] South Africa National HIV/AIDS Spending Assessment 2020

## Standard Table 2.3.1 Investment Profile (Funding Landscape) for HIV Programs

| | Total | Domestic Gov't | Global Fund | PEPFAR | Other Funders | Trend |
|---|---|---|---|---|---|---|
| | $ | % | % | % | % | 2018-2022 |
| Care and Treatment | $1,962,179,993 | 88% | 0% | 12% | 0% | |
| *HIV Care and Clinical Services* | $212,648,331 | 0% | 1% | 99% | 0% | |
| *Laboratory Services Incl. Treatment Monitoring* | $0 | | | | | |
| *Care and Treatment (Not Disaggregated)* | $1,749,531,662 | 99% | 0% | 1% | 0% | |
| HIV Testing Services | $42,365,777 | 85% | 3% | 12% | 0% | |
| *Facility-Based Testing* | $662,815 | 0% | 0% | 100% | 0% | |
| *Community-Based Testing* | $1,617,477 | 0% | 0% | 100% | 0% | |
| *HIV Testing Services (Not Disaggregated)* | $40,085,485 | 90% | 3% | 7% | 0% | |
| Prevention | $364,598,255 | 64% | 5% | 31% | 0% | |
| *Community mobilization, behavior and norms change* | $6,941,987 | 0% | 48% | 52% | 0% | |
| *Voluntary Medical Male Circumcision* | $41,522,139 | 20% | 0% | 80% | 0% | |
| *Pre-Exposure Prophylaxis* | $19,195,953 | 1% | 4% | 95% | 0% | |
| *Condom and Lubricant Programming* | $26,394,253 | 100% | 0% | 0% | 0% | |
| *Opioid Substitution Therapy* | $652,245 | 0% | 34% | 66% | 0% | |
| *Primary Prevention of HIV & Sexual Violence* | $32,005,862 | 0% | 1% | 99% | 0% | |
| *Prevention (Not Disaggregated)* | $237,885,816 | 84% | 5% | 11% | 0% | |
| Socio-economic (Incl. OVC) | $20,768,227 | 0% | 14% | 86% | 0% | |
| *Case Management* | $0 | | | | | |
| *Economic Strengthening* | $0 | | | | | |
| *Education Assistance* | $0 | | | | | |
| *Psychosocial Support* | $0 | | | | | |
| *Legal, Human Rights, and Protection* | $900,447 | 0% | 100% | 0% | 0% | |
| *Socio-economic (Not Disaggregated)* | $19,867,780 | 0% | 10% | 90% | 0% | |
| Above Site Programs | $44,908,758 | 18% | 23% | 59% | 0% | |
| *HRH Systems* | $0 | | | | | |
| *Institutional Prevention* | $0 | | | | | |
| *Procurement and Supply Chain Management* | $7,825,668 | 0% | 47% | 53% | 0% | |
| *Health Mgmt Info Systems, Surveillance, and Research* | $11,698,381 | 0% | 30% | 70% | 0% | |
| *Laboratory Systems Strengthening* | $2,880,000 | 0% | 0% | 100% | 0% | |
| *Public Financial Management Strengthening* | $1,527,133 | 0% | 2% | 98% | 0% | |
| *Policy, Planning, Coordination and Management of Disease Ctrl Programs* | $8,254,518 | 0% | 22% | 78% | 0% | |
| *Laws, Regulations and Policy Environment* | $0 | | | | | |
| *Above Site Programs (Not Disaggregated)* | $12,723,058 | 64% | 11% | 25% | 0% | |
| Program Management | $115,547,944 | 52% | 4% | 44% | 0% | |
| *Implementation Level* | $115,547,944 | 52% | 4% | 44% | 0% | |
| **Total (incl. Commodities)** | **$2,550,368,953** | **81%** | **2%** | **17%** | **0%** | |
| **Commodities Only** | **$15,273,315** | **0%** | **26%** | **74%** | **0%** | |
| *% of Total Budget* | 1% | | | | | |

*Source: HIV Resource Alignment; Note: Domestic Gov't and Other Funders data included where available. Aggregated Domestic Gov't data has been included where disaggregation is not available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.*

## Standard Table 2.3.2 Annual Procurement Profile for Key Commodities, 2022 USD

| Table 2.2.3 Annual Procurement Profile for Key Commodities | | | | | |
|---|---|---|---|---|---|
| **Commodity Category** | **Total Expenditure** | **% PEPFAR** | **% Global Fund** | **% Host Country** | **% Other** |
| Antiretroviral Drugs | $18,290,438 | | $15,126,615 (treatment) $3,163,823 (PrEP) | | |
| Rapid test kits | $6,192,913 | $2,810,690 (HIV SS) $1,100,000 (Recency) | $664,663 (HIV RDTs) $1,617,560 (HIV SS) | | |
| Other drugs | $2,765,340 | | $2,765,340 (3HP) | | |
| Lab reagents | | | | | |
| Condoms | $1,095,556 | | $1,095,556 | | |
| Viral Load commodities | | | | | |
| VMMC kits | $5,027,400 | $5,027,400 | | | |
| MAT | $1,431,710 | $704,151 | $727,559 | | |
| Other commodities | $8,128,029 | | $8,128,029 | | |
| **Total** | **$42,924,386** | **$9,642,241** | **$33,282,145** | | |

## Standard Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration, 2022 USD

| 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 MCH | N/A | N/A | N/A | N/A | |
| USAID TB | 15,000,000 | N/A | N/A | N/A | TB technical assistance to GoSA |
| USAID Malaria | N/A | N/A | N/A | N/A | |
| Family Planning | N/A | N/A | N/A | N/A | |
| National Institutes of Health | | | | | To advance health objectives |
| Centers for Disease Control and Prevention (CDC)-Global Health Security | 135,000 | N/A | N/A | N/A | Provide Global Health Security technical assistance and support to the GoSA |
| Peace Corps | | | | | |
| Department of Defense Ebola | | | | | |
| Millennium Challenge Corporation | | | | | |
| Other (specify) | | | | | |
| | | | | | |
| **Total** | **15,135,000** | | | | |

[b] Implementing Mechanism

## 2.4 National Sustainability Profile Update

The most recent round of PEPFAR SA's National Sustainability Profile was completed in November 2021 using the Sustainability Index and Dashboard (SID). 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 demonstrated a high level of sustainability (score of 7/10 or higher) in 10 of the 17 critical elements, including a score of nine or higher for two elements. Seven elements with scores lower than 7/10 were identified with vulnerabilities to sustainability: Civil Society engagement (6.54); Service delivery (6.53); Human Resources for Health (6.75); Quality Management (5.67); Laboratory (5.29); Epidemiological and Health Data (6.83); and Data for decision-making ecosystem (5.29).

Since completing the SID in 2021, there has been progress made towards reductions in the vulnerabilities within these elements. For example, processes are in place to work towards finalizing the Civil Society engagement and working with all agency teams through Operation Phuthuma Meetings to address data and service delivery gaps identified through facility site visits.

As noted in Section 2.3 (Investment Profile), the GoSA funds the vast majority of the HIV response in the country, with PEPFAR SA the next largest contributor with about 24% of the overall investment. In COP22, PEPFAR SA will continue to invest in the seven program elements with the weakest sustainability scores (see above). Details on how these vulnerabilities will be addressed are included throughout this document, including in 5.0 Program Support and other sections focused on civil society engagement, service delivery, etc.

Addressing vulnerabilities identified through the SID process calls for a multisectoral, collaborative response. PEPFAR SA is committed to a collaborative approach for donor coordination to promote co-investment at provincial and district levels; promotion of joint planning at all levels to promote local program ownership; and encouraging local championing and accountability for long-term sustainability. The Global Fund for AIDS, TB and Malaria (GFATM) has also made commitments with regard to the SID vulnerabilities noted above. Their current funding cycle expires in March 2022; and PEPFAR SA will continue engagement with them throughout the next funding cycle. In terms of service delivery, GFATM has historically funded important programming for Key Populations and vulnerable populations, in particular core and layered, comprehensive prevention programs for AGYW and Key Populations. In the area of HRH, the GFATM has supported 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. PEPFAR SA expects that GFATM's commitments will be similar in the new funding cycle.

Other donors contribute to specific geographic or program areas, including the Bill & Melinda Gates Foundation (BMGF) which has enabled important formative research that informs

PEPFAR SA program direction. Investments for HIV/AIDS and TB by major donors have remained relatively stable over the past year; however, the infusion of COVID response funding in the country has created new opportunities for supporting and collaborating on key PEPFAR SA priorities.

Civil Society is also involved in the response. In 2021, the SID process was conducted in parallel with the National Sustainability Framework for HIV/AIDS and TB process, which was led by SANAC and involved participation of donor partners, civil society, and the GoSA.

Finally, local partners will be key to addressing the SID vulnerabilities. To date, almost all of PEPFAR SA's implementing partners are based within the country. PEPFAR SA also works closely with community-based organizations to promote and capacitate small scale organizations to strengthen their activities at the local level. This effort is made through the Community Grant Program that targets indigenous organizations, funding them directly.

## 2.5 Alignment of PEPFAR Investments Geographically to Disease Burden

In COP22, PEPFAR SA continues to prioritize the 27 districts that account for 82% [25]of the national HIV burden, which are the same 27 focus-for-impact districts in the 2017-2022 NSP. To further focus PEPFAR SA's investment, COP22 resources are further focused in the four largest metropolitan districts, which account for approximately 35% 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 South Africa. In COP19-COP21, PEPFAR SA provided targeted DSD support to these facilities with enhanced support at the largest volume facilities. In COP22 PEPFAR SA will continue to focus investments on the highest burden sites where these investments will have the most significant impact on HIV/TB epidemic control.

PEPFAR SA remains committed to reach the UNAIDS 95-95-95 targets Focusing on the 27 districts for COP22 remains aligned with this long-term goal of epidemic control in South Africa. PEPFAR SA's targets for COP22 aim to reach or exceed 81% ART coverage[26] in all 27 districts, and to reach or exceed 81% coverage in every 5-year age-sex band within each district inclusive of private sector coverage.

PEPFAR SA will provide targeted support to facilities to reach the target of 81% ART coverage, with support linked to HIV burden and growth needed. In COP22, 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.

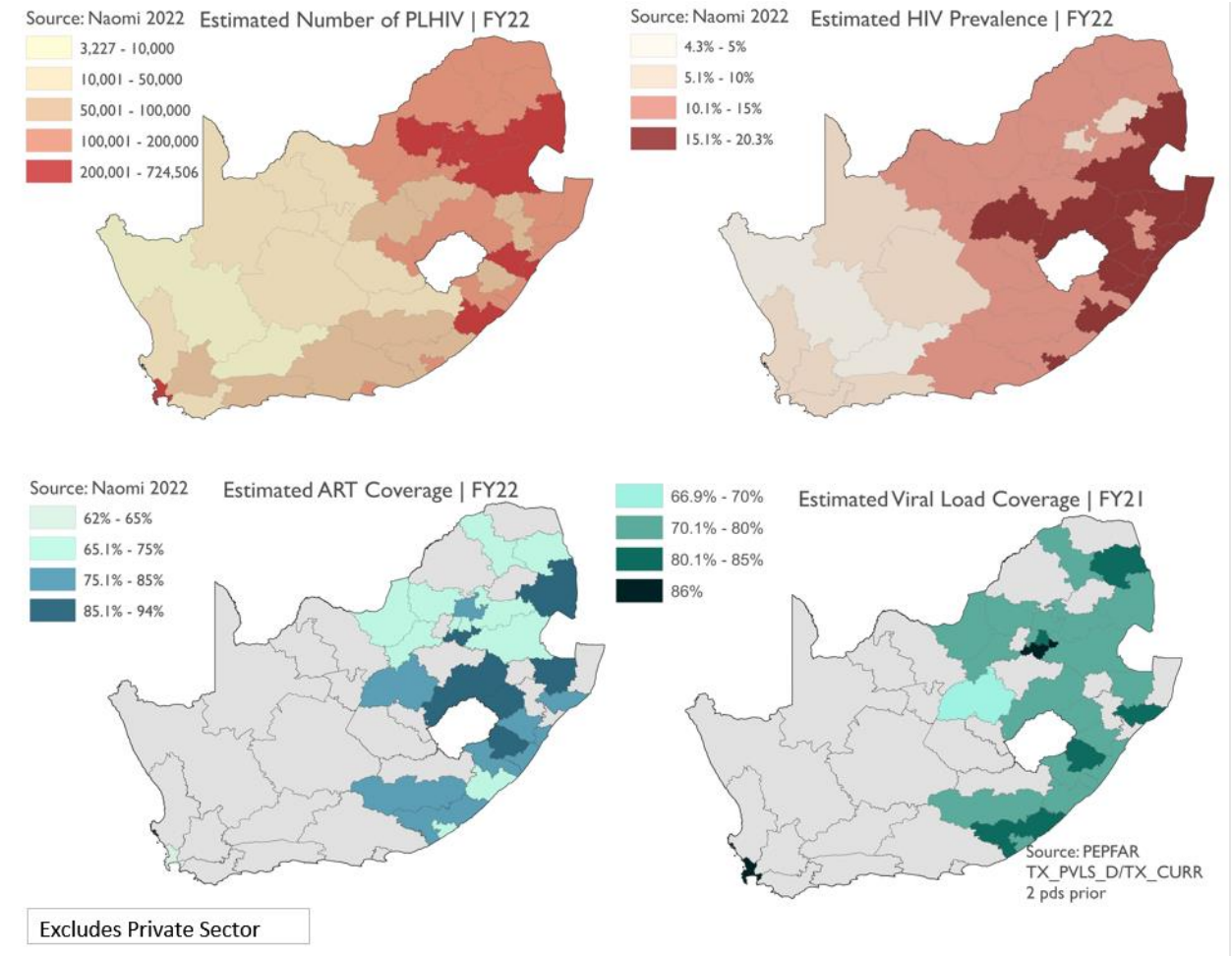
As in COP20 and COP21, PEPFAR SA will not be setting individual facility level targets in COP22, instead opting for a partner performance management approach to ensure districts

[25] Section 2.1 Summary statistics, disease burden and country profile
[26] Table 4.8.4 ART Targets by Prioritization for Epidemic Control

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 COP22 will continue to focus on AGYW and their communities in 24 districts. This includes the four historic DREAMS districts, and the 20 more expansion districts which were added to the program in COP20 (further described in Section 3.0).

**Figure 2.5.1 Estimate PLHIV, HIV Prevalence, ART Coverage and Viral Load Coverage for South Africa (Excludes Private Sector)**




## 2.6 Stakeholder Engagement

PEPFAR SA engages with (SANAC) which brings together government, Civil Society and the private sector to create a collective response to HIV, TB and STIs in South Africa. The Council is co-chaired by the Deputy President of South Africa and a leader of Civil Society Forum (CSF). Through the SANAC Secretariat, PEPFAR SA further engages with the CSF. The CSF is a broad-spectrum platform of 18 organized sectors of society, including women; men; lesbian, gay, bisexual, transgender, queer, and intersex people (LGBTI+); youth; NGOs; labor; people with disabilities; PLHIV; and other representatives. PEPFAR SA also closely collaborates with multiple stakeholders including the GoSA, other donors, and multilateral organizations, such as

the GFATM, UNAIDS, WHO, the Clinton Health Access Initiative (CHAI), the BMGF, the International AIDS Society (IAS), AIDS Health Foundation, and Médecins Sans Frontières (MSF), among others.

PEPFAR SA engages with these stakeholders through quarterly and even more frequent meetings, across which areas of funding and focus are similar, to ensure alignment and synergy of activities. To strengthen this collaboration, PEPFAR SA is part of the Health Partners Forum which is coordinated by the GoSA to improve donor coordination. The Health Partners Forum meets on at least a quarterly basis.

Additionally, PEPFAR SA representatives actively participate in the Technical Working Groups (TWGs) of SANAC (e.g., Human Rights Technical Support Unit, AGYW), the GFATM Country Coordinating Mechanism, and HIV/TB project or program teams at the various levels of GoSA.

Annually, Civil Society provides strategic inputs towards the PEPFAR SA COP development processes. As in previous COP processes, during COP22, the PEPFAR SA team facilitated several meetings with the Civil Society Forum through the PLHIV sector to strengthen a community-led monitoring program (called Ritshidze, which means Saving Our Lives), that is part of the multiple initiatives to strengthen community involvement towards addressing the HIV/AIDS epidemic. For COP22, the CSF meaningfully participated–through coordinated Civil Society multisectoral input—in the PEPFAR SA strategic retreat and COP planning meetings. Also present in the strategic retreat were the SANAC Secretariat; SA Government Departments (NDoH, Department of Basic Education, Department of Social Development); the WHO; GFATM Portfolio Manager; and UNAIDS.

**Community-led Monitoring**

During COP20 and COP21 community- monitoring focused on two major programs, namely the Ritshidze community-led monitoring (CLM) program and the KP community-based monitoring (CBM). The KP CBM intervention will be changed to CLM in COP22 and will be led by Ritshidze. CLM activities were strengthened by the close collaboration between Civil Society, the GoSA, and PEPFAR SA to ensure successful monitoring of public health facilities in the 27 priority districts by PLHIV monitors.

Data from the Ritshidze dashboard are utilized at various levels of the health systems such as the monthly Operation Phuthuma meetings, Provincial Nerve Center meetings, and AIDS Councils to identify service delivery challenges as well as plan mitigation strategies.

Ritshidze informed the development of the annual Provincial or program-specific State of Health Reports (ongoing). These outputs formed the basis for dialogue between Civil Society and the Executive Leadership of Provincial DoHs to improve accountability for efficient and effective service delivery.

Ritshidze PLHIV site monitors conducted visits to 400 PEPFAR Operation Phuthuma sites and 80 non-facilities in 27 districts. Between COP21 Q1 and early Q2, Ritshidze interviewed 13,989 community members accessing public health facilities. Their experiences with public healthcare

service delivery were documented and this contributed towards the development of the People's COP22 for South Africa.

Ritshidze launched the 'State of Healthcare for Key Populations" report in January 2022. The Draft People's COP22 and the State of Healthcare for Key Populations report were presented at the PEPFAR COP22 strategic retreat. Stakeholder recommendations were addressed by PEPFAR SA during the COP22 processes.

Table 2 below provides examples of the recommendations from the People's COP22, COP22 strategic retreat and PEPFAR SA's responses.

| **Recommendations from People's COP,**<br><br>**COP22 Strategic Retreat** | **PEPFAR SA's Response** |
|---|---|
| Key Populations | |
| Negative attitudes in public facilities | Upon receiving any report, PEPFAR SA will follow up and take action within three months. In addition, we will encourage DoH to develop and circulate an official circular reminding staff to provide respectful services. |
| Sensitization training | NDoH and PEPFAR SA will provide a list of facilities that have been trained by DSPs, DoH, or the regional training centers.<br><br>The CLM partner will conduct assessments of the number of health staff that were trained, and the effect on services to key populations. |
| KP Centers of Excellence | Set up two Centers of Excellence (CoE) in each province. This will result in 18 CoE by the end of COP21. Work will continue in COP22 to maintain KP sensitive services in existing clinics, and to expand services in other clinics. Facilities may serve more than one population, but it may not always be appropriate to combine all KP into single settings given differential needs between KP groups. On the other hand, it is also important to consider overlapping KP behaviors and identities, and the need to address these in one setting. GoSA public facilities will be capacitated to be KP-Friendly, and are not intended to replace the PEPFAR-funded KP sites. For these in COP22, PEPFAR SA and KP implementing partners will support the development of |

| Recommendations from People's COP,<br><br>COP22 Strategic Retreat | PEPFAR SA's Response |
|---|---|
| | KP CoE through limited staff support and sharing KP targeted IEC materials.<br><br>PEPFAR-supported KP sites will continue to provide a comprehensive package of services, and will ensure peer-led active linkages to additional services where necessary. |
| Availability of harm reduction services | Harm reduction services are available at PEPFAR SA sites.<br><br>Expansion of the number of clients on opioid substitution therapy (OST) in COP22 in PEPFAR-funded KP sites.<br><br>Advocacy organizations (e.g., South African Network of People who Use Drugs) will continue to advise NDoH on the value of OST. |
| Linkage and Retention | |
| Waiting times | Poor filing systems negatively impact waiting times. Implementing partners are working with DoH to ensure that all supported facilities attain ideal clinic status which includes filing systems.<br><br>Implementing Partners will support the implementation of the appointment system. |
| Tracing and re-engaging PLHIV in care | PEPFAR SA supported community health workers and linkage officers have access to reliable transport, phones, airtime, and data to effectively track and trace PLHIV who miss their appointments. |
| Optimize Treatment Regimens | Accelerate the transition to TLD<br><br>Enhanced Adherence Counselling (EAC)<br><br>Enhance patient engagement and case management |
| Amplify HIV and VL Treatment Literacy | Through CLM, strengthen new and existing client empowerment initiatives<br><br>Improve provider education on messaging and promote U=U to patients at facility and community level |

| Recommendations from People's COP,<br><br>COP22 Strategic Retreat | PEPFAR SA's Response |
|---|---|
| DREAMS | |
| Scaling up prevention of HIV and sexual violence among at-risk youth | LIVES training (described previously) for all facilitators of HIV and violence prevention interventions<br><br>Ensure that "safe spaces" or "hubs of hope" remain functional and accessible to AGYW and adolescents, boys, and young men (ABYM)<br><br>Strengthen linkages of beneficiaries to mental health services, including psychosocial support<br><br>Expand provision of post-exposure prophylaxis (PEP) beyond post-violence care |
| Strengthen multisectoral collaboration in DREAMS | Continue collaboration with key departments of health, social development, and education, as well as AIDS councils at national, provincial, and district levels<br><br>Continue collaboration with GFATM to standardize interventions, increase coverage, pool resources, cost share on interventions, avoid duplication, and promote program efficiencies<br><br>Work with consular offices to enhance collaboration and leverage private sector opportunities and partnerships<br><br>Develop strategies and leverage opportunities to conduct a comprehensive review of the DREAMS program and alignment with OVC prevention program |
| OVC | |
| Actively include COVID-19 affected households as OVC sub-population priority | COVID-19 affected households to be included as priority sub-population due to escalation in vulnerability |
| Actively include children and caregivers living with | Engage with the CSO focusing on people living with disabilities |

| Recommendations from People's COP,<br><br>COP22 Strategic Retreat | PEPFAR SA's Response |
|---|---|
| disabilities as a priority sub-population | Review sub-population priorities to equitably include children and caregivers of children living with disabilities<br><br>Capacitate community care workers to have the ability to work with people living with disabilities |
| Inclusion of Children's Civil Society Sector and Child Participation | Actively include and involve children in all program activities.<br><br>"Nothing about us, without us" |
| Above-Site | |
| GoSA HIV and TB Policy<br><br>Multi-sectoral engagement | Review and the impact of policies and regulations on health outcomes and HIV and TB program effectiveness<br><br>Develop and share People's COP with relevant key stakeholders (GoSA, SANAC, donors)<br><br>Facilitate discussion through multi-sectoral platforms at all levels to improve coordination, strengthen implementation and monitoring of activities for the AGYW and the KP cascade including disseminating key policies and guidelines |
| Monitor quality of care of services for PLHIV and TB | Ritshidze Report and data dashboard accessible and shared with key stakeholders<br><br>Quarterly ~~c~~Civil ~~s~~Society public meeting where health sector and SANAC are held accountable for the needs of their constituents |

During COP22, PEPFAR SA will also support the development and implementation of the PEPFAR SA and Civil Society engagement strategy. There will be expansion of community led monitoring for PEPFAR-funded KP sites and KP services within the public health system. The scope of the Ritshidze program will continue to include monitoring of TB, Treatment Literacy, Pediatrics, and other programs. There will be increased focus on community participation, through community dialogues, to identify challenges as well as proposed solutions.

## 2.7 Stigma and Discrimination

In COP22, PEPFAR SA, similarly to COP21 will support programming which seeks to reduce stigma and discrimination in line with South Africa's National Human Rights Plan: A comprehensive response to human rights-related barriers to HIV, TB services and gender inequality in South Africa.[27] Particular focus will be placed on reduction of stigma and discrimination as a part of DREAMS and Key Populations programming.

In the DREAMS portfolio, the primary focus is on the reduction of stigma and discrimination experienced by both at risk/vulnerable adolescent girls and young women (AGYW) and adolescent boys and young man (ABYM) who are seeking health services such as HIV testing and other prevention services (PrEP, condoms & sexual and reproductive health (SRH)), which are delivered through various platforms including Primary Health Care facilities, school-based and community-based platforms. In addition to continuing to support capacity building in adolescent and youth friendly services (AYFS), including Youth Zones, for client-centered sensitive care, DREAMS also strengthens the implementation of parenting and caregiver programs such as Let's Talk/Sinovuyo and Family Matters!, which aim to create a supportive environment for AGYW and serve as a platform to generate awareness of prevention services targeting AGYW such as PrEP and SRH. Through evidence-based, community and norms change interventions such as No Means No, Stepping-Stones and SASA!, DREAMS seeks to reduce stigma and discrimination for ABYM and AGYW and create awareness of issues and prevention of gender-based violence. DREAMS SA will strongly focus on engaging community leaders and generating awareness around prevention of gender-based violence and the availability of post-violence care services in the communities and which will enable access to survivors of violence.

The KP program integrates anti-stigma and discrimination communication in all aspects of direct service programming through social asset building and mental health services. KP peer educators are recruited from the communities in which they live and host community dialogues to increase visibility of KP members and answer questions in a safe environment. Social workers at PEPFAR SA's sites provide comprehensive psychosocial services and verified linkages to social support to all our KP. PEPFAR SA's Female Sex Worker (FSW) and People Who Inject Drugs (PWID) programs work closely with the South African Police Service to improve relationships between police and criminalized KP groups. This collaboration is done at a local level through informal dialogues, continuous engagement, and discussions with local police precincts in areas where outreach occurs and invitations to sensitization workshops. In COP19, PEPFAR SA supported the development of a robust KP sensitization toolkit which has been rolled out to all DSPs, Civil Society, and Department of Health staff and is freely available online. This toolkit has been adopted by the NDoH to be incorporated as a part of standard in-service training for all facility staff. The training toolkit features moving personal stories from KP service beneficiaries and provides an overview of clinical and social needs of specific KP members. In COP20, approximately 150 trainers from the DSPs, Civil Society, and Department of Health representatives participated in a training of trainers on the toolkit and were provided with training materials to cascade the sensitization to other DSP and DoH staff. The Department

[27] https://sanac.org.za/wp-content/uploads/2020/03/HR-STRATEGY-FULL-electronic.pdf

of Health continues to monitor the facilities that have been trained. A retraining will be conducted in COP21, and additional data on numbers of individuals and facilities who have undergone training will be collected. KP individuals will continue to be involved in sensitization training. Post sensitization training, PEPFAR will work together with GoSA and with Ritshidze to assess the quality of KP service provision at site level (to show the success of the sensitization program). PEPFAR SA will work closely with GoSA to urgently investigate any reports of poor staff attitude, privacy violations, verbal or physical abuse/harassment and/or of services being restricted or refused and disciplinary action will be taken where appropriate. Further, PEPFAR will investigate any reports in PEPFAR-funded KP sites. For sites reported on, a response will be issued within 3 months with actions that have been taken.

Additionally, PEPFAR SA is supporting an overhaul of the National Department of Health's Key Populations Program (Formerly the High Transmission Area Program). The new program is embodied in the Key Populations Health Implementation Plan and translated into practice through the KP Centers of Excellence (KP CoEs). To date, six facilities in three provinces (Gauteng, KwaZulu-Natal, and Mpumalanga) have been identified and training has begun. The program is a highly collaborative activity, involving DSPs, KP IPs, Civil Society, and the Provincial and District DoHs. PEPFAR SA will establish two KP CoEs per province in COP21, and then continue to disseminate lessons learned and establish additional CoEs in COP22. Finally, we will continue to fund community-led monitoring for PEPFAR SA funded KP sites and NDoH facilities in COP22.

PEPFAR Civil Society points of contact are working with the SANAC Civil Society Forum's (CSF) TWG on Human Rights. In a recently held multi-stakeholder meeting, a mid-term review of the Human Rights Plan[28] was presented for discussion. The review sought to (a) assess South Africa's progress towards creating a supportive environment and putting in place comprehensive, quality programming to remove human rights-related barriers to HIV and TB services; (b) describe emerging evidence of impact; and (c) inform future efforts and investment towards scaling-up to comprehensive levels programs aimed at removing human rights-related barriers to HIV, tuberculosis (TB) and malaria services. Further meetings will be convened on a quarterly basis and stakeholders, including PEPFAR SA, are expected to identify an area of support that aligns with their programming.

[28] https://www.theglobalfund.org/media/11371/crg_2021-midtermassessmentsouthafrica_report_en.pdf

# 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. As shown in Table 3.1, these 27 districts contained 78% of total PLHIV in COP21 and over 4 million people on ART. Since COP17, an increased emphasis has been placed on the four metropolitan districts with the highest unmet need (Johannesburg, eThekwini, Ekurhuleni, Tshwane) and in COP19 Cape Town was also included as a priority metro. For COP21, targets were set to ensure >81% coverage by the end of FY22 across all districts and all age/sex bands within each district. PEPFAR SA utilized district-level modeling (the NAOMI model) estimates of 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). In COP21 PEPFAR SA's program was 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. In COP22, PEPFAR SA's program prioritization and subsequent target setting approach added a focus on the 3rd 95 to ensure ART continuity and increased viral load coverage and suppression. In COP22, integration of activities to provide psychosocial and mental health support will address gaps for some of our hardest-to-retain populations across priority geographies. The KP partners will continue to use social workers and psychologists to provide therapeutic counselling and structural support, including linkages to social welfare and support to children of KP.

As in COP19 and COP20, and continuing into COP21, all PEPFAR SA-supported districts were heavily impacted by the SARS-CoV-2 pandemic. In COP21, PEPFAR SA continued intensification and tailoring of back to care efforts to return patients to care, as well as the focus on closing the treatment gap. With the intensified focus on viral load coverage and suppression in COP22, core care and treatment interventions described above (Section 2.2) and below (Section 4.2) have been designed to specifically address these priorities.

The MINA campaign and roll out of the Coach Mpilo case management strategy have been 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 VMMC and treatment programs, with a focus on incorporating knowledge of HIV status and adherence to ART as part of a broader self-care approach. The VMMC program continues to review the most reliable VMMC coverage level estimates to assist with strategic COP target allocation. The HSRC VMMC coverage estimates/projections in FY19 and the more recent Imperial College of London VMMC coverage estimates in FY20 (results of which are still to be formally released) consistently show that the estimated VMMC coverage remains low, with not a single district reporting the desired 80% VMMC coverage in any of the target age groups. Therefore, the program continues to set targets for all 27 PEPFAR SA-supported districts, taking into account prior performance and districts with a comparative advantage to perform better going forward. All 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 COP21 guidance. The SABSSM VI survey rolled out at the beginning of COP21, and more robust VMMC coverage estimates generated through this survey are anticipated in FY23; these estimates will then be used to refine geographic

prioritization, with highest priority given to geographies remaining well below the 80% coverage benchmark.

Priority populations for prevention were identified based on HIV risk profiles, with the greatest focus being on AGYW and OVC. DREAMS programing in COP20 expanded from four original implementation districts to an additional 20 districts with extremely high incidence and high burden of PLHIV. In COP21 and COP22, PEPFAR SA DREAMS retained its population- and need-based target setting approach across DREAMS districts, utilizing key variables as age band-specific risk proxy multipliers (e.g., orphanhood, multiple sexual partners, inconsistent condom use, etc.) in order to ensure robust estimates of the target population. In COP22, DREAMS will maintain a focus on scaling up in the COP20 approved geographic expansion districts, as well as its focus on development and implementation of a multi-year saturation and maintenance model. Given the multitude of dynamic factors which impact the DREAMS program and its target beneficiaries (e.g., mobility, changing program requirements and priorities, variable and unpredictable AGYW risk profiles, ageing in and out of primary target age bands, etc.), understanding when DREAMS SA has reached district-level saturation (signaling the need to move into a "maintenance" phase) is quite complex; and as such, a model which considers key dynamic factors over time is necessary to inform program planning.

PEPFAR SA DREAMS will continue to work in collaboration with Global Fund in the seven shared districts in order to ensure complementary programming and additive coverage of vulnerable AGYW and ABYM with customized and targeted interventions. In COP21, the SA OVC Program contributed to the PEPFAR SA pediatric surge through continued scaling up and enrollment of C/ALHIV and support for the continuity of treatment for children under 18 years of age.

In COP22, the OVC program has further refined the target setting process to more deeply focus on using a data-driven approach to strengthen alignment to high burden facilities using TX_CURR (<19year-olds) in order to ensure geographic prioritization fully supports C/ALHIV needs across the 27 priority districts. Additionally, COP22 target setting prioritized the existing caseload of beneficiaries, and sub-population prioritization was informed by data on particular sub-populations at highest risk, including households dually affected by HIV/AIDS and COVID-19.

Key Population groups are characterized by high HIV prevalence with social marginalization and stigmatization contributing to high infections; KP groups include sex workers, men who have sex with men, transgender people, PWID, and people in prisons. Focus districts for KP detailed in the table below (Geographic Distribution of PEPFAR SA Key Populations Programming) are selected based on KP epidemiology including size estimations and presence of hotspots in careful coordination with GFATM to ensure expanded coverage of KP programs with no program overlap. PEPFAR SA funded sites provide a comprehensive package of prevention, treatment and complementary services through drop-in centers and mobile outreach. By expanding services across the HIV cascade including treatment, viral load suppression, and prevention interventions for key and priority populations in the highest KP burden districts, SA will disrupt HIV transmission and reduce HIV incidence.

Across priority and key populations and geographies, the CLM expansion in COP22 will identify gaps and provide data to support corrective action and iterative re-prioritization of program activities. Additionally, further strengthening of bi-directional referrals and a focus on 'breaking down siloes' between programs will ensure provision of needed services across priority populations and geographies, mitigating identified 'missed opportunities.' Close collaboration with Ritshidze, the community-led monitoring partner, will support strengthening and sustainability of KP COE in public health facilities as well as in PEPFAR SA-funded KP sites.

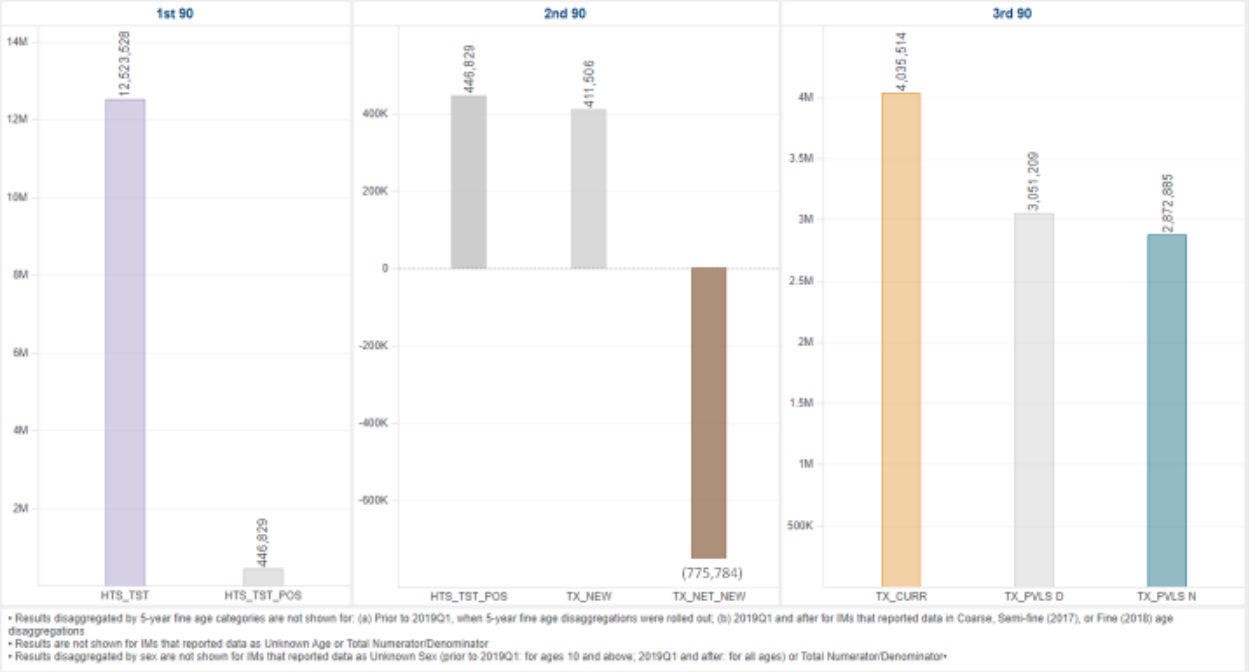
| **Geographic Distribution of PEPFAR SA Key Populations Programming (by population)** | | | | | |
|---|---|---|---|---|---|
| **District** | **People in Prisons** | **FSW** | **MSM** | **TG** | **PWID** |
| ec Amathole District Municipality | X | | | | |
| ec Buffalo City Metropolitan Municipality | X | | X | X | |
| ec Nelson Mandela Bay Municipality | X | | X | X | |
| ec Oliver Tambo District Municipality | X | X | | | |
| ec Sarah Baartman (Cacadu) District Municipality | X | | | | |
| gp City of Johannesburg Metropolitan Municipality | X | X | X | X | |
| gp City of Tshwane Metropolitan Municipality | X | X | X | | X |
| gp Ekurhuleni Metropolitan Municipality | X | X | X | | |
| gp Sedibeng District Municipality | X | | | | |
| kz eThekwini | X | X | X | | |
| kz Harry Gwala District Municipality | X | | | | |
| kz uMgungundlovu District Municipality | X | X | X | | |
| kz King Cetshway | X | | | | |
| kz Zululand District Municipality | X | | | | |
| lp Capricorn District Municipality | X | | | | |
| lp Vhembe District Municipality | X | X | | | |
| mp Ehlanzeni District Municipality | X | X | X | | X |
| mp Gert Sibande District Municipality | X | X | | | |
| mp Nkangala District Municipality | X | X | | | |
| nw Bojanala Platinum District Municipality | X | | | | |
| nw Dr Kenneth Kaunda District Municipality | X | X | | | |
| nw Ngaka Modiri Molema District | X | X | | | |
| wc Cape Winelands District Municipality | X | | | | |
| wc City of Cape Town Metropolitan Municipality | X | X | X | X | |
| wc Eden District Municipality | X | | | | |
| wc Overberg District Municipality | X | | | | |
| wc West Coast District Municipality | X | | | | |

## Table 3.1 Current Status of ART saturation

| Table 3.1 Current Status of ART saturation | | | | |
|---|---|---|---|---|
| **Prioritization Area** | **Total PLHIV (% of all PLHIV for COP21) [1]** | **# Current on ART (Nov FY2021) [2,3]** | **# of Districts FY2022(COP21)** | **# of Districts FY2023 (COP22)** |
| Attained | | | - | - |
| Scale-up Saturation | 2,280,918 (29%) | 1,426,006 | 4 | 4 |
| Scale-up Aggressive | 3,884,205 (49%) | 2,604,042 | 23 | 23 |
| Sustained | | | - | - |
| Central Support | 1,696,196 (22%) | 1,050,988 | 25 | 15 |
| [1] Eaton, J & Johnson, L. Unpublished Document – NAOMI 2022 District-level modeling of South Africa Prevalence by Age and Sex, excluding private sector (COP22 Datapack) | | | | |
| [2] Scale-up Saturation and Scale-up Aggressive calculated from DATIM FY21Q4 Annual Program Results | | | | |
| [3] Central Support calculated from NDoH Program data (DHIS), November 2021 | | | | |

# 4.0 Client-Centered Program Activities for Epidemic Control

**Figure 4.0.1 Overview of 95/95/95 Cascade, FY21**




## 4.1 Finding People with Undiagnosed HIV and Getting Them Started on Treatment

In COP22, PEPFAR SA will continue to support HIV 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 MNCH patient care streams. PICT optimization including risk screening tools and HIVSS at facilities will be the focus to ensure HIV testing is routinely offered to all clients at high risk for HIV infection. In addition to identifying high risk individuals in need of an HIV test, the risk screening tools will also identify previously diagnosed individuals who have fallen out of care so that they can be linked to and re-engaged in HIV treatment services. PICT will be integrated within other healthcare services provided at the clinic, to minimize stigma and increase HIV testing for those who are eligible to be tested. Routine analysis of patient headcount versus PICT will be used to identify gaps in testing service provision as well as to help determine when facility testing opportunities have been saturated.

PEPFAR SA will additionally support assisted and unassisted HIVSS efforts for patient populations with a special focus on men and key populations including: (1) Patients in the queues waiting to consult clinicians, (2) distribution channels such as workplaces and transport hubs, (3) partners of pregnant and breastfeeding women, and (4) through KP program sites. In

COP22, the targets for self-screening as a targeted testing modality will focus on 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 who have unsuppressed viral loads, STI patients, and patients with presumptive and diagnosed TB. The focus on ART clients with unsuppressed viral loads is crucial because these clients are at high risk for transmitting HIV to sexual and needle sharing partners and to neonates or infants during pregnancy, labor and delivery, and during breastfeeding. In addition, adolescent girls will also be included as part of priority populations for index testing. Index testing affords an opportunity to identify known positives who have either fallen off treatment or were never linked after diagnosis and therefore remains an important modality to bring those clients back to care.

Screening and monitoring instances of intimate partner violence (IPV) is a key component of the index testing modality. All implementing partners will fully comply with the government SOP in screening all clients for risk of violence before contacting partners. No contacts who have ever been violent or are at risk of being violent will ever be contacted in order to protect the individual and other partners the contact may have that are unknown. To ensure fidelity in the scale-up of index testing, including alignment with the WHO's "Five C's" of HIV Testing Services (HTS).[29] The DoH supports ongoing and refresher training for its staff on the correct implementation and monitoring of index testing. Similarly, PEPFAR SA funded DSPs will implement training and mentorship for their staff. Additionally, with the help of adverse event monitoring tools which are documented for each DSP and shared with Civil Society, the fidelity of index testing will be scrutinized at every facility performing this work. Index testing will always be voluntary as per the government SOP and human rights requirements. Monthly analyses comparing site level acceptance rates and partner elicited acceptance rates against the average will be conducted to identify sites where coercion may be happening. In addition, healthcare providers will follow-up with index clients after a reasonable period (1-2 months) to assess whether there were any adverse events—including but not limited to violence, dissolution of the relationship, economic harms, unauthorized disclosure of the client's HIV status, loss of housing, or other harms raised by the client as a result of their participation in index testing services. In cases of violence, clients will be referred to the nearest GBV support services. If no IPV services are available either at the facility or by referral, index testing will not be (re-) implemented. All referrals will be actively tracked to ensure individuals who wish to access them do and referral sites have adequate capacity to provide services to the individual. All adverse events are monitored through a proactive adverse event monitoring system capable of identifying and providing services to individuals harmed by index testing. All adverse events identified will be documented and reported to the DSPs, agencies, and PEPFAR SA who will report these to Civil Society and the DoH. PEPFAR SA will ensure that all referral options listed for adverse events will be of the highest quality, with proven track records. Index testing will not continue at the facility for any population where an IP cannot meet these criteria. Index testing implementation reporting is part of the weekly nerve center meetings where clinical cascade performance is discussed at the

[29] World Health Organization (WHO). 2015. Consolidated guidelines on HIV testing services. 5Cs: consent, confidentiality, counselling, correct results and connection. Available at: https://apps.who.int/iris/bitstream/handle/10665/179870/9789241508926_eng.pdf

sub-district level. PEPFAR will also work closely with community-led monitoring through Ritshidze to action any feedback received during facility assessment for index testing.

PEPFAR will report to CSOs the results of the REDCap assessments and the specific remediation steps that have been taken. REDCap tool results will be shared for all facilities. All sites implementing PEPFAR supported index testing will report on: a) The number and proportion of index clients who have been screened for IPV; b) The number and proportion of index clients that have screened positive for IPV. All IPs will report for all facilities implementing index testing where patients are referred for GBV/IPV services not provided on site as well as have transport options available for patients. PEPFAR will select a representative sample of facilities implementing index testing to administer PEPFAR's GBV Quality Assurance Tool. Results of the tool's implementation will be shared with CSO representatives and a remediation plan put into place for any gaps identified.

Community testing in COP22 will focus on testing the contacts of index clients and enhanced case-finding among men by targeting community hotspots that men frequent. These will include, but are not limited to, workplaces, men's hubs, and travel hubs. PEPFAR SA testing partners in the community will be trained to also use self-screening as a way to reach men who are not utilizing testing services at facilities. PEPFAR SA 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 with management closer to the community as a strategy to reach, initiate, and retain men. A yield of 4% is expected from community mobile testing. Additionally, in COP22, DSPs will ensure coordination of smaller CBOs, including those funded through the PEPFAR SA Community Grants Program 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.

Both facility-based and community HIV testing will continue to be supported to ensure quality assured HIV rapid testing services are provided through the Rapid Test Continuous Quality Improvement (RTCQI) program, involving tester certification, proficiency testing and annual site audits, using the Stepwise Process for Improving the Quality of HIV Rapid Testing (SPI-RT) assessment tool.

Recency Testing remained in the pilot/study phase during COP21, and in COP22 it will transition into Direct Service Delivery as part of the DSP HTS program model at selected facilities within selected Districts, namely Ekurhuleni, Tshwane, eThekwini, uMgungundlovu, Bojanala, and OR Tambo. The transition will include implementation of continuous quality improvement (CQI) activities such as proficiency testing. Recency hotspot mapping will be utilized through a South Africa Recency dashboard that is TRACE-based and will assist DSPs in acting upon recent hotspots by providing Index Testing services to all confirmed recently infected individuals in order to interrupt transmission within sexual networks.

### 4.1.1 Pediatric Case Finding

While South Africa has made significant strides toward identifying 95% of adults infected with HIV, progress on this target amongst pediatric and adolescent populations remains slow. Only 79% and 85% of children and adolescents, respectively, know their status. Among those who know their status, only 70% are on treatment. Common challenges to identifying pediatric and adolescent cases include the complexity of disclosure, consent, and testing among children; low yield; and health care worker sensitization to the importance of targeted screening and testing.

PEPFAR SA will work to close these gaps by employing more targeted approaches to identify undiagnosed children and adolescents. PEPFAR SA investments will scale-up case finding across the health system, particularly TB screening, routine immunization, and other child health entry points. This approach will be especially critical in districts with high TB burden, as program data illustrates that a high proportion of children and adolescents presenting with confirmed or presumptive TB also test positive for HIV. Despite this, program data suggest that the volume of testing for children and adolescents presenting with TB symptoms remains relatively low.

Even though South Africa has made immense strides in preventing mother-to-child transmission (PMTCT) of HIV, the PEPFAR SA program will continue strengthening early infant diagnosis by coaching providers to better implement national PMTCT guidelines, targeting common gaps such as the follow-up and testing of all HIV exposed infants, as well as screening for and offering pre-exposure prophylaxis (PrEP), when eligible, to all negative breastfeeding mothers. PEPFAR SA partners will also coach providers to use NICD RfA reports, which detail weekly facility-level HIV PCR results to assist with tracing HIV-exposed infants.

Recent district-level data show that 30% of newly identified HIV positive women were between the age of 15-24 years. Furthermore, there are indications that the SARS-CoV-2 pandemic has exacerbated factors that place adolescent and young women at higher risk of contracting HIV. The change strategy for reaching adolescents will be anchored in the integration of HIV testing across the health system, including universal testing in antenatal, family planning, TB and inpatient services. PEPFAR SA will improve the quality of testing and follow-up of index clients by strengthening counselling of index clients, supporting disclosure counselling with caregivers, improving tracking of children and adolescents who have not returned for follow-up as well as offer HIVSS to improve testing outcomes. PEPFAR SA is also engaging with Civil Society for strengthening demand creation for testing of children of PLHIV.

The PEPFAR SA program will strengthen program implementation across facility and community structures to better reach adolescents that do not routinely use health services. With PEPFAR SA's significant investments in community-based institutions through the DREAMS and OVC programming, PEPFAR SA partners are well-positioned to help bridge gaps between health facilities and the community. For instance, PEPFAR SA will promote HIV testing by facilitating partnerships between health facilities and youth focused, community institutions to implement joint programming and/or bi-directional referrals processes. PEPFAR SA will also increase case finding among children and adolescents by supporting community health workers to screen for and encourage testing during routine household visits, community TB contact tracing, and immunization drives. These health system entry points will also help identify

previously diagnosed children who have interrupted treatment. The program would also explore other potential strategies that involve school and early childhood development centers

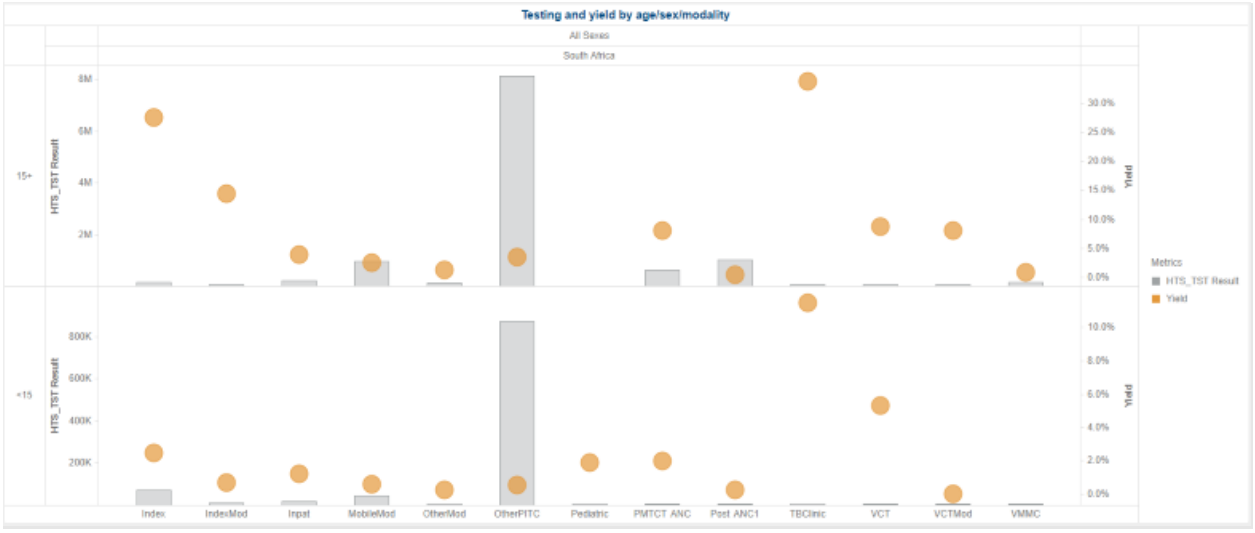
### 4.1.2 Key Populations

The target setting approach for HIV case-finding in COP22 was more streamlined and cognizant of the needs of each KP group. For example, VCT is most appropriate for people in prisons, while social network strategy and ethical index testing has been used successfully among MSM, FSW, TG, and PWID. Risk screening tools will be scaled up to reduce over-testing and HIV fatigue among those that PEPFAR SA reaches regularly, and a blended social network strategy/index testing approach will be used to find "hidden" KP individuals who do not know their status.

All counselors engaged in index testing/partner notification will receive KP sensitization and LIVES training to ensure that IPV and GBV do not occur due to contact solicitation. This training will be extended to KP Centers of Excellence, where many KP individuals continue to access services. As detailed in the DoH's SOP for HIV index testing, contact registers only contain the identity number of the index client and no information on the mode of transmission so as to protect the confidential information of both the index client and contacts when doing tracking and tracing.

Additionally, the KP recency testing protocol received final approval in COP21. Recency testing will be scaled up rapidly, in conjunction with index testing to further find hard-to-reach KP individuals, and to identify emerging hot-spots. The focus will be on determining high HIV transmission hotspots, and on locating untested permanent sexual partners, biological children, and regular injecting partners of KP individuals. Finally, self-screening test kits will be distributed via index clients and peers and assisted self-screening will be used in settings such as prisons and other enclosed and crowded spaces. The KP program will increase utilization of HIV self-screening tests in PrEP programs and will track these to allow disaggregating from those intended for case-finding. Key Populations teams primarily use assisted self-screening which allows for immediate confirmation of HIV status, and linkage to either PrEP or ART.

**Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY21**



## 4.2 Ensuring Viral Suppression and ART Continuity

ART Continuity

Maintaining patients on ART is an ongoing and substantial challenge for the SA national HIV program. The program has well-established mechanisms to reach patients who dropped out of care and relink them to ART, as demonstrated by the overall greater number of people returned to care versus interrupted care in FY21. For the remainder of COP21 and COP22, PEPFAR SA will aim to prevent treatment interruptions by providing people-centered approaches, which address specific reasons for non-adherence and missed clinical appointments, and by focusing on improving quality of care. PEPFAR SA's activities will be targeted towards improving clients' experience during clinic visits, including reducing their waiting times and improving professionalism of service delivery. PEPFAR SA will continue efforts for decongesting centers by decanting stable clients, extending hours of operation, and providing population-specific services such as Men's Corner, men-friendly service days, or youth-friendly services after school hours. PEPFAR SA will also continue providing enhanced support through SMS reminders and case managers or "peer-buddies" as treatment adherence strategies and address common mental health issues (such as anxiety, depression, and alcohol abuse) to prevent loss from care.

PEPFAR SA will actively support GoSA with dissemination, training and implementation of the national Welcome Back Strategy (October 2011). PEPFAR will support training on the welcoming environment and will advocate for staff accountability in the training to provide a friendly and welcoming environment for all public healthcare users whether accessing HIV prevention, PLHIV accessing ART, PLHIV returning to care after a treatment interruption, or key populations. Where PLHIV may have had a treatment interruption or have missed an appointment, staff will treat those returning respectfully and with compassion. Overall accountability will be with the Facility Manager if no improvements are made. Working with GoSA, PEPFAR SA will strive that no PLHIV is sent to the back of the queue if they miss an appointment. PEPFAR partners can work with facility managers and NDoH to address reports of poor staff attitude by staff and to ensure that disciplinary action is taken where appropriate. DSPs in PEPFAR supported sites will be made aware of the Department of Health's directives regarding transfer letters.

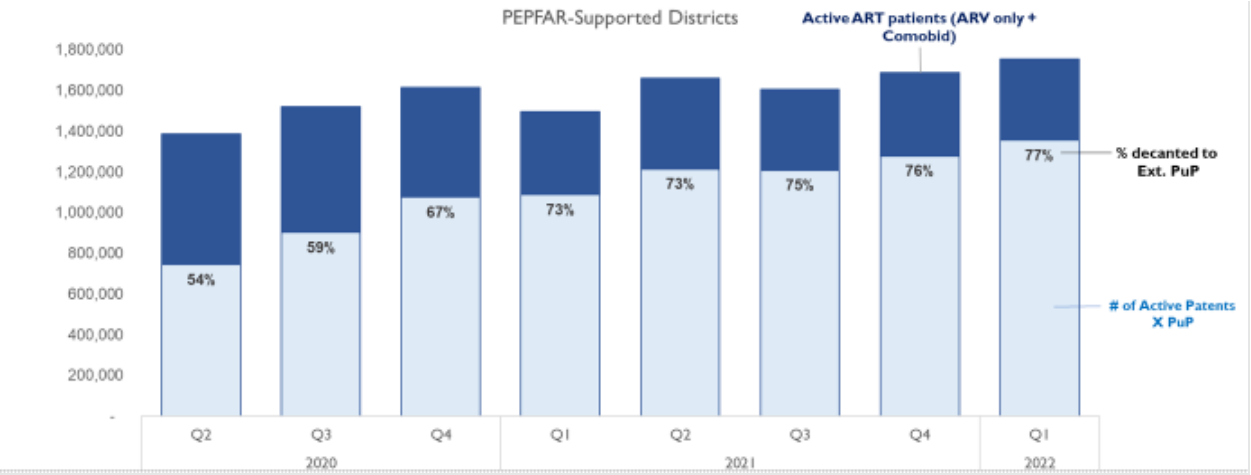
In COP22, PEPFAR SA will provide a package of psychosocial support at all PEPFAR SA-supported sites that includes provision of individualized counseling to patients. Where possible, peer-led case managers and support groups will further act as a bridge between clinicians and clients. Mapped networks of referral services, optional support groups linked to 100% of PEPFAR SA-supported sites, and other psychosocial support services will be offered. Any person living with HIV can access these services at any time, with an enhanced focus provided for patients who are new on treatment, recently experienced a treatment interruption, or have an unsuppressed viral load. PEPFAR SA will focus on gaining a better understanding of the characteristics and reasons of individuals disengaging from care and ensure that those who return to care are offered support (e.g., via psychosocial support and voluntary support groups) to improve long term retention and viral suppression. As part of the PEPFAR SA Community Grants Program, funded local community-based organizations will implement tailored person-

centered, community-based strategies to address the gap to treatment and retention efforts at community level.

One key retention strategy is to expand the options PLHIV have to choose their model of TB/HIV care based on individual lifestyle. South Africa's decanting program or the CCMDD system has shown its resilience, despite the SARS-CoV-2 pandemic, with over 1.6 million PLHIV in the program and 77% collecting medicine parcels in external pick-up points (Figure 4.2.1). In COP22, PEPFAR SA will expand decanting services through an increase in the number of external pick-up points and registering mobile clinics as community pick-up points. The home delivery model will be implemented through tracers, linkage officers, and other HIV support personnel to reduce interruption in treatment. PEPFAR SA partners will also strengthen supply chain services to promote consistent, on-time delivery of medication.

SyNCH facilitates online patient registration in the country's decanting system—CCMDD. This CCMDD information system includes an electronic selection of pick-up points and electronic submission of prescriptions to and feedback from CCMDD service providers. SyNCH has contributed to advances in the treatment space: supporting multi-month dispensing; prompting TLD transition; flagging treatment interrupters; and generating lists of patients due for clinical review. PEPFAR SA initiated transition of funding responsibility for SyNCH to the NDoH in COP21, and CCMDD and SyNCH will continue to play a critical role in the retention of clients in the years ahead.

**Figure 4.2.1 Number and Active ART Patients Receiving CCMMD by Quarter**




Source: NDoH Data

Another retention strategy in COP22 will be ensuring that all protocols are routinely followed for missed appointments (e.g., SMS, phone call, and home visit), which will be closely monitored through the PEPFAR SA-supported Operation Phuthuma program. PEPFAR SA will incorporate Ritshidze data into planning and programming to improve the quality of treatment services at these sites to prevent missed appointments and loss from care. PEPFAR SA will continue to provide human resource investments for direct service delivery and ensure PEPFAR SA funded

staff have equipment (phones/airtime/data/computers) needed to effectively follow-up on missed appointments.

In FY21, young PLHIV (both males and females) aged 20–24 years had the highest proportion of treatment interruptions, while PLHIV aged 35–49 years contributed the greatest number of people to the ART coverage gap. Additionally, data show that alcohol and substance abuse, high levels of gender-based violence, and mental health challenges increase the risk of interrupting HIV treatment and contribute significantly to this retention gap. In COP 22, PEPFAR SA will address these population-specific gaps and challenges. To increase retention among both young men and women, PEPFAR SA will continue to provide male-friendly services, such as the MINA (For Men. For Health. “Me” in the context of “my community”) Campaign, and support groups (I-ACT), postnatal care clubs, community ART (ART initiation and maintenance), and enrolment in Repeat Prescription Collection Strategies (RPCs). To improve ART coverage among PLHIV aged 30–49 years, we will scale up services like Men’s Corner and men-friendly services days, , which are designated spaces to provide comprehensive services to male clients. PEPFAR SA will embed messages on adherence to treatment, retention in care, treatment literacy, and U=U (Undetectable = Untransmittable) in the MINA campaign to improve engagement of men in their health. Similar strategies will be extended to women in COP22. PEPFAR SA will implement a campaign targeting women, continue peer-peer based case management, and promote the integration of services for women to reduce queuing at various types of health-care delivery sites (e.g., provision of HIV services in the family planning service point).

In COP22, PEPFAR SA will provide support to the NDoH at national, provincial, and district levels to routinize mental health (MH) screening at the primary care level with management at that level of common issues such as anxiety, depression, and alcohol abuse. The referral network for more complex MH cases will be strengthened.

Finally, through continuous collaboration with the NDoH, PEPFAR SA aims to serve hard to reach populations with MMD of ART through fixed and mobile clinics in COP22. PEPFAR SA aims to expand to full scale, 3MD in all PEPFAR SA-supported districts, and PEPFAR SA will continue engaging NDoH for ground preparation, including logistical planning and financial considerations for 6-month dispensing.

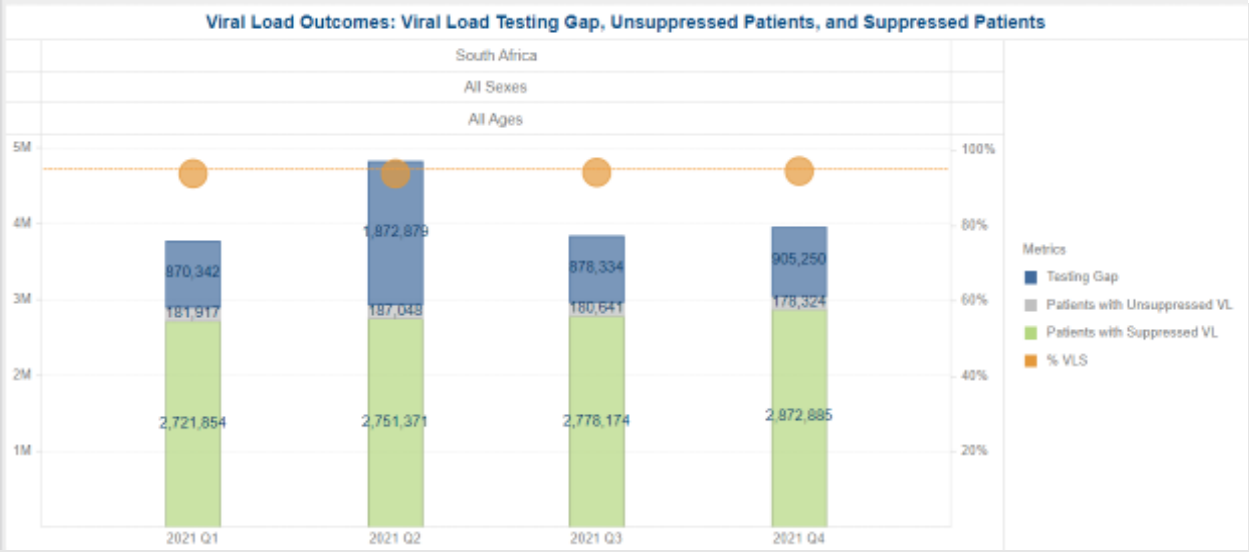
### 4.2.1 Population-level viral suppression

Although VL suppression rates are high among PLHIV currently on ART (Figure 4.2.2), the roll-out of TLD and DTG-based regimens during COP21 and COP22 are expected to further improve VL suppression and thus 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 collaboration with NDoH, PEPFAR SA will accelerate the transition to DTG-based regimens by working with the districts of health to set robust targets and assess and address TLD transition bottlenecks. PEPFAR SA will promote the transition by contributing to the development of simpler clinical guidance that addresses clinician hesitancy and supports the

sensitization of TLD transition throughout the health system, working through supply chain partners to ensure that TLD is available at all ART service delivery points.

### Figure 4.2.2 Viral Load Outcomes, FY21




Source: Panorama, Treatment Single OU Dossier; Treatment Overview chapter; Multi-month Dispensing by Age/Sex page; current quarter, by sex.

Many facilities continue to see delays in actioning of viral load results, with some clients waiting months before enhanced adherence counselling is done and stay on a failing regimen for months before a viral load test is repeated, or the regimen is changed. PEPFAR SA partners will continue to promote clinic laboratory interface strengthening through provider use of NICD Results for Action (RfA) reports and the eLABS application, which provides clinicians real-time access to patient lab results, with the potential of reducing the lag time between testing and provider action. With the eLABS platform, patients who are virally unsuppressed or have a rejected VL specimen could be identified early and recalled for enhanced adherence counselling or a repeat blood draw with the support of case managers. PEPFAR SA will also continue to support expansion of an eLABS intervention, started in COP21, which sends viral load results directly to patients accompanied by guiding messages based on the result, reminders of their next viral load test date, and educational health messages emphasizing the importance of adherence, viral load testing, suppression, and U=U messaging to motivate, educate and empower PLHIV who are on treatment.

The current PEPFAR VL coverage is 76%. To achieve population-level viral suppression of 73% and viral suppression of 95% among those tested, PEPFAR SA will need to aim for close to 100% viral load coverage and scale up VL testing so that every eligible patient receives a VL test. Among the first steps to improve HIV viral load testing coverage, PEPFAR SA will conduct a thorough assessment of the drivers of low VL coverage to develop facility and population-specific strategies. Interventions will focus on three main areas: 1) reducing missed appointments for those due for VL (e.g., calling patients ahead that are due for VL); 2) missed opportunities to draw a VL (e.g., creating a VL due list, fast tracking clients due for VL to a phlebotomist); and 3) installing Quality Improvement Plans to optimize VL coverage (e.g.,

defining VL management process flows at facilities and appointment of VL champions at facilities). These activities will synergize with enhanced patient and provider reminder systems, and integration of home phlebotomy into home delivery of medication models.

PEPFAR SA will continue to provide technical assistance to facilities to streamline patient file management and data entry into TIER.Net for all ART clients, which will facilitate data completeness and the ability to generate, review, and manage viral load due dates. Further, support will be provided to district health management teams to implement NDoH-supported "nerve center" meetings, which motivate facilities to closely monitor their performance, identify gaps, develop corrective action plans, and share best practices with other facilities to improve patient management. PEPFAR SA will continue to support the needs of facilities, such as with additional blood sample collection points; extended facility hours, including weekends; and support to the National Health Laboratory Service (NHLS)to ensure quality testing services through laboratory accreditation, proficiency testing and a stable supply chain for viral load testing commodities.

Some additional measures to improve VL coverage will be to align prescriptions of decanted patients with VL draw appointments and collaborating with the NDoH in various TWGs to address some of the policy/guideline or implementation barriers that are impeding on both VL coverage and suppression. NDoH will be issuing a memo for health care providers to practice flexibility in VL blood draws outside patients' cohort that is based on the ART start date, which has been flagged as a barrier to VL testing.

Treatment literacy among PLHIV on ART is a critical tool to empower patients in their own care, complementing the efforts of DSPs to improve retention and adherence. U=U messaging supports both these goals, works to create patient demand for viral load testing and prompt communication of results, and is a potent weapon against the stigma and self-stigma that undermine continuity of and adherence to ART. Especially for younger patients and those initiating therapy while immunologic function remains strong, U=U messaging may provide stronger motivation to getting on and staying on ART than does traditional messaging about avoiding death and living a long, healthy life. Findings from recent Ritshidze community-led monitoring efforts demonstrate that patient literacy and understanding of U=U messaging remain inadequate. PEPFAR SA will enhance work to build patient treatment literacy, expand use of U=U messaging within PEPFAR-supported services, and support the uptake of the "New Status" communications campaign as one of the effective means of promoting U=U. KP partners will select appropriate channels of communication and messages based on the feedback from KP groups to ensure that U=U messaging is communicated effectively, and understood by each KP group. KP groups are not homogenous, and so messaging and communication channels may vary across groups and geographies.

PEPFAR will work with GoSA to ensure that all healthcare workers provide accurate and easily understandable information on treatment adherence, the importance of an undetectable viral load, and the if undetectable, the availability of RPCS (less frequent ART refill collection closer to home with group support if desired) when talking to PLHIV, through consultations, counseling, outreach, and health talks at clinics — and that viral load test results are properly explained to all PLHIV in a timely manner.

Critical to ensuring ART continuity and viral suppression, PEPFAR SA will work directly with the GoSA to scale up with fidelity, the National Adherence Guidelines and Standard Operating Procedures (SOPs) that were revised to address key challenges across the HIV care continuum.

### 4.2.2 Pediatric

PEPFAR SA will target specific interventions to the needs of pediatric populations, including appointment time flexibility, family care days, and optimizing ART regimens. Partners are also supporting enrollment of C/ALHIV into RPCs to improve retention outcomes, improve quality of care and reduce the burden on C/ALHIV and caregivers for clinic attendance. PEPFAR SA implementing partners are conducting file audits among pediatric files to assess reasons for unsuppressed viral loads including underdosing and inappropriate formulations and regimens. Treatment literacy and disclosure support sessions for both caregivers and C/ALHIV are being planned through peer support groups. Dolutegravir-based regimens have been discussed with NDoH and will be translated into action in FY22Q3-4. Monitoring transition of C/ALHIV to Dolutegravir-based regimens has been discussed with NDoH and will also be translated into action in FY22Q3-4. Partners are also supporting enrollment of C/ALHIV into RPCs to improve retention outcomes, improve quality of care, and reduce the burden on C/ALHIV/caregivers for clinic attendance.

### 4.2.3 Key Populations

The KP program will prioritize continuity on treatment among all KP groups (i.e., Sex Workers (SW), men who have sex with men (MSM), transgender (TG) people, People who Inject Drugs (PWID), and people in prisons) in COP22. We aim to strengthen the second and third 95s through same-day or rapid ART initiations, multi-month dispensing, and drug drop-offs at homes or hotspots. Our comprehensive package of HIV prevention and treatment services is supported by peer-led health literacy initiatives, and together with concurrent screening and treatment of co-morbidities like STIs, TB, and viral hepatitis. PEPFAR-funded KP sites, as with public health facilities, will continue to ensure availability of internal and external condoms and compatible lubricants. Psychosocial support through social workers or psychologists will support continuity on treatment through counseling and motivational interviewing. KP partners will support CoE with one or two peers for the duration of COP21, with DoH taking on more responsibility for this resource in COP22.

Although viral load coverage in PEPFAR SA funded KP sites still lag, the use of eLABS has strengthened coverage, with an overall increase from 62% in FY21Q1 to 74% in FY22Q1. Several provincial and district DoHs do not allow PEPFAR-funded KP sites to use eLABS, and PEPFAR SA continues to advocate for this use with the support of our PEPFAR SA lab team and the NHLS. The NHLS provides PEPFAR SA with biweekly reports from eLABS, and this allows partners to take immediate remedial actions. Challenges faced by KP individuals further contribute to low viral load coverage. These include high mobility; homelessness; and a lack of internet access/data, transportation funds, and cell phone access. IPs have responded to these barriers through interventions including taking blood draws for viral loads at home, hotspots, or other venues, and via mobile clinics, and strengthening SOPs for tracking due viral loads.

Although VL coverage is suboptimal, the VL suppression of those with VL done among KP groups is approaching the third 95 goal, with an average of 92% viral load suppression of less than 1,000 cp/ml across all KP groups. The suppression rates are 93% among MSM, 92% among inmates, 91% among sex workers, 84% among transgender people, and 73% among PWID. Strengthening suppression rates may be attributable to development and rollout of tailored U=U messages and channels of communication. There is evidence that opioid substitution therapy (OST) is associated with a 54% increase in ART initiation, and 45% increase in the odds of VL suppression.[30] With new methadone products being approved in South Africa, PEPFAR SA will increase the number of PWID on OST to improve continuity on treatment. Similarly, there is strong evidence that gender affirming healthcare (GAHC), including hormone replacement therapy (HRT), is critical for maintaining individuals on ART.[31,32] An expansion of the GAHC program, including the purchase of a backup supply of HRT drugs in COP22 will increase VL suppression amongst transgender women. For MSM, for example, social media platforms were used effectively to influence their community, while peer-to-peer support was scaled up among SWs, PWID, and people in prisons.

Finally, point-of-care viral load testing is being investigated. Early interruption of treatment (<3 months) will be monitored, and clients will be followed up, and provided with enhanced adherence counselling using motivational interviewing techniques. Social workers/case managers will continue to follow-up and extend psychosocial support to clients on treatment. Same-day initiations will be strengthened with the support of motivational interviewing and peer role models, MMD, and drop-offs of medication at hot-spots or places of choice by the client. SMS motivational messages that have been developed by the SW team will be expanded to other KP groups: this comprises a daily message that encourages and reminds the client to "take their pill" every day.

### 4.3 Prevention, specifically detailing programs for priority programming:

#### 4.3.1 DREAMS incorporates HIV Testing Services (HTS) in prevention programming and prevention monitoring

DREAMS SA has substantially increased mobile HIV Testing Services targets for AGYW aged 10-24 years from 215,863 to 242,142. HIV testing services remain a core component as one of the DREAMS objectives is for AGYW to remain HIV negative. With the increased targets for Pre-Exposure Prophylaxis (PrEP) and gender-based violence (GBV), HIV testing services will be scaled-up/available during the implementation of multi-session interventions, safe spaces, and at PrEP demand activations. HIV testing services will be provided in alignment with COP22 guidance to ensure direct linkage to HIV prevention services and or HIV treatment services.

[30] Low, A.J. et al. Impact of Opioid Substitution Therapy on Antiretroviral Therapy Outcomes: A Systematic Review and Meta-Analysis. Clin Infect Dis. 2016 Oct 15;63(8):1094-1104. doi: 10.1093/cid/ciw416.
[31] Sevelius et al. Correlates of antiretroviral adherence and viral load among transgender women living with HIV. AIDS Care, Volume 26, February 2014, pages 976-982
[32] Summers, N et al. Effects of Gender-Affirming Hormone Therapy on Progression Along the HIV Care Continuum in Transgender Women. Open Forum Infectious Diseases, Volume 8, Issue 9, September 2021

Through DREAMS, HIV testing services are also offered to the male sexual partners of AGYW and to parents and care givers who are in the program.

#### *4.3.1.1 Scaling up PrEP for AGYW in DREAMS districts*

DREAMS SA has substantially increased PrEP targets in COP22 by close to 1% to continue reaching AGYW who are vulnerable and at high risk of attaining HIV. DREAMS SA will continue to implement PrEP as part of the core package of interventions and offered as part of a comprehensive sexual reproductive health services package and post violence care services with Post Exposure Prophylaxis (PEP). DREAMS will continue to support the DoH to institutionalize the provision of PrEP services in health facilities and continue to accelerate the services in community-based settings through mobile vans. DREAMS SA will ensure PrEP is prioritized for the most at-risk/vulnerable AGYW, including pregnant breastfeeding women (PBFW), GBV survivors, and sero-discordant couples. Implementing partners have been sensitized not to deny older females and males requesting PrEP services. Targets for the older females (aged 25-29 years) transitioning out of DREAMS, PBFW, and including male sex partners have been slightly increased in COP22.

In COP 22, DREAMS SA will continue to prioritize the scaling-up of the prevention of sexual violence and HIV amongst at-risk youth and interventions will include boys and girls where feasible. The implementation of evidence and curriculum-based multi-session interventions that address risk; violence prevention which includes focused attention on increasing knowledge on HIV prevention; self-efficacy; and linkage to HIV testing will be scaled-up. DREAMS interventions will continue to include the LIVES training for facilitators of HIV and violence prevention interventions, mentors and linkage officers who support beneficiaries in targeted “Safe Spaces” or “Hubs of Hope”. Training and support for mentors will be scaled-up so they can be better equipped in supporting beneficiaries and to improve direct linkages to services through health facilities and the Integrated School Health Program (ISHP) for youth in schools. DREAMS implementation will focus on strengthening direct bi-directional referrals from other implementing partners, collaborating on PrEP demand creation and ensuring VMMC and DREAMS implementing partners plan and work closely to provide services to beneficiaries. DREAMS SA will ensure targeted and strengthened linkages to mental health and psychosocial support (MHPSS) for the beneficiaries especially those who have been impacted by COVID-19, GBV, and/or sexual violence.

DREAMS SA has also increased the GEND-GBV targets to support continuing high levels of GBV, which were specifically reported during COVID-19 lockdowns. Overall efforts to prevent GBV are expanded to focus communities through targeted interventions addressing gender norms, violence prevention with AGYW beneficiaries, and males in community settings. DREAMS interventions target community leaders, change agents, and the male sexual partners of AGYW. DREAMS SA will continue to increase access to post violence care service points both at facility and community levels to expand the provision of targeted comprehensive services to vulnerable beneficiaries (decentralized services).

#### *4.3.1.2 Strengthen the intensive economic strengthening interventions to link AGYW to entrepreneurial activities, income generating, job readiness and wage employment opportunities*

DREAMS SA has substantially increased the resources, targets, and strategies for linking DREAMS beneficiaries to intensive economic strengthening opportunities which include linkages to wage employment, entrepreneurial and income generation. Different implementation strategies will continue to be strengthened and utilized to ensure that there are opportunities aimed at AGYW in the health sector and within the PEPFAR SA program through implementing partners. While continuing with training and linking young women to select trades, and vocations using the Siyakha Girls, intensive economic strengthening approach and Accelerating Strategies for Practical Innovation and Research in Economic Strengthening (ASPIRES), targeted strategies will be used to directly link young women to wage employment opportunities in the health sector. DREAMS SA will continue to target and penetrate male dominated industries within the supply chain through the Association for Supply Chain Management (ASCM) model and also ensure that AGYW are assisted with minimal capital to start-up small businesses in the beauty industry and small businesses. DREAMS SA will work with implementing partners to improve reporting on all categories of intensive economic strengthen for young women.

#### *4.3.1.3 Progress and plans for saturation by SNU (including any maintenance plans), and any approved geographic expansion.*

There are no planned DREAMS geographic expansions in COP22. DREAMS SA will continue to focus implementation in the current 24 districts and the focus will be on recovery and increasing coverage reach of the vulnerable beneficiaries in the current districts. In COP22, DREAMS SA will review and monitor HIV incidence levels in focus districts and determine in collaboration with South African stakeholders whether saturation level have been reached and if so develop relevant maintenance plans. DREAMS SA will continue to consolidate and strength HIV and violence prevention interventions to ensure performance improvement and achievement of the DREAMS primary package, including working with key multi-sectoral stakeholders sustain the implementation of the primary package. This is coupled with the standardization of the use of the national ID (where possible) to collect and report data under the AGYW-PREV indicator and strengthen the layering of DREAMS interventions through the improved web-based cohort tracking system (known as CBIMS.NET).

#### *4.3.1.4 Primary prevention of HIV and sexual violence among 10–14yearolds: Describe which intervention(s) will be used across different platforms (e.g., DREAMS, OVC).*

DREAMS targets 147,835 10–14-year-old adolescent girls through school-based interventions. The interventions targeting these age groups include boys and girls as the majority of 10–14-year-old youth are still in school settings in the focus districts. The interventions cover topics that address violence prevention and address risk, including creating awareness about sexual violence, healthy and unhealthy relationships, sexual consent, gender stereotyping, sexism and abuse, sexual grooming, bullying. See Section 4.3.4.2 OVC Preventive below with more details on the OVC-specific implementation of primary prevention of HIV and sexual violence for 10–14-year-old boys and girls. To ensure that parents and caregivers along with community leaders are included to protect both boys and girls, targeted radio lessons have been recently launched

and these are broadcast through community radio stations and are also used as teaching and learning materials in schools. These interventions are aimed at mobilizing communities to prevent violence and change harmful norms.

To achieve the coordination efforts DREAMS SA Team will continue to strengthen multisectoral collaboration to support the successful implementation of AGYW/ABYM interventions with key departments of health, social development, education - and AIDS councils at national, provincial and district levels. DREAMS will also continue to work with Global Fund to standardize and harmonize AGYW interventions, increase access and coverage of services, pool together resources, cost share on common interventions, avoid duplication and promote program efficiencies.

#### *4.3.1.5 Comprehensive DREAMS Review*

DREAMS SA in collaboration with USG headquarters implementation subject matter experts (iSMEs) and relevant stakeholders will conduct a comprehensive review of the SA DREAMS program to understand successes and challenges and better align programming by selecting the most successful interventions moving forward. Planning for this review will begin in COP21, with the review being conducted in COP22.

### 4.3.2 Key Populations

Key populations (KP) do not exist in isolation; they are affected by and impact the HIV epidemic in the broader population. As we move towards 95-95-95, increased KP resources will be needed to sustain epidemic control. Modelling shows that approximately 40% of new infections over the next five years can be attributable to KP and their sexual partners.[33]

Expanding KP Services to Public Health Facilities: In COP19, PEPFAR SA recognized the need for expanded KP services in public facilities, and started working with the DoH to realign the former "High Transmission Area Program" into the current KP program. The Key Populations Health Implementation Plan (KP-HIP) and KP CoE (described in Section 2.7 are key to strengthening KP services in public services. Establishment of KP CoEs is a collaborative effort, including provincial and district DoHs, Civil Society, and implementing partners including District Support Partners and KP partners. The NDoH is leading this activity with the secondment of a PEPFAR SA funded lead. The final component of this activity is community-led monitoring of both the KP CoEs in public facilities as well as PEPFAR-funded KP sites (Section 2.7). This will ensure that KP-competent services are delivered in South African government facilities, and will support continuity of this activity.

#### *4.3.2.1 Policy Development and Alignment*

All KP programs are aligned with strong country strategic plans and informed by population-size estimations and bio-behavioral data. In 2016/17, SANAC launched strategic plans for sex

[33] Stone J et al. Estimating the contribution of key populations towards HIV transmission in South Africa. J Int AIDS Soc. 2021 Jan;24(1):e25650. doi: 10.1002/jia2.25650. PMID: 33533115; PMCID: PMC7855076.

workers[34] and LGBTQI+[35] aligned with the 2017–2022 NSP. The National Sex Worker Plan[36] was updated and LGBTQI+ plan reviewed in 2020 In COP21, PEPFAR will support SANAC to develop guidelines on services for young KP. These plans demonstrate strong consensus on the strategic direction and confirm GoSA's support.

#### *4.3.2.2 Differentiated and Client-Centered Service Delivery*

PEPFAR SA's dedicated drop-in centers (DICs) provide high quality and tailored packages of prevention and harm reduction, care and treatment interventions targeted to sex workers, MSM, transgender women, PWID, and people in prisons. The package of services should be well communicated to DIC users (including through health talks). Several best practices established during the COVID-19 lock-downs have become part of routine work procedures. Peer-led outreach and mobilization is the cornerstone of the KP program, supporting targeted strategic communication and demand creation, and dedicated KP mobile and DICs. In addition to comprehensive HIV services, sites provide STI screening and treatment, TB screening and referral, PrEP (including MMD refill and community collection), PEP, and other primary health services, including sexual and reproductive health, condom compatible lubricants and both male and female condoms that are easily available (not only upon request or in public spaces that make it difficult to pick them up),psychosocial support, mental health services, and gender-based violence services on site or by referral. Where possible, KP will be employed as counselors at PEPFAR-supported sites to improve psycho-social support and counseling for KP. In COP22 KP focused RPCs will be scaled up including access to KP-focused adherence clubs and KP friendly external pick-up points including at drop-in centers. Additional targeted services, including hormone replacement therapy for transgender people, opioid substitution therapy initiation and treatment, drug dependence counselling and support, harm reduction information, wound and abscess care, and access to unused needles, syringes, and other injecting equipment. Where PWID and trans* people live far from these services, adequate resources will be provided to ensure they can uptake those services. Collaboration between KP and OVC partners support children of KP through linkages to OVC teams for structural support. This is particularly important for FSW and women who use and inject drugs. Social workers embedded in the KP teams provide therapeutic counselling and structural support including linkages to social welfare. All KP will be offered voluntary hepatitis screening and testing at PEPFAR-funded KP drop-in centers. Vaccinations for viral hepatitis B will be offered, provided the DoH supports resources, and treatment for viral hepatitis C will be provided to all those who are infected. Our comprehensive package of HIV prevention and treatment services is supported by peer-led health literacy initiatives, and together with concurrent screening and treatment of comorbidities like STIs, TB, viral hepatitis, we aim to reach the 95-95-95 goals and the 10-10-10 structural enablers.

[34] South African National AIDS Council. South African National Sex worker HIV Plan, 2016-2019. https://sanac.org.za/wpfd_file/south-african-national-sex-worker-hiv-plan-2016-2019/

[35] South African National AIDS Council. South African national LGBTI HIV Plan. https://sanac.org.za/wp-content/uploads/2017/06/LGBTI-HIV-Plan-Final.pdf

[36] South African National AIDS Council. South Africa's National Sex Worker HIV, TB, and STI Plan, 2019-2022. https://sanac.org.za/wp-content/uploads/2021/07/NATIONAL-SEX-WORKER-PLAN-WEB-FINAL.pdf

#### *4.3.2.3 PrEP*

New PrEP initiations continue to be scaled up, with targets being increased by 34%; both MSM and inmates targets were increased by more than 20% each. Our partners will continue to develop social media outreach, and scale up other demand creation activities to strengthen continuity on PrEP through loyalty programs and motivational interviewing. PrEP is actively offered to everyone who is eligible and wants it. PrEP refills will be extended to 3-month supply for individuals using PrEP for more than 3 months and RPCs for PrEP will be implemented to simplify service delivery including community collection of PrEP refills.

PEPFAR South Africa data from FY21 (October 2020-September 2021) show that MSM are the largest KP group initiating on PrEP, with steep increases since the start of the rollout. Although there is substantial evidence for the efficacy of event-driven PrEP among MSM, the South African government has not included this in their guidelines. PEPFAR SA is piloting event-driven PrEP among MSM in COP21. The pilot will focus on messaging and acceptability and findings will be shared with NDoH. The aim of the pilot is to provide data to advocate for inclusion of intermittent PrEP in national guidelines.

#### *4.3.2.4 Expand Access to Holistic, Timely, and Gender-Affirming Services*

Gender affirming healthcare including Hormone replacement therapy (HRT) is an essential service for transgender people within the context of HIV epidemic control.[37][38] In 2019, the GoSA added HRT for gender affirming healthcare to the Essential Medicines List (EML); however, supply of HRT drugs remains erratic as the EML calls for initiation at tertiary care facilities. Trust in the program has been eroded with several stock outs in recent months. PEPFAR SA will purchase a buffer stock of HRT drugs and employ additional medical personnel to increase the uptake of HRT and support continuation on ART and PrEP. PEPFAR will ensure that there is easy referral and resources (planned patient transport/resources for transport) provided to ensure that transgender people are better able to uptake these services.

### 4.3.3 Voluntary Male Medical Circumcision (VMMC)

The PEPFAR SA VMMC program was able to re-start operations following a two (2) year program implementation disruption including a full five (5)-month program suspension (during March to August 2020) as a result of the SARS-CoV-2 pandemic. The program was able to gradually re-start in August 2020 at various degrees of implementation determined by provincial departments of health based on COVID-19 severity in the respective districts. After restart, the VMMC program continued to experience the impact of COVID-19 in both the conventional and traditional male initiation (TMI) service sectors throughout COP20(FY21) and into COP21Q1 (FY22Q1). Intermittent and uneven service delivery in COP20(FY21) was largely due to COVID-19 related restrictions. The TMI season was voluntarily suspended by traditional leaders in some districts in Mpumalanga Province, and went forward with a limited intake of initiates in some districts in Eastern Cape Province. COP20(FY21) performance concluded with 164,994

[37] Sevelius et al. Correlates of antiretroviral adherence and viral load among transgender women living with HIV. AIDS Care, Volume 26, February 2014, pages 976-982

[38] Summers, N et al. Effects of Gender-Affirming Hormone Therapy on Progression Along the HIV Care Continuum in Transgender Women. Open Forum Infectious Diseases, Volume 8, Issue 9, September 2021

VMMCs, which was 52% of the set target. The majority of circumcisions continue to be in the PEPFAR priority age group of 15–29 years.

Implementing the program in the COVID-19 context over the past two (2) years has resulted in many lessons learned and has pushed implementing partners to new frontiers in innovations and program adaptations. For COP21(FY22), novel approaches and alternate service delivery modalities developed during the COVID-19 peaks will continue to be optimized in order to drive impact. Innovative demand generation activities that have been key to accessing prospective clients in COP21, such as door-to-door mobilization in hard-to-reach informal settlements and stop-and-talk mobilization at taxi ranks in the metros and high traffic areas, will continue in COP22(FY23) with improved capacitation of mobilisers focusing on linking *all* reached clients to services, as convincing older clients has proven to be challenging. An additional innovation in demand generation in the metros and urban contexts will be the use of the Moya App, which facilitates client referral across all service providers in the VMMC program, including Department of Health RT35 partners, at very minimal cost. The Demand Generation M&E Framework developed in COP21(FY22) will be strengthened in COP22(FY23) to allow for successful monitoring of program performance based on four basic custom indicators (number reached; number of generated leads; number of booked clients; and number of successful circumcisions conducted). PEPFAR SA and implementing partner use of these demand generation data not only allows for monitoring of program success, but also informs decisions around context-responsive demand generation plans. Moving into COP22(FY23), these data will be stratified by short-term (weekly), medium-term (monthly) and long-term (quarterly- yearly) in a user-friendly performance dashboard, in order to interrogate trends and quantify the cost-benefit for each demand generation activity.

In order to overcome COVID-19 interruptions in VMMC and related prevention efforts, the program will continue to expand engagement and collaboration with other technical program areas across the comprehensive HIV continuums. In COP22(FY23), Isibaya Samadoda (the men's kraal) which is led by His Royal Highness Prince Nhlanganiso KaZwelithini Zulu, will strengthen collaborations between DREAMS and VMMC program partners, exploring opportunities for including PrEP in VMMC and intensifying demand generation in Department of Correctional Centers. In COP22, the PEPFAR SA VMMC program will leverage the COVID-19 vaccination collaboration with the Deputy Minister of Health in order to continue support for expansion of the Department of Health "Men's Health" integrated strategy, further exploring additive public private partnership opportunities.

Program quality will continue to be strengthened in COP21(FY22) and COP22(FY23) to ensure client safety and program integrity. PEPFAR SA will strengthen training alignment between NDoH and PEPFAR SA's comprehensive VMMC program quality assurance activities. PEPFAR SA will also continue to support TMI, in order to maximize client safety; activities will include meaningful engagement with individuals who have undergone TMI to ensure that PEPFAR SA support is provided in a culturally sensitive and acceptable manner. Additionally, PEPFAR SA will continue to intensify oversight of the General Practitioner program component whilst ensuring that IPs move towards direct team hires to enable improved control and oversight. PEPFAR SA will continue to accelerate clearing of COVID-19-related backlog of circumcisions by supporting the NDoH catch-up strategies (e.g., Project 300K). In COP22(FY23), PEPFAR SA

will continue the COP21(FY22) focus of strengthening improved and standardized service and data quality initiatives across VMMC program, including the introduction and adoption of an electronic based de-duplication software and routine data quality assurance activities across all service providers.

COP22(FY23) targets have been flatlined at COP21(FY22) levels, with an overall target of 315,008. Adjusted distribution of targets across age bands in COP22(FY23) is based on COP20 (FY21) district-level performance trends: TMI districts will remain heavily weighted in 15–24yearold age bands, with a flatter distribution in non-TMI districts. Both strategies ensure high targets in 'immediate impact' age bands (ages 15–24 years) and align with data on lowest cost per HIV infection averted (Kripke, 2016). PEPFAR SA results and targets are primarily focused in the 15–24 year 'immediate impact' age bands, in addition to 35–39 year age bands as PEPFAR SA is working to support the NDoH priority of serving those who are late adopters to the VMMC program. PEPFAR SA continues to support the NDoH priority of serving those who are late adopters to the VMMC program, by allocating 30-40% of the total COP22 target in the 24–29 year and 30–34 year age bands (30% in TMI and 40% in non-TMI districts).

In COP21, the SA Human Subjects Research Council (HSRC) held a launched SABSSM VI implementation Thise survey has been powered to provide a robust estimate of VMMC coverage. SABSSM VI results will inform targets for all 27 PEPFAR SA supported districts. .

### 4.3.4 Orphans and Vulnerable Children (OVC)

During the last two years, South African children and their families have faced the double burden of COVID-19 and HIV/AIDS. The SARS-CoV-2 pandemic has profoundly impacted children living with and affected by HIV, as well as their caregivers, including the added stresses of unemployment, hunger, violence, interruptions in education, all which have led to increased vulnerability, anxiety and depression. In light of these challenges, the PEPFAR SA OVC partners have provided adapted services for children and their caregivers throughout the four waves of COVID-19 to ensure they remained in care all while continuing to reach their targets.

For COP22, the PEPFAR SA OVC Program will continue to provide service delivery for children and families across the three OVC models: OVC Comprehensive, OVC Preventive, and OVC/DREAMS Family Strengthening. The SA OVC Program will target 571,403 beneficiaries across all 27 Districts, including 68% in the OVC Comprehensive Model, 10% in the OVC Preventive Model, and 22% in the OVC DREAMS Family Strengthening Model. The majority of beneficiaries will be reached through the OVC Comprehensive Model, prioritizing the existing caseload of beneficiaries and to offer enrollment to newly identified C/ALHIV as part of the Accelerating Plan for Pediatrics and PMTCT (AP3). OVC Preventive targets were slightly reduced for COP22 to accommodate and prioritize OVC Comprehensive beneficiaries. The OVC DREAMS Family Strengthening target for USAID remains consistent with COP21 as determined by the DREAMS team.

The PEPFAR SA Community Grants Program will continue to provide an opportunity for direct funding to community-based organizations to provide person-centered community-based care and support for people living with HIV, including for orphaned and vulnerable children and their families. From the overall target mentioned above, the Community Grants Program target

contribution is 6,300 beneficiaries, comprised of 45% OVC Comprehensive and 55% OVC Preventative. The Community Grants Program will also strengthen collaboration with the OVC program at interagency level and between community-based organizations and OVC implementing partners in common implementation districts.

Peace Corps looks forward to the return of a small number of in-person volunteers in August 2022, and will be placing health volunteers with rural community-based organizations and PEPFAR SA implementing partners to implement comprehensive and preventative programming. The initial target of 1,528 OVC beneficiaries (69% comprehensive) and 1,190 Priority Prevention beneficiaries reflects the gradual return of volunteers to service in COP22. Peace Corps hopes to return to full pre-evacuation strength by COP24. Peace Corps also continues to strengthen collaboration with other PEPFAR SA implementing partners in priority districts where volunteers will be serving.

#### *4.3.4.1 OVC Comprehensive*

In COP22, the PEPFAR SA OVC Program will build on COP21 successes and continue the provision of family-centered comprehensive case management for priority sub-populations at highest risk, including, but not limiting to, HIV Exposed Infants (HEI), newly diagnosed C/ALHIV and new on treatment or failing treatment, Children of Female Sex Workers (CoFSW), children with an HIV+ caregiver, adolescent mothers living with HIV, children who have experienced sexual and gender-based violence, AGYW, as well as double orphans. The targeting approach for COP22 leveraged the OVC Target Setting Framework agreed on by the interagency, which prioritized strengthening collaboration with DSPs to enroll unsuppressed C/ALHIV by PSNU and ensure sufficient coverage in the OVC Comprehensive Model against TX_CURR <19. District prioritization remains with high-burden districts, particularly the metro areas, and included two new districts (Dr Kenneth Kaunde & Ngaka Modiri Molema) to support C/ALHIV with comprehensive case management and complement the full coverage of the SA OVC Program in all 27 PEPFAR Districts. OVC IPs will intensify multidisciplinary team efforts with DSPs and KP partners through co-location in proximity of high burden sites, to provide differentiated OVC case management services, including active referrals for HTS and FP services, treatment literacy, disclosure and adherence support and tracking of retention and viral suppression. OVC IPs will continue prioritizing collaboration with KP partners to provide children of FSWs with comprehensive OVC support and specifically documenting the success of the pilot collaboration.

OVC IPs will also scale up LIVES/VAC training for Case Workers and strengthen relationships within the multidisciplinary team to include Thuthuzela Care Centers and school-based cadres to receive active referrals for children and adolescents who have experienced sexual violence and require longer-term support. Mental Health and Psychosocial Support (MHPSS) will be prioritized in COP22 implementation, including parenting support and grief support, in light of the impacts of COVID-19 on children and their caregivers. Linkages to social grants and food support will be streamlined through private sector engagement and Civil Society Organizations for vulnerable households, especially those impacted by COVID-19. School attendance and progression will continue to be monitored, particularly for households impacted by COVID-19 caregiver death and illness or loss of income.

Furthermore, to catalyze a sustained response for comprehensive case management, the SA OVC Program will leverage its existing relationship with the Department of Social Development (DSD) focused on OVC Preventive and establish a new National Government to Government (G2G) Agreement focusing specifically on reaching children and adolescents living with HIV, as well as child survivors of sexual violence. Through a G2G agreement, DSD can support the sustainability of the OVC program beyond PEPFAR SA and our existing implementing partners.

#### *4.3.4.2 OVC Preventive*

In COP22, OVC IPs will continue to implement structured evidence-based interventions to prevent sexual violence and HIV amongst at-risk very young adolescent girls and boys aged 10-14 years through three youth facilitator-led curricula that were developed and evaluated in South Africa and complement DREAMS: Vhutshilo 1, ChommY, and Grassroot Skillz. These curricula use age-appropriate indigenous games and activities that cover topics such as decision-making, self-esteem, adolescent sexual health, HIV/AIDS, and rights/responsibilities. Since COP19, PEPFAR SA has supported the roll out and implementation of primary prevention of sexual violence and HIV activities among 10-14yearolds through the current high performing G2G with Department of Social Development in three districts. COP22 will leverage the success of this existing G2G agreement with the Department of Social Development and expand to additional districts with an intensified focus on reaching boys through enhancing the Boys and Men Championing Change Initiative.

#### *4.3.4.3 OVC DREAMS Family Strengthening*

A key priority for COP22 is to ensure that the right adolescent girls and their parents/caregivers are reached with the Family Strengthening as part of the secondary package of interventions through strengthened active linkages between the USAID primary package implementing partners, and the USAID OVC implementing partners. These strengthened active linkages are also key for accommodating girls at risk in need of comprehensive case management services. For girls that may need additional support, DREAMS IPs refer these girls to the OVC Comprehensive program for assessment and care plan development. To further strengthen active linkages with other secondary package implementing partners, DREAMS Family Strengthening facilitators incorporate and reinforce messaging around PrEP, especially continuity, family planning and the importance of condom use as key messages incorporated into Let's Talk and Parenting for Lifelong Health sessions.

#### *4.3.4.4 Children and PMTCT*

In addition to the broad national- and site-level strategies, PEPFAR SA continues to focus efforts on population-specific strategies to ensure that children/adolescents living with HIV are diagnosed, linked and retained on ART, and virally suppressed.

PEPFAR SA has been working with DSPs and OVC partners to close the gaps for case finding through strengthening index testing and the use of the pediatric and adolescent HIV risk screening tool. The implementation of the National Matrix of Interventions for C/ALHIV to achieve 90-90-90, which includes key entry point testing and index testing is also being supported by our implementing partners. PEPFAR SA will strengthen referrals from the Integrated School Health Program (ISHP) to improve access to care and treatment of school-going children.

Linking children and adolescents living with HIV to care and treatment remains a challenge. Some of the reasons include lack of disclosure, migration of clients and linkage challenges with prevention programs such as DREAMS, VMMC, and other community outreach programs that test adolescents. Strengthening community-facility linkage with the OVC, DREAMS, VMMC programs to improve access for HIV treatment, and enhancing management of KP children has been a key priority in COP21 and remains a priority for PEPFAR SA in COP22. Incorporating adolescent males into the 'MINA' campaign will also help to close the gaps as will the implementation of youth-friendly spaces or youth zones in high volume facilities. PEPFAR SA is looking to implement peer-led support models in the facilities to strengthen treatment literacy and linkage to ART.

Transitioning C/ALHIV to DTG-based regimens remains a key priority for the pediatric program in COP21-COP22 PEPFAR SA is working with NDoH and implementing partners to strengthen weight monitoring with dose adjustments and transition to child-friendly formulations.

Our implementing partners are supporting the NDoH in the enrollment of children in RPCs along with providing psychosocial support interventions, such as disclosure support to the caregivers and children through social workers, pediatric case management, and enrollment in the OVC Comprehensive program.

Achieving viral load coverage and suppression are key to improving enrollment into RPCs; partners are identifying best practices to scale up to improve both coverage and suppression. With the approval for the pediatric Dolutegravir expected by April 2022, viral suppression among the 0-9 years will likely improve dramatically.

SA is moving towards elimination of mother to child transmission; however, gaps persist especially among the teenagers and youth who present late for antenatal care in the third trimester or even at delivery. PEPFAR SA is working with NDoH to support adolescent and youth-friendly services in the antenatal clinic as well as looking at interventions such as PrEP to reduce post-natal transmission. TLD transition is also being supported and monitored by PEPFAR SA to improve viral load suppression among pregnant and breastfeeding mothers to reduce transmission. We are supporting the implementation of postnatal clubs and other peer-led case management modalities, which will improve retention and follow-up of the mother-infant pair. Plans to support the NDoH to reach HIV-positive mothers with RPCs that particularly respond to the needs of the mother-infant pair are also underway.

The absence of a longitudinal cohort monitoring tool for mother-baby pairs, which is critical to validate elimination of mother to child transmission, is a limitation, and implementation of this type of tool is under discussion with the NDoH.

*Accelerating Progress in Pediatrics and PMTCT Plan*

In line with the Accelerating Progress in Pediatrics and PMTCT (AP3), PEPFAR SA will strengthen support around the six pillars:

I. Ensure sufficient HRH at the priority facilities.
II. Adequate budget allocated to the partners to support the pediatric surge.

III. Tools in place to monitor partners progress for key indicators such as case finding, linkage, viral load coverage and suppression as well as ART optimization;

IV. PEPFAR SA is in discussions with Ritshidze to incorporate community-led monitoring for C/ALHIV.

V. The OVC program will play a key role in AP3 to support C/ALHIV at risk of treatment interruption and unsuppressed C/ALHIV through co-locating with priority facilities to enroll C/ALHIV including HEI, HIV positive adolescent mothers, and children of FSW into the Comprehensive Model for differentiated case management.,

VI. PEPFAR SA has already kickstarted surge activities through review meetings over the last year within our agencies, interagency and with NDoH to monitor the progress at partner, district, and national level.

**Figure 4.3.1 PMTCT Cascade**

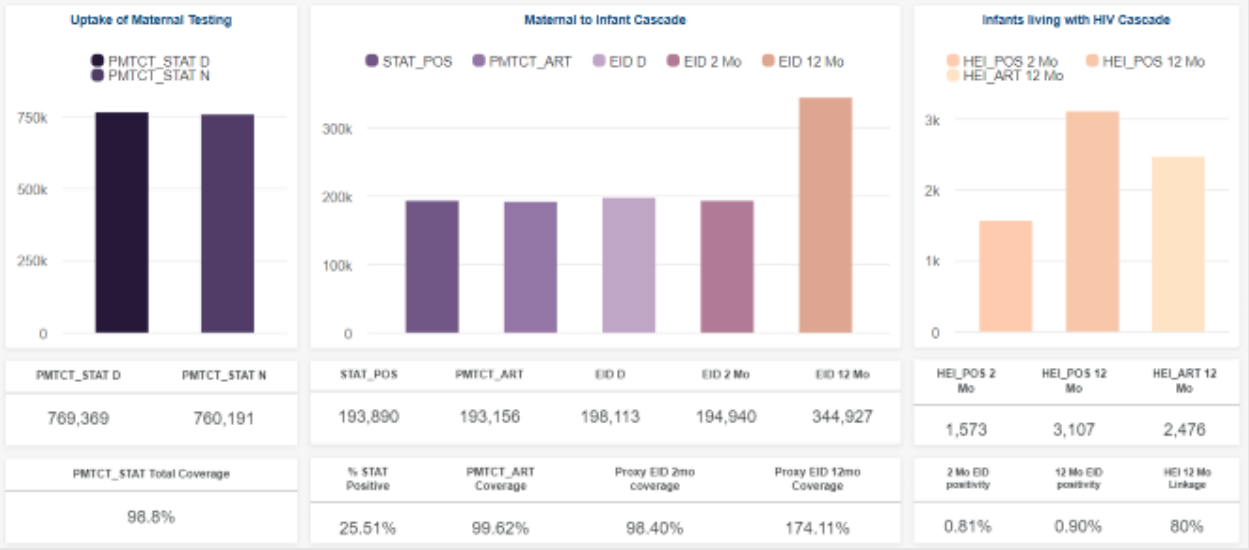
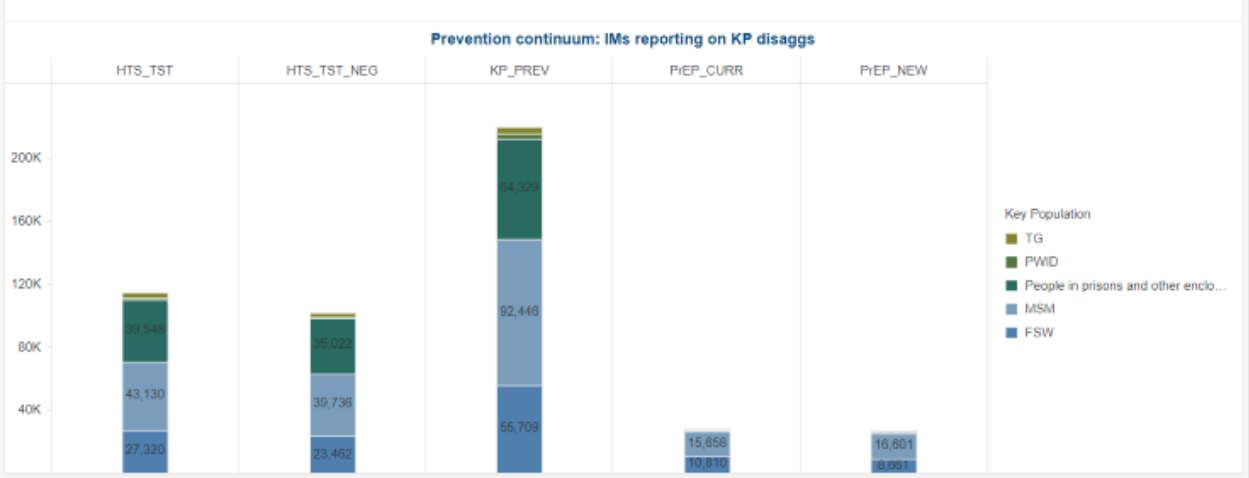
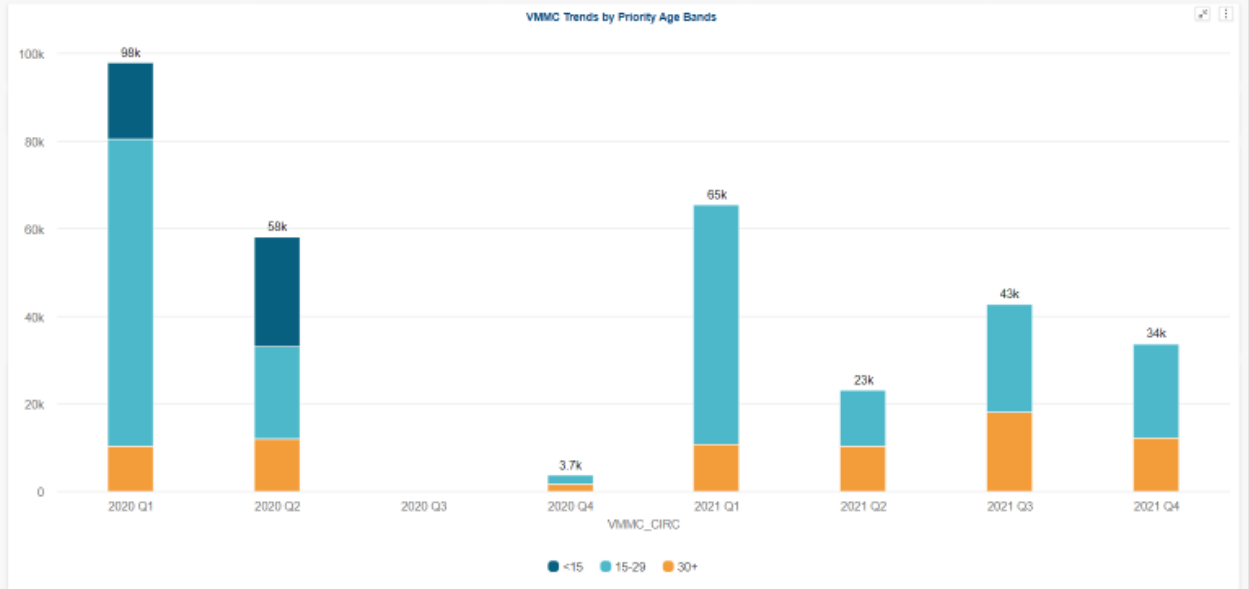



**Figure 4.3.2 Prevention Continuum by Key Population Group**



## Figure 4.3.3 VMMC Quarterly Trends by Age




## 4.4 Additional Country-Specific Priorities Listed in the Planning Level Letter

There are 4 main priorities for PEPFAR SA in COP22. All are addressed in detail elsewhere in this document.

1. Cultivate a cohesive and advantageous policy environment across treatment, prevention, and above site program areas to make progress in key minimum program requirements (MPRs) that are “in process” status. The PEPFAR SA team will collaborate with government counterparts, Civil Society, and other stakeholders to address policy barriers to improve progress in critical program areas such as more rapid transition to superior ARV regimens (e.g., TLD for adolescents and adults, especially women of childbearing potential, and transition to DTG-based regimens for children), universal multi-month dispensing (MMD), and routine viral load services for PLHIV.
2. Identify and implement innovative solutions to address the ongoing gap to achieving the second 95. To close the treatment gap, solutions will include adoption of community-led and private sector strategies that improve the patient experience of receiving care both in and out of facilities; development of community-based solutions to amplify treatment and prevention literacy, including U=U; and improved DSP HRH planning based on lesson learned from the surge. Priority attention will be given to unmet ART needs in focus districts with specific consideration to age and sex gaps.
3. Address the interruptions in VMMC and related prevention efforts due to COVID-19 by expanding engagement and collaboration with other technical program areas across the comprehensive HIV program and improve demand generation activities. PEPFAR SA will strengthen its capacity to collect and analyze VMMC program data to continually innovate and improve VMMC demand generation strategies. Through substantial engagement and collaboration with other technical program areas and IPs (HTS, CT, DREAMS, etc.), the VMMC program will increase its visibility and integration within the

comprehensive HIV program approach. PEPFAR SA has collaborated with the Human Sciences Research Council to strengthen the VMMC data collection for the next national HIV household survey, which should provide more robust VMMC coverage results that will allow for more targeted VMMC program planning and implementation beyond current convenience and best-effort target setting, mostly based on HIV burden, demand for services, prior performance, and perceived feasibility for success.

4. Close gaps across the pediatric cascade, including in case finding, linkage, retention, and viral suppression. Mitigate vulnerabilities for children living with HIV by strengthening multisectoral collaboration, development of a new comprehensive case management G2G agreement with DSD, expanding testing options for youth, and improving pediatric support and services. Comprehensive chart reviews of C/ALHIV on treatment will be conducted to ensure all virally unsuppressed CLHIV are prioritized for OVC enrollment, and monitored and supported for transition to optimal regimens.

## 4.5 Additional Program Priorities

Several recent policy changes have affected HIV-related programming and optimized treatment in South Africa. The new Central Chronic Medicines Dispensing and Distribution (CCMDD) tender for pre-packing medicines will come into effect at the beginning of FY22Q3. This will see an introduction of more 90-count packs and the optimization of 3 months multi-month dispensing (3MMD). However, provision of 3MMD is not uniform across the country as some provinces have firm or temporary suspension of 3MMD depending on provincial stock availability. While improved availability of 3MMD will help ensure continuity of CCMDD, the next step is extending the scripting policy to 12 months and scaling up 6MMD. The expiration at the end of FY21Q4 of the 12-month scripting policy (regulation 43260) that was enacted due to COVID-19 may partially hinder full CCMDD expansion. Regulation 43260, originally issued in April 2020—and renewed in November 2020 and March 2021— was enacted to reduce in-person visits to health facilities for medication retrieval during COVID-19 and temporarily changed the prescription duration of schedule 2, 3, and 4 substances from the original 6-month maximum, as specified in the Medicines and Related Substances Act, to a 12-month maximum. After the scale-up of 3MMD, extending scripting to 12 months and multi-month dispensing to 6 months will be required to support treatment continuity and utilize the work done towards supporting decentralization and increasing the number of external pick-up points.

In June 2021, the National Department of Health released updated guidance for the use of dolutegravir (DTG) in pregnancy which led to DTG being recommended as part of the preferred first line ART regimen for all adults and adolescents living with HIV, including pregnant women and women of child-bearing potential. As such, TLD transition is ongoing for adults and children ≥30kg. For children ≥4 weeks of age, pediatric DTG is expected to be approved in South Africa by the end of April 2022 and will go into tender by July 2022. Pediatric transition to DTG-based regimens is expected to take six to twelve months and will extend into FY23. However, removal of all EFV-based ART regimens will remain challenging as EFV-based regimens are still being

used for TB/HIV coinfected clients and for diabetic clients on high-dose Metformin. NVP based regimen is used to initiate CLHIV <4 weeks of age.[39]

In early 2022, the National PrEP guidelines were revised to include prioritization of at-risk pregnant and breastfeeding women and to remove previous creatinine testing requirements for all clients at initiation, at seven months, and annually. Current guidelines recommend creatinine testing for pregnant clients, at baseline for non-pregnant clients >30 years, and annually for high-risk clients. These changes will help substantially to prevent new infections and scale PrEP uptake.

In response to increasing HIV and STI acquisition and pregnancy rates among adolescents during COVID-19,[2] in December 2021, the Cabinet of South Africa approved the Department of Basic Education's Policy on the Prevention and Management of Learner Pregnancy in Schools. The goal of the policy is to reduce the incidence of learner pregnancy through the provision of Comprehensive Sexuality Education (CSE) and adolescent and youth-friendly Sexual Reproductive Health (SRH) services and to ensure pregnant learners receive a supportive environment for the continuation of learning and are not excluded from school. PEPFAR SA will provide support for CSE through a sustainable capacity building model and strengthen linkage to PEPFAR-supported complimentary SRH, PrEP, and HTS services for youth and adolescents as well as behavioral and structural programming services in DREAMS.

The Protection of Personal Information (POPI) Act, which came into effect in July 2020, continues to cause significant challenges for PEPFAR SA, local institutions, and implementing partners due to its limitations on how patient-level information can be shared and used for HIV programming. Recent changes in the oversight and vision for national-level Health Management Information Systems (HMIS) present a new opportunity to engage the NDoH on data access. PEPFAR SA has already begun dialogue with the newly established NHI Digital Health Unit, which will oversee all HMIS going forward, on ways to improve donor coordination and data access generally. We will continue these efforts throughout COP22.

PEPFAR SA will work with the GoSA to revise national policies to support community-based ART initiation in line with the 2021 updated WHO guidance. Community-based ART initiation commenced in FY21 and continues into FY22, which has positively impacted community linkage, community to facility linkage, and ART continuity.

PEPFAR SA will continue to ensure the scale-up of index testing is in accordance with the PEPFAR Guidance on Implementing Safe and Ethical Index Testing and the GoSA SOPs for HIV Index Testing. PEPFAR SA will continue to monitor the quality improvement plans of all the facilities that did not reach the minimum standards during the index testing assessments. While

[39] South African National Department of Health. 2019 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates.

[2]Peters R, Medina-Marino A, Celum C*, et al.* Impact of COVID-19 on adolescent girls and young women in a community-based HIV PrEP programme in South Africa. *Sexually Transmitted Infections* 2021;**97:**A102.

there are no benchmarks for COP22 relating to index, the following activities will still be undertaken to strengthen the program:

- Intensify supportive supervision and mentoring for all implementers to strengthen sexual partner elicitation skills and documentation of the outcomes per partner;
- Translate scripts into local language to ensure there are no communication barriers between implementers and the clients and standardize communication to avoid potentially coercive or harmful language;
- Integrate rights-related index testing services to the existing patient's rights/Batho Pele (South African political initiative to enhance the quality and accessibility of government services by improving efficiency and accountability to the recipients of public goods and services). IEC materials;
- Develop and integrate strategies to facilitate anonymous reporting of violation of rights to the existing system;
- Conduct refresher LIVES (approach to ensure staff are capacitated to deal with disclosures of violence that trains staff to L: Listen; I: Inquire; V: Validate; E: Enhance safety and S: Support victims through referrals to clinical and non-clinical services including counseling) trainings for implementers to strengthen support for victims of intimate partner violence (IPV);
- Conduct refresher contact elicitation counselling training workshops;
- Monitor adverse events by ensuring that DSPs provide actioned tailored outcomes per event; and
- Conduct KP sensitization training with all counselors involved with contact solicitation.

For ongoing monitoring of index testing, the program will develop a South Africa implementing partner-level dashboard to monitor facility assessments. PEPFAR SA will also continue monthly review of the data from DSPs and follow up on corrective actions. Details on each DSP's implemented adverse-event monitoring system will be shared with Civil Society and CLM programs. The following data will be shared at the district level with Civil Society partners and CLM programs on a quarterly basis:

- Number of clients offered index testing services disaggregated by sex and age (> 15 years and < 15 years);
- Number of clients accepting index testing services disaggregated by sex and age (> 15 years and < 15 years);
- Number of contacts solicited disaggregated by sex and and age (> 15 years and < 15 years);
- Number of contacts screened positive for IPV disaggregated by sex and age (> 15 years and < 15 years);
- Number of contacts tested through index testing disaggregated by sex and age (> 15 years and < 15 years);

PEPFAR SA will maintain the same geographical coverage in the country into COP22. Service delivery packages of care will be tailored to the specific requirements of the health districts supported as determined by progress towards attainment of the 95-95-95 targets.

Given reduced budgets after the previous HRH surge, PEPFAR SA will sustain gains made towards epidemic control through ensuring program efficiencies and effectiveness. PEPFAR SA will continue to accelerate local program ownership through sub-national government to government (G2G) agreements aimed at improving data access and use, strengthening re-engagement of persons back to care, and strengthening primary health in the country. PEPFAR SA has strengthened partner management through formation of robust partner management teams that include site activity, strategic information experts, government liaisons and cross program liaisons (prevention and HSS) for effective partner management.

PEPFAR SA will continue to support Ritshidze, a community-led monitoring (CLM) system developed by organizations representing people living with HIV, to improve the quality of HIV and TB services provided in the public health sector. Routine Ritshidze monitoring occurs on a quarterly basis at 400 clinics and community healthcare centers across 27 districts in 8 provinces in South Africa. Ritshidze CLM results are displayed in publicly-available online dashboards and in regular, province-specific "State of Health" reports and are routinely shared and communicated with PEPFAR SA, implementing partners, and Department of Health staff in order to spur key remediation and improvement activities. Ritshidze also performs large-scale quantitative and qualitative data collection among Key Populations to identify and remove barriers KP face in getting healthcare services. PEPFAR SA will work with and through DoH counterparts to address areas of poor performance identified through CLM. PEPFAR SA will encourage DoH counterparts to develop action plans and quality improvement plans to address these areas at site level and will routinely monitor progress at routine site monitoring and TA visits.

## 4.6 Commodities

While the GoSA will maintain its significant investment in the procurement of HIV-related commodities in 2022/23, the estimated budget at this time is under discussion considering the country's continued response to the COVID-19 pandemic, including the ongoing vaccination drive. Aligned with South Africa's fiscal year, year two of the GFATM's new funding cycle (2022-2025) will include USD15,126,615 for ART, USD3,163,823 for PrEP (annual estimates based on new grant funding planning figures), and USD 2,282,223 for HIV test kits (including rapid diagnostic tests and HIV Self-Screening tests). With HIV commodity needs primarily covered through host country and GFATM financing, PEPFAR SA will invest USD8,938,090 toward the procurement of VMMC commodities and additional HIV tests (including HIV Self-Screening and Recency tests).

Building on gains from 2021, South Africa will continue their first-line transition of clients from an efavirenz-based fixed-dose combination, TEE, to the dolutegravir-based combination, TLD. Data recently derived from local supply chain tracking systems suggest 75–80% of people on ART nationally are receiving TLD. Based on preliminary NDoH/PDoH revised targets, however, the HIV Program's new goal is to have 5.34 million people on treatment by the end of the South African fiscal year (i.e., March 2023) with a 90:10 split. No funding gaps for commodities have been projected for the period covered under COP22.

The NDoH's emergency 12-month scripting policy expired at the end of FY21Q4, althoughthe government has indicated a willingness to hold further discussions about renewing it or making the policy permanent, specifically for ART.

The NDoH is currently working to expand multi-month dispensing (MMD) of ART for 2MD and 3MD through the CCMDD program. The program placed more than 600,000 registered clients on 3MD (across all chronic conditions including HIV) by the end of December 2021. These efforts will continue throughout 2022, which will allow the NDoH to closely monitor treatment outcomes. In addition, 3MD will be expanded for those not decanted to CCMDD. Discussions to expand eligibility criteria to enable the inclusion of TB patients are also on-going. Finally, while the NDoH's 6MD pilot working group began in earnest in February 2021, progress stalled during FY21/22. However, during COP22 discussions, the DoH has committed to reopening the discussions and engaging other key stakeholders with the aim of pushing through with the pilot .

The coronavirus pandemic in South Africa has provided the NDoH an opportunity to explore non-traditional programmatic implementation approaches. Specifically, these unprecedented times allowed NDoH to learn more about the importance of centralized planning; explore non-standard contracting mechanisms; facilitate more robust data aggregation to enable more informed ordering recommendations to provinces; realize the benefits of increased pipeline accuracy vis-a-vis demand planning with suppliers; and demonstrate the reliance on and utility of evidence-based resolutions for supply-chain related challenges with immediate and longer-term benefits. Going forward, the NDoH will continue to build on the lessons learned during the COVID-19 period, ultimately continuing the development of a more resilient health system vis-a-vis supply chain and logistics capacity building. This strategy includes a strengthened workforce management support system, ARV/TB contract management services, and a greater focus on governance infrastructure between central and provincial DoH.

One of the characteristics of a resilient supply chain is a good balance between people, processes, and technologies. There has been an accelerated need to ensure a balance of pharmaceutical and supply chain skills, thus professionalizing the supply chain and centralizing activities to specialized teams. The COVID-19 response planning, including for vaccines, has provided a solid foundation for a joint public and private sector-led set of interventions and will help inform National Health Insurance (NHI) planning going forward.

As part of their role in support of the HIV and TB programs, the Affordable Medicines Directorate will continue their close collaboration with the South African Health Products Authority (SAHPRA), exchanging information and garnering market intelligence to better understand, and prepare for, pending product registration. These efforts are critical, as there are myriad developments vis-a-vis new market entrants, first-in-class treatment/prevention options, and overall efforts to boost ART optimization, all of which necessitate a hand-in-glove approach between regulatory processes and commodities security. Exemplifying the benefits of a more harmonized product roll-out is the recent approval by SAHPRA of the dapivirine vaginal ring for PrEP. Although inclusion into the national Essential Medicines List and review for incorporation into existing treatment guidelines are next steps, AMD is identifying a way forward to include this product in national tenders. It is likely other game-changing commodities will also follow suit (e.g., pediatric oral dolutegravir 10-mg tablets and the 3HP formulation).

## 4.7 Collaboration, Integration and Monitoring

Throughout the past several years, substantial gaps have emerged in performance related to initiation and maintenance of PLHIV onto ART. These gaps were further widened by the SARS-CoV-2 pandemic in COP19, COP20 and COP21 due to the strict nationwide lockdown periods (which resulted in significant drops in facility headcount), health facility closures, healthcare worker COVID-19 infections and deaths, and healthcare workers in quarantine in South Africa.

In COP21, the NDoH's Operation Phuthuma forum launched a revised Operation Phuthuma Handbook to guide provinces, districts, and health facilities in targeted HIV/TB quality improvement program management for attainment of 95-95-95. PEPFAR SA is supporting the roll-out of the new handbook and guidance at all levels of the health system in COP21 and continuing into COP22. This will include the rebranding of "Siyenza" to "PEPFAR Operation Phuthuma Support" (POPS) which will continue implementation of intense, site level support with key programmatic focus areas. In addition, the COVID-19 adjusted activities implemented in COP21 will continue into COP22, including 1) building off of the NDoH's SOP for all HIV/AIDS, STI and TB (HAST) Managers, 2) increasing commitments to viral load results reporting and actioning, and 3) documenting and addressing facility-based challenges through in-person and remote support. Careful monitoring of the fidelity of the implementation of these interventions will help South Africa reach the 95–95–95 targets.

Notable activities for collaboration, integration and monitoring include:

- PEPFAR SA and IPs continue to support Operation Phuthuma at all levels of government. Through Operation Phuthuma and more than 400 PEPFAR Operation Phuthuma Supported (POPS) facilities, PEPFAR SA and NDoH established a new way of doing business that includes routine 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) regularly review performance, identify and address bottlenecks, and monitor implementation of action items continuously to improve the quality of health services. These forums provide a space for DoH to "own" their programs and drive performance in alignment with the NDoH circulars that were sent in COP19. PEPFAR SA's COP22 activities will continue to bolster these forums for optimal collaboration and coordination to effectively expedite the resolution of site-level challenges.
- In COP22, PEPFAR SA will continue its focus on retention, viral load coverage, viral load suppression and more specifically, the pediatric program. PEPFAR SA has directed attention to improving IP capacities to continue PLHIV on treatment and to re-engage those who have defaulted treatment. IPs who are underperforming will be placed under Corrective Action Plans (CAPs) that are monitored closely by agency leads.
- PEPFAR SA and NDoH are committed to improving the use of unique identifiers across sites and programs in clinical settings. PEPFAR SA and NDoH will continue to monitor full implementation of the Health Patient Registration System (HPRS), a national-level system that generates unique Health Patient Registration Numbers (HPRNs) 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 the HPRS within South Africa.

- PEPFAR SA and NDoH will continue to hold high level weekly coordination meetings to evaluate program performance, identify gaps, and determine the need for additional support to the provinces, districts, and facilities. PEPFAR SA technical staff, in coordination with the NDoH, will support the development of any technical material, as needed.
- PEPFAR SA will consolidate and analyze timely facility data and quality improvement work to identify interventions that successfully lead to improved program performance. Results will be presented in "best practices" packages, which will be scaled up in the remaining Operation Phuthuma facilities to accelerate performance improvement. Understanding resilience and best practices during the SARS-CoV-2 pandemic is important as these strategies will strengthen health systems and better prepare facilities for this and future pandemics.
- PEPFAR SA has contributed to the country's SARS_CoV-2 response by increasing its support for PPE procurement and distribution between national and provincial levels; hosting the Knowledge Hub through which all pandemic-related health care worker training has been facilitated; and through monitoring of data and establishment of quality improvement plans at the national and provincial level—frequently using data systems supported by PEPFAR SA. Support for this work will continue, albeit with shifting emphasis to increased local leadership and financing.
- IPEPFAR SA plays a key role in donor coordination meetings on country health priorities, new initiatives, and progress in policy implementation as well as resource allocation. This work will continue in COP22.
- Over time, PEPFAR SA's program has been strengthened by increased collaboration with GFATM and Civil Society. This collaboration has improved program planning, resulting in a more robust and comprehensive HIV response. This collaboration will further increase in COP22, as PEPFAR SA will continue to benefit from community-led monitoring through the PLHIV sector's Ritshidze, which will continue to monitor HIV services at PEPFAR-supported sites within the 27 priority districts. PEPFAR SA and Civil Society 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).

## 4.8 Targets by Population

The targets for the following four tables have been generated using data from the COP22 approval memos:

### Standard Table 4.8.1 ART Targets by Prioritization for Epidemic Control

| Table 4.8.1 ART Targets by Prioritization for Epidemic Control | | | | | | |
|---|---|---|---|---|---|---|
| **Prioritization Area** | **Total PLHIV** | **Expected current on ART (APR FY22)** | **Additional patients required for 80% ART coverage** | **Target current on ART (APR FY23) *TX_CURR*** | **Newly initiated (APR FY23) *TX_NEW*** | **ART Coverage (APR 23)** |
| Attained | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| Scale-Up Saturation | **2,280,918** | **1,824,146** | **588** | **1,789,506** | **254,190** | **78%** |
| Scale-Up Aggressive | **3,884,205** | **3,180,438** | **0** | **3,214,747** | **433,684** | **83%** |
| Sustained | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| Central Support | **1,696,196** | **2,333** | **N/A** | **4,503** | **1,296** | **N/A** |
| Commodities (if not included in previous categories) | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| **Total** | **7,861,319** | **5,006,917** | **N/A** | **5,008,756** | **689,170** | **81%** |

*[1] Eaton, J & Johnson, L. Unpublished Document – NAOMI 2022 District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)*
*[2] Additional patients required for 80% ART coverage calculated in Scale-Up Saturation and Scale-Up Agressive only. Value is "0" where coverage >80%.(Total PLHIV *.8)- Expected current ON ART (FY22)*
*[3] ART coverage reported among Scale-Up Saturation and Scale-Up Aggressive districts only*

## Standard Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

| Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts | | | | | |
|---|---|---|---|---|---|
| **District** | **Target Populations** | **Population Size Estimate** | **Current Coverage*** | ***VMMC_CIRC Target*** | ***VMMC_CIRC Target*** |
| | | **(FY2022)** | **(FY2022 expected)** | **(in FY2022)** | **(in FY2023)** |
| ec Alfred Nzo District Municipality | 15-34 year olds | 115,183 | 44.0% | 13,077 | 13,075 |
| ec Amathole District Municipality | 15-34 year olds | 119,623 | 17.0% | 17,080 | 17,080 |
| ec Buffalo City Metropolitan Municipality | 15-34 year olds | 111,694 | 22.0% | 30,000 | 29,999 |
| ec Chris Hani District Municipality | 15-34 year olds | 105,219 | 9.0% | 10,289 | 10,289 |
| ec Oliver Tambo District Municipality | 15-34 year olds | 265,962 | 19.0% | 8,743 | 8,744 |
| fs Lejweleputswa District Municipality | 15-34 year olds | 105,970 | 33.0% | 2,462 | 2,460 |
| fs Thabo Mofutsanyane District Municipality | 15-34 year olds | 124,620 | 26.0% | 3,922 | 3,922 |
| gp City of Johannesburg Metropolitan Municipality | 15-34 year olds | 1,041,268 | 50.0% | 15,357 | 15,356 |
| gp City of Tshwane Metropolitan Municipality | 15-34 year olds | 665,885 | 47.0% | 16,117 | 16,116 |
| gp Ekurhuleni Metropolitan Municipality | 15-34 year olds | 730,681 | 35.0% | 5,894 | 5,894 |
| gp Sedibeng District Municipality | 15-34 year olds | 168,823 | 53.0% | 3,738 | 3,738 |
| kz eThekwini Metropolitan Municipality | 15-34 year olds | 710,344 | 28.0% | 56,455 | 56,455 |
| kz Harry Gwala District Municipality | 15-34 year olds | 82,733 | 34.0% | 5,603 | 5,606 |
| kz King Cetshwayo District Municipality | 15-34 year olds | 159,565 | 31.0% | 9,571 | 9,570 |
| kz Ugu District Municipality | 15-34 year olds | 147,568 | 22.0% | 9,597 | 9,596 |
| kz uMgungundlovu District Municipality | 15-34 year olds | 197,171 | 25.0% | 8,658 | 8,659 |
| kz Uthukela District Municipality | 15-34 year olds | 118,336 | 24.0% | 6,136 | 6,136 |
| kz Zululand District Municipality | 15-34 year olds | 140,997 | 22.0% | 7,293 | 7,293 |
| lp Capricorn District Municipality | 15-34 year olds | 191,749 | 19.0% | 3,923 | 3,923 |
| lp Mopani District Municipality | 15-34 year olds | 178,070 | 7.0% | 5,386 | 5,386 |
| mp Ehlanzeni District Municipality | 15-34 year olds | 301,759 | 24.0% | 7,270 | 7,270 |
| mp Gert Sibande District Municipality | 15-34 year olds | 232,600 | 29.0% | 8,623 | 8,624 |
| mp Nkangala District Municipality | 15-34 year olds | 309,397 | 15.0% | 20,620 | 20,621 |

| Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts | | | | | |
|---|---|---|---|---|---|
| **District** | **Target Populations** | **Population Size Estimate** | **Current Coverage*** | ***VMMC_CIRC Target*** | ***VMMC_CIRC Target*** |
| | | **(FY2022)** | **(FY2022 expected)** | **(in FY2022)** | **(in FY2023)** |
| nw Bojanala Platinum District Municipality | 15-34 year olds | 357,374 | 33.0% | 10,284 | 10,285 |
| nw Dr Kenneth Kaunda District Municipality | 15-34 year olds | 136,181 | 31.0% | 3,166 | 3,165 |
| nw Ngaka Modiri Molema District Municipality | 15-34 year olds | 155,509 | 21.0% | 13,249 | 13,249 |
| wc City of Cape Town Metropolitan Municipality | 15-34 year olds | 758,055 | 24.0% | 11,186 | 11,186 |
| Centrally Supported Districts | 15-34 year olds | 903,652 | 19.4% | 1,309 | 1,308 |
| **TOTAL** | **15-34 year olds** | **8,635,988** | **30.0%** | **315,008** | **315,005** |
| VMMC coverage rates are calculated by dividing TOTAL Circumcisions in the host country by the Estimated Population Size. Sources for Total Circumcisions include MER Reporting, Data from National Department of Health, and Model Outputs from Imperial College London. | | | | | |
| SOURCE: VMMC coverage modelling estimates, DHIS and DATIM | | | | | |
| VMMC targets in centrally supported districts represent Department of Correctional Services programming in 9 centrally supported districts (fs Felize Dabi District Municipality, fs Mangaung Metropolitan Municipality, fs Xhariep District Municipality, ks Amajuba District Municipality, kz Umzinyathi District Municipality, lp Vhembe District Municipality, lp Waterberg District Municipality, wc Overberg District Municipality, and wc West Coast District Municipality).<br><br>VMMC population size estimates and coverage rates in the 9 centrally supported districts are displayed for the total male population, not just inmates. | | | | | |

## Standard Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

| Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control | | | | |
|---|---|---|---|---|
| **Target Populations** | **Districts** | **Population Size Estimate* (SNUs)** | **Disease Burden*** | **FY23 Target** |
| AGYW [10-24 yrs] (AGYW_PREV) | ec Alfred Nzo District Municipality | 37,198 | 6% | 16,941 |
| | ec Amathole District Municipality | | | |
| | ec Buffalo City Metropolitan Municipality | 24,327 | 9% | 11,560 |
| | ec Chris Hani District Municipality | | | |
| | ec Oliver Tambo District Municipality | 62,920 | 9% | 18,158 |
| | fs Lejweleputswa District Municipality | 22,639 | 7% | 9,589 |
| | fs Thabo Mofutsanyane District Municipality | 29,387 | 8% | 12,640 |
| | gp City of Johannesburg Metropolitan Municipality | 185,984 | 5% | 109,305 |
| | gp City of Tshwane Metropolitan Municipality | 108,699 | 5% | 14,693 |
| | gp Ekurhuleni Metropolitan Municipality | 103,919 | 6% | 13,844 |
| | gp Sedibeng District Municipality | 29,194 | 6% | 13,700 |
| | kz eThekwini Metropolitan Municipality | 112,665 | 7% | 30,635 |
| | kz King Cetshwayo District Municipality | 37,845 | 11% | 16,740 |
| | kz Ugu District Municipality | 30,204 | 10% | 13,070 |
| | kz uMgungundlovu District Municipality | 37,361 | 10% | 11,214 |
| | kz Uthukela District Municipality | 28,531 | 10% | 7,690 |
| | kz Zululand District Municipality | 36,491 | 10% | 9,232 |
| | lp Capricorn District Municipality | 49,527 | 5% | 21,990 |
| | lp Mopani District Municipality | 45,713 | 6% | 19,620 |
| | mp Ehlanzeni District Municipality | 73,430 | 9% | 30,744 |
| | mp Gert Sibande District Municipality | 48,314 | 10% | 18,819 |
| | mp Nkangala District Municipality | 61,068 | 6% | 24,550 |
| | nw Bojanala Platinum District Municipality | 57,505 | 7% | 7,163 |
| | nw Dr Kenneth Kaunda District Municipality | 27,690 | 7% | 3,535 |
| | nw Ngaka Modiri Molema District Municipality | 33,602 | 6% | 4,524 |
| | wc City of Cape Town Metropolitan Municipality | 160,718 | 4% | 64,629 |
| AGYW [10-24 yrs] (AGYW_PREV) - subtotal* | | 1,444,931 | | 504,585 |
| | ec Oliver Tambo District Municipality | 4,455 | 53% | 3,564 |
| | gp City of Johannesburg Metropolitan Municipality | 7,839 | 58% | 6,272 |
| | gp City of Tshwane Metropolitan Municipality | 5,152 | 52% | 4,120 |
| | gp Ekurhuleni Metropolitan Municipality | 5,478 | 52% | 4,380 |
| | kz eThekwini Metropolitan Municipality | 9,314 | 78% | 7,452 |
| | kz uMgungundlovu District Municipality | 2,948 | 53% | 2,360 |
| | lp Vhembe District Municipality | 4,059 | 53% | 3,248 |
| | mp Ehlanzeni District Municipality | 4,866 | 53% | 3,892 |
| | mp Gert Sibande District Municipality | 3,255 | 53% | 2,604 |

| Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control | | | | |
|---|---|---|---|---|
| Target Populations | Districts | Population Size Estimate* (SNUs) | Disease Burden* | FY23 Target |
| | mp Nkangala District Municipality | 3,880 | 53% | 3,104 |
| | nw Dr Kenneth Kaunda District Municipality | 2,164 | 53% | 1,732 |
| | nw Ngaka Modiri Molema District Municipality | 2,697 | 53% | 2,160 |
| | wc City of Cape Town Metropolitan Municipality | 6,589 | 43% | 5,272 |
| | wc West Coast District Municipality | | | 452 |
| FSW (KP_PREV) - subtotal* | | 62,696 | | 50,612 |
| MSM (KP_PREV) | ec Buffalo City Metropolitan Municipality | 4,604 | 30% | 2,300 |
| | ec Nelson Mandela Bay Municipality | 7,435 | 30% | 3,720 |
| | gp City of Johannesburg Metropolitan Municipality | 40,199 | 44% | 20,100 |
| | gp City of Tshwane Metropolitan Municipality | 21,221 | 30% | 10,613 |
| | gp Ekurhuleni Metropolitan Municipality | 27,493 | 30% | 13,747 |
| | kz eThekwini Metropolitan Municipality | 25,633 | 30% | 12,816 |
| | kz uMgungundlovu District Municipality | 5,414 | 30% | 2,707 |
| | mp Ehlanzeni District Municipality | 7,772 | 30% | 3,887 |
| | wc City of Cape Town Metropolitan Municipality | 28,734 | 27% | 14,367 |
| | wc West Coast District Municipality | | | 316 |
| MSM (KP_PREV) - subtotal* | | 168,505 | | 84,573 |
| TGW (KP_PREV)** | ec Buffalo City Metropolitan Municipality | 830 | 46% | 333 |
| | ec Nelson Mandela Bay Municipality | 1,260 | 46% | 505 |
| | gp City of Johannesburg Metropolitan Municipality | 3,892 | 63% | 1,560 |
| | wc City of Cape Town Metropolitan Municipality | 2,413 | 46% | 967 |
| | wc West Coast District Municipality | | | 156 |
| TGW (KP_PREV) - subtotal* | | 8,395 | | 3,521 |
| People Who Inject Drugs (KP_PREV)*** | gp City of Tshwane Metropolitan Municipality | 9,028 | 58% | 2,707 |
| | mp Ehlanzeni District Municipality | 2,790 | 53% | 840 |
| | wc West Coast District Municipality | | | 208 |
| People Who Inject Drugs (KP_PREV) - subtotal* | | 11,818 | | 3,755 |
| Inmates (KP_PREV) | ec Amathole District Municipality | 1,104 | 12% | 880 |
| | ec Buffalo City Metropolitan Municipality | 3,712 | 12% | 2,970 |
| | ec Nelson Mandela Bay Municipality | 2,855 | 12% | 2,284 |
| | ec Oliver Tambo District Municipality | 4,197 | 12% | 3,360 |
| | ec Sarah Baartman District Municipality | 1,651 | 12% | 1,320 |
| | fs Fezile Dabi District Municipality | 3,234 | 12% | 2,586 |
| | fs Lejweleputswa District Municipality | 2,014 | 12% | 1,614 |
| | fs Mangaung Metropolitan Municipality | 682 | 12% | 546 |

| Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control | | | | |
|---|---|---|---|---|
| **Target Populations** | **Districts** | **Population Size Estimate* (SNUs)** | **Disease Burden*** | **FY23 Target** |
| | gp City of Johannesburg Metropolitan Municipality | 10,658 | 12% | 8,526 |
| | gp City of Tshwane Metropolitan Municipality | 10,390 | 12% | 8,314 |
| | gp Ekurhuleni Metropolitan Municipality | 8,074 | 12% | 6,460 |
| | gp Sedibeng District Municipality | 700 | 12% | 560 |
| | kz Amajuba District Municipality | 2,500 | 12% | 2,000 |
| | kz eThekwini Metropolitan Municipality | 2,500 | 12% | 2,000 |
| | kz Harry Gwala District Municipality | 566 | 12% | 454 |
| | kz King Cetshwayo District Municipality | 2,612 | 12% | 2,090 |
| | kz uMgungundlovu District Municipality | 1,151 | 12% | 920 |
| | kz Zululand District Municipality | 657 | 12% | 526 |
| | lp Capricorn District Municipality | 1,308 | 12% | 1,046 |
| | lp Vhembe District Municipality | 1,076 | 12% | 860 |
| | mp Ehlanzeni District Municipality | 1,314 | 12% | 1,054 |
| | mp Gert Sibande District Municipality | 540 | 12% | 434 |
| | nc Frances Baard District Municipality | 3,810 | 12% | 3,046 |
| | nw Bojanala Platinum District Municipality | 820 | 12% | 656 |
| | nw Dr Kenneth Kaunda District Municipality | 1,568 | 12% | 1,254 |
| | nw Ngaka Modiri Molema District Municipality | 1,783 | 12% | 1,426 |
| | wc Cape Winelands District Municipality | 750 | 12% | 600 |
| | wc City of Cape Town Metropolitan Municipality | 855 | 12% | 684 |
| | wc Garden Route District Municipality | 554 | 12% | 440 |
| | wc Overberg District Municipality | 1,206 | 12% | 964 |
| | wc West Coast District Municipality | 1,221 | 12% | 980 |
| **Inmates (KP_PREV) - subtotal*** | | **76,062** | | **60,854** |
| **TOTAL*** | | **5,302,087** | | **709,423** |
| **Key Populations data has been taken from the UCSF, Key Populations Cascasde Project 2016.* | | | | |
| *Source: Naomi estimates, Datapack* | | | | |
| *wc West Coast District targets for AGYW_PREV and KP_PREV Targets for FSW, MSM, TGW, and PWID are placeholder targets for the Community Grants Program. KP_PREV Targets for Inmates in wc West Coast District represent the Department of Correctional Services targets.* | | | | |

## Standard Table 4.8.4 Targets for OVC and Linkages to HIV Services

| Table 4.8.4 Targets for OVC and Linkages to HIV Services | | | | | |
|---|---|---|---|---|---|
| District | Estimated # of Orphans and Vulnerable Children | Target # of active OVC (FY23 Target)<br>OVC_SERV Comprehensive | Target # of OVC (FY23 Target)<br>OVC_SERV Preventative | Target # of active OVC (FY23 Target)<br>OVC_SERV DREAMS/Family Strengthening | Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target)<br>OVC* |
| ec Alfred Nzo District Municipality | 78,899 | 5,922 | 2,360 | 6,504 | 6,916 |
| ec Amathole District Municipality | 63,153 | 6,118 | 2,318 | | 6,443 |
| ec Buffalo City Metropolitan Municipality | 48,839 | 7,067 | 2,360 | 4,466 | 7,556 |
| ec Chris Hani District Municipality | 57,441 | 5,804 | 2,317 | | 6,125 |
| ec Oliver Tambo District Municipality | 141,099 | 13,126 | 2,318 | | 13,880 |
| fs Lejweleputswa District Municipality | 58,656 | 2,616 | 2,360 | 3,831 | 3,028 |
| fs Thabo Mofutsanyane District Municipality | 80,599 | 5,753 | 2,360 | 5,045 | 6,396 |
| gp City of Johannesburg Metropolitan Municipality | 254,127 | 37,490 | 2,360 | 52,892 | 41,588 |
| gp City of Tshwane Metropolitan Municipality | 167,106 | 13,386 | 2,318 | | 14,085 |
| gp Ekurhuleni Metropolitan Municipality | 183,091 | 13,736 | 2,317 | | 14,518 |
| gp Sedibeng District Municipality | 42,291 | 7,912 | 2,360 | 4,929 | 8,978 |
| kz eThekwini Metropolitan Municipality | 245,135 | 31,454 | 2,318 | | 33,020 |
| kz Harry Gwala District Municipality | 46,137 | 5,780 | 2,360 | | 6,245 |
| kz King Cetshwayo District Municipality | 80,601 | 6,141 | 2,360 | 6,395 | 7,028 |
| kz Ugu District Municipality | 66,929 | 4,894 | 2,360 | 4,740 | 5,578 |
| kz uMgungundlovu District Municipality | 83,333 | 8,649 | 2,318 | | 9,176 |
| kz Uthukela District Municipality | 62,093 | 7,161 | 2,318 | | 7,573 |
| kz Zululand District Municipality | 80,729 | 8,376 | 2,318 | | 8,899 |
| lp Capricorn District Municipality | 77,346 | 8,550 | 2,360 | 9,422 | 9,888 |
| lp Mopani District Municipality | 70,201 | 8,527 | 2,360 | 8,025 | 9,713 |
| mp Ehlanzeni District Municipality | 123,727 | 19,102 | 2,360 | 11,126 | 20,725 |

| Table 4.8.4 Targets for OVC and Linkages to HIV Services | | | | | |
|---|---|---|---|---|---|
| District | Estimated # of Orphans and Vulnerable Children | Target # of active OVC (FY23 Target)<br><br>OVC_SERV Comprehensive | Target # of OVC (FY23 Target)<br><br>OVC_SERV Preventative | Target # of active OVC (FY23 Target)<br><br>OVC_SERV DREAMS/Family Strengthening | Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target)<br><br>OVC* |
| mp Gert Sibande District Municipality | 76,412 | 11,434 | 2,360 | 7,018 | 12,499 |
| mp Nkangala District Municipality | 91,934 | 12,237 | 2,835 | 8,703 | 13,141 |
| nw Bojanala Platinum District Municipality | 104,768 | 11,449 | 2,317 | | 12,214 |
| nw Kenneth Kanuda District Municipality | 46,481 | 3,538 | 2,317 | | 3,765 |
| nw Ngaka Modiri District Municipality | 58,258 | 4,319 | 2,318 | | 4,607 |
| wc City of Cape Town Metropolitan Municipality | 122,674 | 18,487 | 2,360 | 7,271 | 20,910 |
| wc West Coast District Municipality* | N/A | 2,833 | 3,467 | | 2,486 |
| **TOTAL** | **2,612,058** | **291,861** | **67,154** | **140,367** | **316,980** |

Footnotes: Population size estimates for OVC represents the provincial-level orphanhood estimates (SADHS, 2016)*population size. Data displayed for Priority districts only.
*West Coast District is used to house Community Grants targets temporarily as grants selection is not completed at time of COP planning and will be moved to the selected districts during the first Operational Plan Update (OPU) cycle.

## 4.9 Cervical Cancer Program Plans

PEPFAR SA does not implement cervical cancer activities.

## 4.10 Viral Load and Early Infant Diagnosis Optimization

The revised FY20 PMTCT guidelines have included additional VL testing for pregnant women at birth and at 6 months post-delivery to strengthen VL monitoring of pregnant and breast-feeding women. NHLS is monitoring the use of eGK (electronic gate keeping) code usage nationally. These codes are used to allow for repeat VL testing for pregnant and post-partum women and prevent rejection of specimens. The PEPFAR partners have supported the implementation of the eGK codes although gaps still exist at in the Facility-Laboratory interface. The national PMTCT team together with PEPFAR SA partners have embarked on a rapid assessment of the eGK codes implementation to identify key bottlenecks. Since there were no provisions made for reporting VL that were missed during delivery but performed early in the postnatal period, this finding led to the NDoH PMTCT team changing the birth VL indicator to include all VL done within 6 weeks post-delivery.

In addition, PEPFAR SA has funded the eLABS system that is being used to improve turnaround times, reduce specimen rejection rates, and improve results usage to manage patients for VL and EID. This has been rolled out to 2,082 facilities in 24 of the 27 PEPFAR SA supported districts. PEPFAR SA has been working with the DoH at the provincial and district levels to improve the utilization of the system to improve VL management.

PEPFAR SA is working with their implementing partners to strengthen HIV testing and treatment literacy among pregnant mothers during the antenatal clinic to improve retention and postnatal follow-up of the mother-infant pair. Proactive referrals to desired sites for the mother-infant pair will be made. Discussions are ongoing with NDoH for high-risk facilities (with poor linkage to ART for infants) to have access to POC infant PCR testing.

The Paediatric Workstream at NDoH, with the support of CHAI and PEPFAR SA implementing partners, is rolling out a matrix of interventions nationally to support the pediatric cascade; these interventions include the use of NHLS Results for Action (RfA) datasheets which provide a facility line list used to identify missed diagnostic opportunities for infants and children with unsuppressed viral loads, as well as rejected specimens, where there has been no action taken. These lists are used by DoH and partner staff to improve management of PLHIV.

Although the SARS-CoV-2 pandemic has had a significant impact on clinic attendance, there have been some innovations introduced including providing access to community VL testing and immunization catch-up campaigns which have helped to identify exposed infants who missed their PCR tests. These new activities are being used to improve access to and quality of care.

# 5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Functional systems are the foundation for successful implementation of HIV prevention and treatment services. PEPFAR SA's above site investments are designed to address the critical systems-level barriers that slow progress towards achieving HIV epidemic control in South Africa, while contributing to sustainability and resilience. For COP22, systems-level barriers have been identified through a range of strategic processes, including the progress review for the National Strategic Plan for HIV, TB and STIs, review of PEPFAR MER data, intensive site improvement and monitoring (including Siyenza/Phuthuma, and CLM), Civil Society engagement, and analysis of the SID scores. As noted above in section 2.4, seven SID elements received scores lower than 7/10 in late 2021: Civil Society engagement; Service Delivery; Human Resources for Health; Quality Management; Laboratory; Epidemiological and Health Data; and Data for decision-making ecosystem.

Systems-level barriers to epidemic control are supported in numerous ways across PEPFAR SA's entire program or work. PEPFAR SA's planned above site portfolio (ASP) investments for COP22 are aligned with the low-scoring SID elements as well as additional areas made vulnerable by the SARS-CoV-2 pandemic—such as health financing, supply chain systems, and commodity security. Budgets for the ASP have declined or remained flat in recent years, constraining the work and demanding trade-offs. However, our COP22 above site investments remain aligned with the priorities and plans of the GoSA and other development partners, particularly, the GFATM. These priorities include facilitating the necessary adaptation and institutionalization of existing systems while leveraging and optimizing investments, improving donor-government coordination, and ensuring continued return on these investments as the country transitions to National Health Insurance (NHI).

The tables below provide further detail on prioritized systems-level barriers and the ASP response in COP22. The structure is aligned to the SID domains, elements, and health system barriers that are now included in Table 6. In summary, the ASP activities address the following priority areas:

- Improving service delivery through socio-behavioral change communication;
- Collaborative planning for optimized, equitable distribution of Human Resources for Health;
- Supporting the vital supply chain and commodity security systems necessary to ensure the high levels of coverage and retention needed for epidemic control;
- Improved laboratory service quality to support consistent and correct use of laboratory data for patient management;
- Continued leveraging of local resources and technical and allocative efficiency in their expenditure;
- Moving the country toward real time data use and evidence-informed decision making through improved information systems; and
- Furthering our understanding of the context in which we work and best practices through surveys, research, and evaluation.

All of these efforts will need to be evaluated in the context of the monumental shifts taking place in the health system as new structures and processes are built to manage the SARS-CoV-2

pandemic and prepare for NHI. Leadership capacity development and mentorship will also remain critical for effective governance across system components and improved health outcomes. Clearly defined benchmarks for progress have been established and documented for each of the funded activities (summarized below). 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. Further detail on ASP activities can be found in the attached Table 6 and Appendix E; additional information on systems-level interventions not undertaken by the ASP can be found elsewhere in this document.

## 5.1 SID Domain: Governance, Leadership, and Accountability

SID elements: Planning and coordination, Policies and governance, Civil Society engagement, Private sector engagement, Public access to information

The elements included in this SID domain are addressed throughout PEPFAR SA's programming. ASP activities will include the activities listed below, all of which are aligned to the GoSA's plans and priorities.

| Summary of COP22 Above Site Investments (Governance, Leadership, and Accountability) | Expected Outcome |
|---|---|
| ● Support for changes to key policies, such as extending maximum scripting to 12-months and enabling 6MMD.<br>● Support for strategic planning, coordination, policy development and implementation in South Africa aligned to NHI.<br>● Participation in development of the National Strategic Plan for HIV, TB, and STIs.<br>● Contributing to sustainable capacity within GoSA to manage and oversee implementation of the HIV/AIDS response.<br>● Support for quarterly and annual program planning and target-setting at NDOH and SANAC.<br>● Advocacy and support for the use of HIV information systems for monitoring the response and progress toward targets.<br>● Engagement with the private sector to ensure innovation for service delivery, and in particular, supply chain and commodity access goals. | Progress toward removal of policy barriers; more responsive, adaptive governance; improved efficiencies with regard to business processes and information use; and innovative solutions to persistent challenges. |

## 5.2 SID Domain National Health System and Service Delivery

SID elements: Service delivery, Human Resources for Health, Commodity security and supply chain, Quality management, Laboratory

Addressing this SID domain, the ASP will focus on the following in COP22:

1. Expanding on our already successful strategic marketing work, by working collaboratively with National and Provincial Departments of Health to expand treatment literacy and other socio-behavioral change communication campaigns;

2. Ensuring efficient, optimized allocation of HRH—including new initiatives to create collaborative donor-government processes for allocation;
3. Supporting the fundamental systems and processes necessary to ensure availability of affordable HIV and TB commodities and the capacity and flexibility to pivot to new commodities, such as the dapivirine ring, when available; and
4. Building on past successes to further improve laboratory service quality and innovations for supporting viral load completion;

*Strategic Marketing.* Prior to COP20, the NDoH did not implement a strategic marketing program that will promote health seeking behavior, retention in care and raise awareness and knowledge on HIV/AIDS while achieving efficiency and ensuring returns on PEPFAR SA investments. In response, PEPFAR SA took best practices garnered in the private sector in terms of marketing strategies for brand recognition, uptake, retention, etc. and began implementing these with the intent of positively influencing HIV program outcomes across the clinical cascade. In addition, has provided technical assistance to the NDoH to improve and sustain private sector engagement and continued support of national media communication efforts aimed at community sensitization and education.

In COP22, PEPFAR SA's ASP will continue support for the NDoH to scale up evidence-based, differentiated models of care to expand the uptake and retention of patients in care across the clinical cascade to achieve VL suppression through the activities outlined below.

| **Summary of COP22 Above Site Investments (National Health System and Service Delivery)**<br><br>Element: Service delivery (through Strategic Marketing) and Private sector engagement | **Expected Outcome** |
|---|---|
| **Case findings and Linkage to Care**<br><br>• Expand the MINA, men's health brand (from lessons learned) to all facilities (including non-Siyenza) noting rapid uptake in Siyenza facilities and strong endorsement of the brand in different communities and across level of health care.<br><br>**Retention**<br><br>• Provide TA to roll-out patient treatment literacy for targeted populations (AGYW, KP)<br>• Scale-up of 3MD for first line ARVs through differentiated care modalities, including external pick-up-points (ePUPs) through strategic demand generation using marketing approaches | A better integrated and coordinated private-public health partnership.<br><br>Improved population uptake and coverage of HIV services to reduce clinical cascade gaps.<br><br>• U=U campaign scaled to 8 more provinces and 27 priority districts<br>• Proxy linkage >90% in U=U campaign districts<br>• Decline of LTFU rates to <10% in U=U campaign districts<br><br>Service provider tenders (including CMMDD) supported for smooth transition if needed.<br><br>All feasible, innovative external pick-up point models transitioned to domestic resources. |

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| • Expand the number of ePUPs particularly in rural and informal settlements in collaboration with the private sector though PPPs<br>• Advocate for domestic funding and oversight (including assessment) of ePUPs by district health department PPPs<br>• Provide technical assistance to DSPs to support facility-based institutionalization of the CCMDD with continued promotion of the (Daplapmed) brand and services collaborating with the private sector<br>• Enhance CCMDD operations and coordination at provincial level working with provincial pharmacy leads to fast-track approvals of ePUPs, liaise with PEPFAR and Global Fund implementing partners (IPs) on CCMDD issues, foster coordinated activities between donors and stakeholders.<br><br>**Viral suppression**<br><br>• The completion of the pilot in one of the provinces (Eastern Cape) will be used as a benchmark and lessons learned will inform national expansion of The New Status campaign which is a new messaging approach to promote U=U.* | |

*This initiative is jointly coordinated and supported by the C&T and HSS TWGs in response to the need raised by the Deputy President, on World AIDS Day to VLS. The design and implementation are directed by TWG consisting of PEPAFR SA, NDoH, SANAC, Civil Society, private sector brand marketing experts, and other donors.

*HRH.* In March 2020, the NDoH published the 2030 Human Resources for Health Strategy for South Africa which focuses on increasing investments in the health workforce to improve health service quality, equity, and access on the path towards universal health coverage. This strategy illustrates how efficient allocation, capacity building, sustainable HRH planning post surge/PEPFAR, and improved performance of HRH are critical to reach 95-95-95 HIV and TB goals. However, the strategy lacks a monitoring and evaluation plan and an implementation plan, and given the additional fiscal constraints within the GoSA, operationalizing the plan will be very difficult. In COP22, PEPFAR SA's ASP will work to address these challenges through the activities outlined below.

| **Summary of COP22 Above Site Investments (National Health System and Service Delivery)**<br><br>*Element: Human Resources for Health* | **Expected Outcomes** |
|---|---|
| ● Establishing a joint-task force on HRH with NDoH to enable discussion, planning and problem solving to support implementation of the Human Resources for Health 2030 strategy.<br>● Developing a clear HRH roadmap and M&E plan that addresses HRH needs at all levels.<br>● Supporting optimal utilization and maintenance of current HRH information systems, including the Human Resources Information System (HRIS) and the Human Resources Information Database (HRID) (which tracks PEPFAR SA-supported staffing) to facilitate HRH analytics, planning, and deployment.<br>● Facilitating the interoperability of the HRIS with other workforce registries and financial systems to support evidence-informed planning and shifts towards NHI.<br>● Advocating for the uptake of specific job functions unique to PEPFAR SA-supported cadres within GoSA-supported staffing. critical to the care and treatment cascade including sharing job descriptions and costing data with NDoH .<br>● Second staff to the NDoH to provide essential HR support for condom and Key Populations programming as well as provincial and district level coordination and capacity building. | Collaborative approaches, strengthened local leadership, and improved capacity to manage; and maximize the efficiency, accountability, and impact of HRH on 95-95-95 goals.<br><br>Fully comprehensive/integrated and functional health workforce database inclusive of all cadres across the public and private sectors; integrated HRH with programmatic data and financial systems to monitor district or site-level staff allocation and performance ensuring optimal human resources planning. |

*Supply chain.* Currently, there is a lack of information on costs and program requirements for commodities at provincial and district levels. Different and unlinked information systems continue to disrupt cohesive planning, procurement, and storage and security for drugs and commodities. Further, limited access to real-time ART needs (patient-level data by gender, age, and facility) compromises decision making, contributing to irregular demand and supply continuum, and hampering the ability of the NDoH's Affordable Medicines Directorate (AMD) to make informed decisions based on accurate commodity gaps at provincial and district levels. PEPFAR SA facilitates data triangulation to inform planning for drugs and commodities, decision-making on allocation, and ensures responsiveness based on changing demand. For example, in the past financial year, the NDoH requested emergency support from PEPFAR SA to supplement TLD due to shortages in the country. PEPFAR SA support facilitates data triangulation to inform planning for drugs and commodities, decision-making on allocation, and ensures responsiveness based on changing demand. In COP22, PEPFAR SA's ASP will work to address these challenges through the activities outlined below.

| **Summary of COP22 Above Site Investments (National Health System and Service Delivery)**<br><br>*Element: Commodity security and supply chain* | **Expected Outcome** |
|---|---|
| ● Support National Surveillance Centre (NSC) and other information platforms in the collection, analyses, and subsequent provision of accurate and real-time information, thereby increasing the availability of supply chain data | Routine integration and triangulation of Supply Chain National Surveillance Centre (NSC) and program data implemented for all PEPFAR_SA supported sites. |
| ● Expand supply chain, logistics and pharmaceutical management support to all service delivery points enabling DSPs to provide direct supply chain management support aligned to and in conjunction with other above site partners | Improved responsiveness to changing demand for commodities at provincial and district levels support enrollment and retention in HIV and TB care. |
| ● Support to the NDOH's AAMD by applying a change management approach to facilitate planning and implementation of PEPFAR supported initiatives including completion of the TLD transition for all eligible patients and supply planning using business processes with service providers. | All stable patients (including children and adolescents) accessing an RPCS receiving a minimum of 3MD |
| ● Strengthen national roll-out of replenishment management by linking facility max/min stock levels to the national surveillance center, mitigating stock anomalies, and improving pharmaceutical management. | Improved implementation of MMD modality, including expanded period of MDD beyond 3 months and increased uptake of all MMD options. |
| ● Accelerate the scale up of TLD and pediatric formulations to reach the second and third 95-95-95 cascade goals to better inform decision making to mitigate stock anomalies and increase access to life-saving health commodities | ART optimization through the supply of quality commodities, aligned with national ART guidelines. |
| ● Urgently shift all stable patients including adolescents and children from 2- to 3-month dispensing as already supported by policy, predicated on locally generated data to support feasibility and inform rollout in the South African context | Improved supply chain resiliency and health commodity security |
| ● Provide evidence and analytics to support decision-making and implementation of 6MD in South Africa. | |
| ● Provide TA at national and provincial levels to strengthen CCMDD and second national and provincial CCMDD coordinators to the NDoH to | |

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| support CCMDD activities; Assist with expansion and monitor the accreditation of external pick up points (PUP); Strengthen coordination of provincial M&E of CCMDD Service Providers<br><br>● Facilitate communication between SAHPRA and AMD and fast track product registration of novel therapies indicated in the management of HIV (and TB), including long acting injectable cabotegravir, the dapivirine vaginal ring, and scale up of long-acting injectable PrEP as a prevention tool amongst KP | |

*Laboratory.* Financial resources to maintain the quality of HIV rapid test kits and support quality of laboratory testing through accreditation are still required in South Africa. Noting the current gaps in VL completion and VLS, improved access to viral load is critical to achieving epidemic control. PEPFAR SA will ensure that the South African laboratory network can provide all patients timely results, specifically for viral load testing and other priority diagnostic tools. In COP22, PEPFAR SA's ASP will work to address these challenges through the activities outlined below.

| **Summary of COP22 Above Site Investments (National Health System and Service Delivery)**<br><br>*Element: Laboratory* | **Expected Outcome** |
|---|---|
| ● PEPFAR SA will improve VL suppression and coverage across adult and pediatric populations through clinic laboratory interface strengthening: (1) expansion and usage of eLABS including addition of more tests and features; viral load laboratory support and monitoring; (2) maintenance and expansion of NHLS Results for Action (RfA) reports (VL, EID, CD4, CrAg, TLD transition, maternal EGK etc.) and HIV dashboards.<br><br>● PEPFAR SA will strengthen patient literacy and improve demand creation for HIV viral load through the eLABS Patient Support System mobile application for sending test result outcomes, appointment reminders and educational health messages directly to patients. | Strengthened laboratory infrastructure and processes will ensure improved access to viral load and other HIV-associated results. Improvement in turnaround time, reduced specimen rejection rates and improved acknowledgement of and action taken on laboratory test results (HIV VL, EID, CD4, TB, creatinine, Hemoglobin, CrAg).<br><br>Improved VL suppression and coverage through empowerment of PLHIV who are on treatment. Improvement in number of patients returning, as well as turnaround time to return, to facilities for necessary action based on their test result outcome as well as for their next laboratory test appointment. Improvement in patient's knowledge of HIV. |

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| ● PEPFAR SA will Support NHLS to ensure quality assurance is provided for HIV rapid testing and laboratory testing (EID, VL, TB and CD4) through: (1) Post-market surveillance of HIV rapid test kits; (2) preparation and distribution of proficiency testing panels and independent quality controls to facilities and labs; (3) laboratory accreditation through SLMTA. | Quality HIV rapid testing and laboratory testing (EID, VL, TB and CD4) services are provided. All HIV rapid tests are quality assured before marketed; an increased number of NHLS laboratories are accredited. |

### *5.3 SID Domain: Strategic Financing and Market Openness*

SID elements: Domestic resource mobilization, Technical and allocative efficiencies, Market openness

(NB: We also included Financial/Expenditure data from the fourth SID Domain.)

*Health financing:* PEPFAR SA has been supporting financial management capacity to improve budgeting and budget execution for HIV/TB, and it is envisioned that by the end of COP21, district-level support will be achieved. However, COVID-19 has negatively impacted South Africa's economy, and the National Treasury expects a full economic recovery only by 2027. Moreover, service delivery challenges persist as the country progresses towards epidemic control. Ensuring availability of adequate resources to support the expansion of the HIV/AIDS Program amidst the current economic situation will require mobilizing domestic resources and strategic investments that are efficiently allocated and executed. In COP22, PEPFAR SA will support national-, provincial-, and district-level capacity for HIV and TB forecasting, budgeting, and budget execution—ensuring technical and allocative efficiency in the distribution of available resources.

| **Summary of COP22 Above Site Investments (Strategic Financing and Market Openness)**<br><br>*Elements: Domestic resource mobilization and Technical and allocative efficiencies* | **Expected Outcome** |
|---|---|
| ● Health financing technical assistance for the transition to NHI. This will include assembly of cost and best practice data and provision of TA to inform development of the processes and structures necessary for NHI. Examples will range from contributions to Health Technologies Assessment capacity to identifying best practices for strategic purchasing mechanisms for HRH. This work may also include testing projects in NHI pilot districts.<br>● Provincial- and district-level training and support for NHI-focused activities.<br>● Contribute to technical and allocation efficiency gains in the HIV program through health financing technical assistance. This could include updating local cost and cost- | Increased local resources for HIV Program as a result of clearly identified needs and advocacy for funding through the Investment Case, etc.<br><br>Improved technical and allocative efficiency in local HIV expenditure. |

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| effectiveness data, analytics to identify opportunities for efficiency gains, and updates to the national investment case and Thembisa Model, which routinely inform the national HIV Program budget and which will be integral for the next iteration of the National Strategic Plan. | Identification of health financing best practices for NHI implementation. |

## *5.4 SID Domain: Strategic Information*

SID elements: Epidemiological and health data, Financial/expenditure data, Performance data, Data for decision-making

(NB: Financial/Expenditure data from this SID Domain are included in the activities table provided above.)

*HMIS.* The Health Management Information Systems (HMIS) space in South Africa is characterized by fragmented systems that hinder informed decision-making. The National Health Act, Section 74, provides that the NDoH should be able to fund, facilitate and coordinate the development, implementation and maintenance of a comprehensive national health information system that links provincial, district health councils, municipalities and the private health sector information systems. The NHI White Paper and bill before Parliament further elaborate on the HMIS and processes required to ensure equitable and efficient access to health care.

To date, these goals have not been realized, but recent movement on the NHI has reinvigorated processes. As indicated by the Circular No 1of 2022 published and shared on the 14th of February 2022: interoperable HMIS are required for evidence-informed decision making and a number of business processes including: documenting population health needs and understanding utilization patterns, budgeting and expenditure, forecasting and procurement of commodities, patient registration, service provider contracting and reimbursement, performance management, and fraud and risk management. The NHI Digital Health Unit, established by the circular, will oversee all future HMIS work. In a first step towards capacitating this new unit, a systems audit will take place in COP21. PEPFAR SA has been invited to participate. In addition, there is an expectation for collaboration with the NDoH on all technical development and management of HMIS going forward. PEPFAR SA supports this initiative and will collaborate with the NHI Digital Health Unit to ensure that currently supported information systems are interoperable and in support of the future vision of the Unit.

PEPFAR SA's COP22 work will include working collaboratively with the GoSA to support its vision for electronic medical records by supporting interoperable information systems, improved access to data, and evidence-informed decision-making at all levels. It will also include capitalizing on local and PEPFAR SA capacity for surveys, research, and evaluation that contribute to improved understanding of the context and identification of opportunities for advancing efforts to end HIV—locally and globally.

| **Summary of COP22 Above Site Investments (Strategic Information)**<br><br>Elements: All except financial/expenditure data | **Expected Outcomes** |
|---|---|
| ● Collaborate with NDoH to support national and province-level information systems governance, access, and interoperability, including with NHI billing systems, to enable:<br>o Unique identification and longitudinal tracking of patients,<br>o Improved visibility of data,<br>o Improved utility and use of data, and<br>o Improved HIV program performance.<br><br>● Support capacity building for use of routine data and electronic medical records for planning, patient care, and target setting.<br><br>● Facilitate the transfer of the Consolidated Health Informatics SA (CHISA) (formerly InfoHub) to NDoH ownership under NHI Digital Unit<br><br>• Enhance, monitor and support linked quality, availability, and usefulness of OVC program-data to address critical intervention gaps.<br><br>● Support utilization of DHIS2 and facilitate ownership of the system under NHI Digital Unit.<br><br>● Facilitate transfer of the Synchronized National Communication in Health (SyNCH) system with helpdesk support for CCMDD program monitoring to NDoH ownership under NHI Digital Unit<br><br>● Improve the surveillance of priority public health interventions (through population-based household surveys, recency testing, BBS on PWID, case | • Increased use of HIV/TB data to inform programming, HRH allocation and procurement of commodities at national and the sub-national level.<br>• Linked, interoperable national HMIS with relevant SOPs and indicators<br><br>• Health Patient Registration Number utilized in interoperable health information systems leading to improved HIV/TB program efficiencies<br><br>• Quarterly reporting on HIV/TB via CHISA continues in a timely fashion with NHI Digital Health Unit oversight.<br>• Trained and mentored information and program managers on the use of integrated systems for decision-making<br><br>• Improved quality, availability, and usefulness of program-linked data to improve outcomes for Orphans and Vulnerable Children.<br><br>• Improved management of health resources and quality of care based on accurate patient-level data<br><br>• SyNCH system successfully supports widespread use of CCMDD, with oversight from NHI Digital Health Unit<br>• Production and dissemination of integrated and higher quality surveillance tools and data to inform public health response to achieve epidemic control |

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| reporting/clinical surveillance, TPT analysis, mortality, VMMC, GBV QA, drug resistance) to provide critical information on HIV incidence; the status of 95–95–95 progress disaggregated by sex, age and gender; and vulnerable populations to inform appropriate program interventions. | • Improved access to and use of HIV epidemiological and longitudinal data and estimates to drive program response and improve patient tracking and resource allocation |

# 6.0 USG Operations and Staffing Plan to Achieve Stated Goals

*Redacted*

# APPENDIX A -- PRIORITIZATION

**Continuous Nature of SNU Prioritization to Reach Epidemic Control**

**Table A.1.1 1 Treatment Coverage 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* | | | | | | | | Child ART Coverage (PEPFAR) <15 Years | Adult ART Coverage (PEPFAR) 15+ Years |
| | | | | | Female (<15 years)* | | | | Male (<15 years)* | | | | | |
| | | | | | <1 year | 1-4 years | 5-9 years | 10-14 years | <1 year | 1-4 years | 5-9 years | 10-14 years | | |
| gp City of Johannesburg Metropolitan Municipality | COP 16 | Scale-Up Saturation | APR 17 | reported | 54% | | | | 53% | | | | 54% | 53% |
| | COP 17 | Scale-Up Saturation | APR 18 | reported | 101% | 37% | | 42% | 100% | 37% | | 39% | 40% | 54% |
| | COP 18 | Scale-Up Saturation | APR19 | reported | --- | 35% | | 36% | --- | 30% | | 33% | 33% | 48% |
| | COP 19 | Scale-Up Saturation | APR 20 | reported | 51% | 58% | 70% | 73% | 51% | 57% | 69% | 72% | 69% | 78% |
| | COP 20 | Scale-Up Saturation | APR 21 | reported | 136% | 82% | 82% | 82% | 100% | 82% | 82% | 82% | 82% | 78% |
| | COP 21 | Scale-Up Saturation | APR 22 | expected | 94% | 79% | 79% | 79% | 94% | 79% | 79% | 79% | 79% | 77% |
| | COP 22 | Scale-Up Saturation | APR 23 | expected | 102% | 59% | 69% | 76% | 105% | 55% | 64% | 73% | 69% | 77% |
| 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 | reported | 43% | 56% | 67% | 68% | 43% | 56% | 67% | 67% | 65% | 83% |
| | COP 20 | Scale-Up Saturation | APR 21 | reported | 99% | 87% | 87% | 87% | 89% | 77% | 82% | 87% | 85% | 81% |
| | COP 21 | Scale-Up Saturation | APR 22 | expected | 77% | 79% | 79% | 79% | 77% | 79% | 79% | 79% | 79% | 77% |
| | COP 22 | Scale-Up Saturation | APR 23 | expected | 70% | 82% | 82% | 82% | 68% | 82% | 82% | 83% | 82% | 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* | | | | | | | | Child ART Coverage (PEPFAR) <15 Years | Adult ART Coverage (PEPFAR) 15+ Years |
| | | | | | Female (<15 years)* | | | | Male (<15 years)* | | | | | |
| | | | | | <1 year | 1-4 years | 5-9 years | 10-14 years | <1 year | 1-4 years | 5-9 years | 10-14 years | | |
| gp 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 | reported | 42% | 60% | 68% | 67% | 42% | 60% | 67% | 67% | 65% | 77% |
| | COP 20 | Scale-Up Saturation | APR 21 | reported | 100% | 74% | 81% | 81% | 85% | 69% | 73% | 81% | 78% | 77% |
| | COP 21 | Scale-Up Saturation | APR 22 | expected | 65% | 79% | 79% | 79% | 65% | 79% | 79% | 79% | 80% | 81% |
| | COP 22 | Scale-Up Saturation | APR 23 | expected | 131% | 65% | 68% | 73% | 131% | 59% | 62% | 73% | 70% | 73% |
| kz eThekwini 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 | reported | 48% | 78% | 79% | 75% | 48% | 78% | 79% | 74% | 76% | 83% |
| | COP 20 | Scale-Up Saturation | APR 21 | reported | 119% | 87% | 87% | 87% | 98% | 83% | 83% | 81% | 85% | 82% |
| | COP 21 | Scale-Up Saturation | APR 22 | expected | 32% | 80% | 80% | 80% | 31% | 81% | 80% | 80% | 80% | 81% |
| | COP 22 | Scale-Up Saturation | APR 23 | expected | 89% | 78% | 77% | 79% | 86% | 65% | 77% | 77% | 77% | 83% |
| ec Alfred Nzo District Municipality | COP 16 | Scale-Up Aggressive | APR 17 | reported | 38% | | | | 35% | | | | 37% | 50% |
| | COP 17 | Scale-Up Aggressive | APR 18 | reported | 137% | 40% | | 40% | 137% | 40% | | 35% | 40% | 60% |
| | COP 18 | Scale-Up Aggressive | APR19 | reported | 88% | 35% | | 34% | 70% | 32% | | 30% | 33% | 53% |
| | COP 19 | Scale-Up Aggressive | APR 20 | reported | 32% | 88% | 91% | 73% | 32% | 87% | 90% | 71% | 79% | 80% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 88% | 89% | 95% | 89% | 90% | 89% | 90% | 84% | 89% | 87% |

| 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 | | |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 49% | 83% | 86% | 83% | 49% | 83% | 85% | 83% | 83% | 83% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 31% | 75% | 89% | 89% | 31% | 79% | 85% | 88% | 85% | 85% |
| 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 | reported | 45% | 88% | 88% | 86% | 44% | 78% | 88% | 78% | 83% | 84% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 100% | 88% | 88% | 88% | 80% | 78% | 88% | 78% | 84% | 83% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 68% | 83% | 82% | 83% | 66% | 84% | 83% | 83% | 82% | 81% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 96% | 81% | 87% | 82% | 100% | 81% | 81% | 81% | 82% | 86% |
| ec Buffalo City Metropolitan Municipality | COP 16 | Scale-Up Aggressive | APR 17 | reported | 107% | | | | 103% | | | | 105% | 47% |
| | COP 17 | Scale-Up Aggressive | APR 18 | reported | 213% | 30% | | 25% | 204% | 30% | | 24% | 29% | 37% |
| | COP 18 | Scale-Up Aggressive | APR19 | reported | 78% | 37% | | 43% | 54% | 30% | | 39% | 37% | 40% |
| | COP 19 | Scale-Up Aggressive | APR 20 | reported | 33% | 55% | 60% | 47% | 33% | 55% | 60% | 46% | 52% | 75% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 85% | 81% | 84% | 84% | 36% | 70% | 84% | 80% | 82% | 79% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 56% | 79% | 79% | 79% | 54% | 79% | 79% | 79% | 79% | 79% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 33% | 69% | 68% | 69% | 34% | 65% | 65% | 69% | 67% | 71% |
| ec Chris Hani District Municipality | COP 16 | Scale-Up Aggressive | APR 17 | reported | 48% | | | | 30% | | | | 39% | 53% |
| | COP 17 | Scale-Up Aggressive | APR 18 | reported | 39% | 17% | | 51% | 38% | 16% | | 38% | 31% | 57% |
| | COP 18 | Scale-Up Aggressive | FY19 Q1 | reported | 57% | 108% | 0% | 35% | 24% | 100% | 0% | 33% | 33% | 55% |

| 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 | | |
| | COP 19 | Scale-Up Aggressive | APR 20 | reported | 40% | 72% | 77% | 60% | 39% | 71% | 76% | 60% | 66% | 88% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 100% | 88% | 88% | 88% | 50% | 85% | 88% | 75% | 84% | 85% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 115% | 85% | 85% | 85% | 115% | 85% | 85% | 85% | 85% | 84% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 104% | 81% | 81% | 81% | 104% | 82% | 81% | 81% | 82% | 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 | reported | 14% | 82% | 81% | 66% | 13% | 67% | 81% | 65% | 71% | 79% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 100% | 82% | 83% | 83% | 83% | 67% | 83% | 69% | 78% | 79% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 95% | 82% | 81% | 82% | 93% | 82% | 81% | 82% | 82% | 80% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 100% | 80% | 80% | 81% | 97% | 81% | 80% | 81% | 81% | 81% |
| 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 | reported | 57% | 84% | 76% | 73% | 57% | 83% | 74% | 72% | 75% | 83% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 89% | 86% | 91% | 91% | 74% | 91% | 91% | 91% | 91% | 86% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 55% | 81% | 80% | 80% | 55% | 80% | 80% | 80% | 80% | 80% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 36% | 64% | 68% | 81% | 36% | 63% | 72% | 79% | 74% | 86% |
| fs Thabo Mofutsanyane | COP 16 | Scale-Up Aggressive | APR 17 | reported | 49% | | | | 97% | | | | 73% | 56% |

| 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 | | |
| District Municipality | 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 | reported | 26% | 86% | 72% | 74% | 25% | 73% | 71% | 74% | 73% | 92% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 27% | 89% | 85% | 95% | 27% | 73% | 89% | 95% | 90% | 92% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 100% | 81% | 81% | 81% | 100% | 82% | 81% | 81% | 81% | 87% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 89% | 74% | 79% | 90% | 89% | 65% | 78% | 89% | 83% | 90% |
| 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 | reported | 47% | 63% | 86% | 86% | 50% | 56% | 82% | 82% | 80% | 82% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 100% | 63% | 86% | 86% | 71% | 57% | 82% | 82% | 80% | 78% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 41% | 82% | 80% | 82% | 40% | 82% | 80% | 80% | 80% | 81% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 130% | 72% | 89% | 104% | 125% | 71% | 81% | 93% | 90% | 92% |
| 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 | reported | 74% | 99% | 99% | 94% | 73% | 99% | 99% | 92% | 95% | 96% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 100% | 99% | 99% | 99% | 100% | 99% | 99% | 99% | | |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 95% | 82% | 92% | 83% | 95% | 83% | 92% | 82% | 85% | 91% |

| 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 | | |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 71% | 92% | 93% | 95% | 71% | 88% | 95% | 95% | 94% | 95% |
| 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 | reported | 51% | 88% | 88% | 85% | 50% | 88% | 88% | 83% | 85% | 84% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 100% | 88% | 88% | 88% | 89% | 88% | 88% | 88% | 99% | 95% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 76% | 82% | 89% | 81% | 76% | 82% | 81% | 81% | 82% | 83% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 65% | 84% | 91% | 83% | 65% | 80% | 84% | 87% | 85% | 88% |
| 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 | reported | 55% | 97% | 93% | 84% | 54% | 94% | 92% | 82% | 87% | 96% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 112% | 97% | 97% | 97% | 85% | 94% | 97% | 97% | 97% | 93% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 71% | 82% | 82% | 82% | 71% | 82% | 82% | 82% | 82% | 87% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 119% | 78% | 81% | 87% | 116% | 74% | 77% | 83% | 83% | 89% |
| 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 | reported | 39% | 78% | 81% | 78% | 39% | 76% | 81% | 75% | 78% | 81% |

| 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 | | |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 126% | 84% | 84% | 84% | 110% | 84% | 84% | 84% | | |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 72% | 83% | 82% | 83% | 71% | 83% | 82% | 82% | 82% | 80% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 72% | 73% | 82% | 82% | 70% | 68% | 83% | 82% | 80% | 83% |
| kz Uthukela District Municipality | COP 16 | Scale-Up Aggressive | APR 17 | reported | 51% | | | | 32% | | | | 41% | 52% |
| | COP 17 | Scale-Up Aggressive | APR 18 | reported | 103% | 47% | | 41% | 100% | 47% | | 35% | 43% | 62% |
| | COP 18 | Scale-Up Aggressive | APR19 | reported | 89% | 41% | | 39% | 53% | 36% | | 33% | 37% | 58% |
| | COP 19 | Scale-Up Aggressive | APR 20 | reported | 22% | 82% | 79% | 73% | 21% | 82% | 78% | 72% | 75% | 85% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 75% | 88% | 88% | 88% | 75% | 88% | 88% | 77% | 85% | 80% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 33% | 90% | 89% | 90% | 33% | 89% | 89% | 90% | 89% | 90% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 74% | 85% | 84% | 84% | 71% | 84% | 84% | 84% | 84% | 92% |
| 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 | reported | 21% | 88% | 85% | 80% | 20% | 88% | 85% | 78% | 81% | 87% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 100% | 88% | 88% | 88% | 88% | 88% | 88% | 88% | 88% | 85% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 68% | 86% | 86% | 86% | 68% | 86% | 86% | 86% | 86% | 87% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 79% | 82% | 82% | 82% | 79% | 81% | 83% | 82% | 82% | 89% |
| 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% |

| 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 | | |
| | COP 18 | Scale-Up Aggressive | APR19 | reported | --- | 41% | | 43% | --- | 36% | | 42% | 40% | 55% |
| | COP 19 | Scale-Up Aggressive | APR 20 | reported | 47% | 82% | 81% | 79% | 46% | 81% | 81% | 79% | 80% | 78% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 88% | 82% | 82% | 82% | 63% | 82% | 82% | 82% | 82% | 77% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 66% | 80% | 79% | 79% | 65% | 80% | 79% | 79% | 79% | 77% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 87% | 74% | 87% | 88% | 87% | 73% | 81% | 83% | 83% | 74% |
| 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 | reported | 34% | 83% | 84% | 80% | 34% | 82% | 84% | 81% | 82% | 84% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 111% | 84% | 84% | 84% | 95% | 84% | 84% | 84% | 85% | 81% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 63% | 83% | 83% | 83% | 62% | 83% | 83% | 83% | 82% | 83% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 48% | 84% | 87% | 87% | 47% | 80% | 85% | 82% | 84% | 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% |
| | COP 19 | Scale-Up Aggressive | APR 20 | reported | 50% | 91% | 95% | 88% | 49% | 90% | 94% | 86% | 89% | 86% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 96% | 96% | 96% | 96% | 76% | 96% | 96% | 96% | 96% | 92% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 88% | 82% | 82% | 81% | 87% | 82% | 82% | 81% | 82% | 91% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 127% | 78% | 82% | 91% | 129% | 74% | 79% | 87% | 85% | 94% |

| 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 | | |
| 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 | reported | 42% | 77% | 81% | 77% | 42% | 76% | 80% | 76% | 77% | 78% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 90% | 84% | 84% | 84% | 96% | 79% | 84% | 84% | 84% | 80% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 54% | 82% | 81% | 81% | 54% | 82% | 81% | 81% | 81% | 80% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 78% | 65% | 78% | 82% | 75% | 66% | 76% | 79% | 77% | 79% |
| 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 | reported | 48% | 62% | 65% | 62% | 48% | 61% | 65% | 61% | 44% | 72% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 105% | 85% | 85% | 92% | 93% | 85% | 85% | 85% | 87% | 82% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 82% | 79% | 79% | 79% | 81% | 79% | 79% | 78% | 79% | 77% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 81% | 67% | 76% | 83% | 81% | 59% | 72% | 80% | 76% | 78% |
| 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 | reported | 24% | 61% | 65% | 66% | 23% | 59% | 64% | 64% | 63% | 75% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 107% | 80% | 81% | 81% | 92% | 76% | 78% | 81% | 81% | 75% |

| 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 | | |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 57% | 81% | 81% | 81% | 56% | 81% | 81% | 81% | 81% | 79% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 88% | 63% | 71% | 79% | 86% | 59% | 69% | 74% | 72% | 79% |
| 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 | reported | 13% | 62% | 61% | 65% | 13% | 61% | 62% | 68% | 79% | 79% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 100% | 81% | 84% | 84% | 84% | 80% | 84% | 84% | 84% | 80% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 61% | 81% | 80% | 81% | 61% | 81% | 81% | 81% | 80% | 79% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 90% | 76% | 82% | 82% | 93% | 69% | 82% | 82% | 80% | 80% |
| nw Ngaka Modiri Molema District Municipality | COP 16 | Scale-Up Aggressive | APR 17 | reported | 42% | | | | 43% | | | | 42% | 47% |
| | COP 17 | Scale-Up Aggressive | APR 18 | reported | 56% | 42% | | 42% | 55% | 43% | | 42% | 43% | 52% |
| | COP 18 | Scale-Up Aggressive | APR19 | reported | 71% | 40% | | 41% | 48% | 38% | | 40% | 40% | 50% |
| | COP 19 | Scale-Up Aggressive | APR 20 | reported | 93% | 73% | 71% | 77% | 82% | 72% | 70% | 74% | 74% | 83% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 91% | 74% | 87% | 87% | 83% | 77% | 87% | 87% | 85% | 83% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 55% | 82% | 81% | 82% | 55% | 82% | 82% | 82% | 81% | 81% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 90% | 82% | 81% | 81% | 90% | 82% | 82% | 81% | 81% | 83% |
| wc City of Cape Town Metropolitan Municipality | COP 16 | Scale-Up Aggressive | APR 17 | reported | 62% | | | | 41% | | | | 51% | 52% |
| | COP 17 | Scale-Up Aggressive | APR 18 | reported | 116% | 40% | | 64% | 113% | 39% | | 50% | 48% | 60% |
| | COP 18 | Scale-Up Aggressive | APR19 | reported | 103% | 41% | | 55% | 42% | 33% | | 46% | 43% | 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* | | | | | | | | 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 | | |
| | COP 19 | Scale-Up Aggressive | APR 20 | reported | 38% | 65% | 67% | 58% | 37% | 65% | 64% | 58% | 62% | 80% |
| | COP 20 | Scale-Up Aggressive | APR 21 | reported | 113% | 80% | 80% | 83% | 84% | 65% | 64% | 77% | 76% | 80% |
| | COP 21 | Scale-Up Aggressive | APR 22 | expected | 45% | 80% | 80% | 80% | 45% | 80% | 80% | 80% | 79% | 78% |
| | COP 22 | Scale-Up Aggressive | APR 23 | expected | 89% | 63% | 66% | 72% | 90% | 65% | 61% | 65% | 67% | 74% |

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

## Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (Central Support Districts) [1

| 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 20 | Central Support | APR 21 | expected | N/A: No target required | N/A |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |

| 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 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | expected | N/A: No target required | N/A |
| kz Umzinyathi District Municipality | COP 17 | Central Support | APR 18 | reported | N/A: No target required | 70% |
| | COP 18 | Central Support | APR 19 | expected | N/A: No target required | 76% |
| | COP 19 | Central Support | APR 20 | expected | N/A: No target required | N/A |
| | COP 20 | Central Support | APR 21 | expected | N/A: No target required | N/A |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |

| 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | expected | N/A: No target required | 1% |
| 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 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | expected | N/A: No target required | N/A |
| nc John Taolo Gaetsewe District Municipality | COP 17 | Central Support | APR 18 | reported | N/A: No target required | 38% |
| | COP 18 | Central Support | APR 19 | expected | N/A: No target required | 62% |
| | COP 19 | Central Support | APR 20 | expected | N/A: No target required | N/A |
| | COP 20 | Central Support | APR 21 | expected | N/A: No target required | N/A |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | expected | N/A: No target required | N/A |
| nc Zwelentlanga Fatman Mgcawu District Municipality | COP 17 | Central Support | APR 18 | reported | N/A: No target required | 35% |
| | COP 18 | Central Support | APR 19 | expected | N/A: No target required | 44% |
| | COP 19 | Central Support | APR 20 | expected | N/A: No target required | N/A |
| | COP 20 | Central Support | APR 21 | expected | N/A: No target required | N/A |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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% |

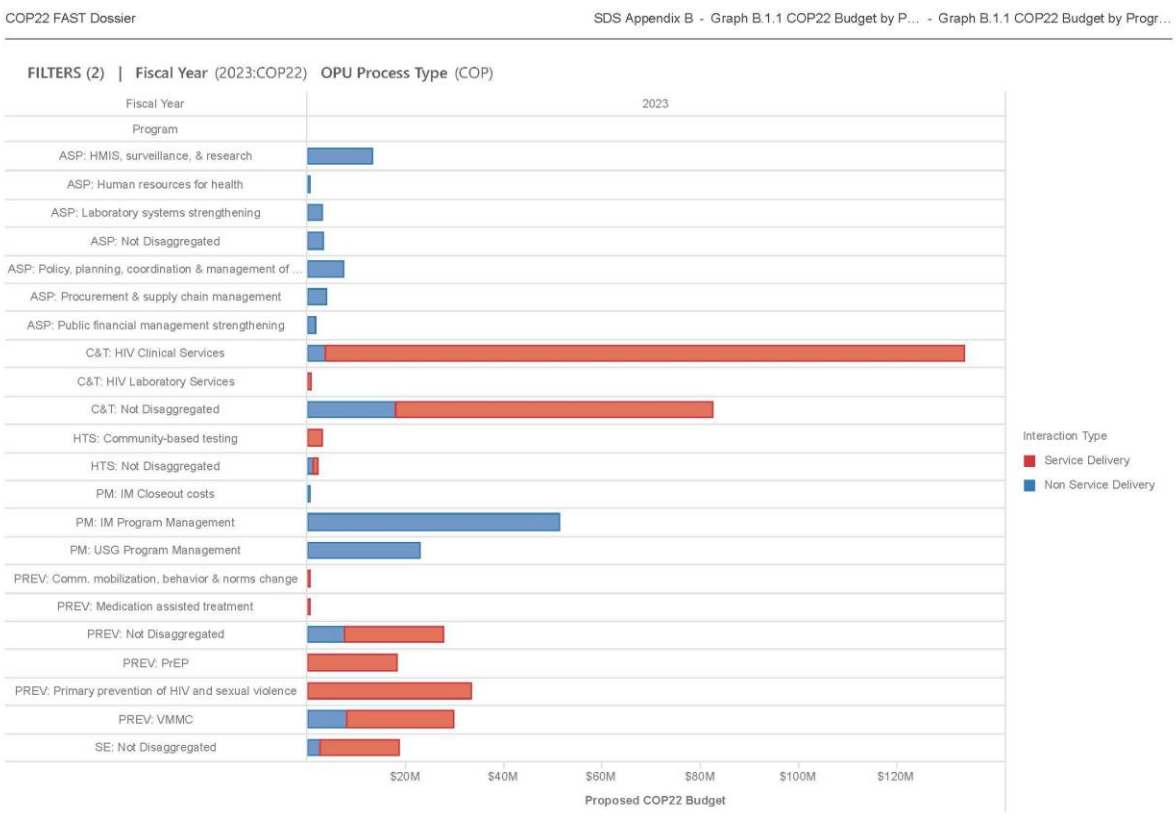
| Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (Central Support Districts) [1] | | | | | | |
|---|---|---|---|---|---|---|
| District | COP | Prioritization | Results Reported | Coverage: Reported/ Expected | Targets by Age and Sex | Overall ART Coverage (PEPFAR) |
| | COP 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 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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 |
| | COP 21 | Central Support | APR 22 | expected | N/A: No target required | N/A |
| | COP 22 | Central Support | APR 23 | 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.

# APPENDIX B – Budget Profile and Resource Projections

## B1. COP22 Planned Spending in alignment with planning level letter guidance

### Table B.1.1 COP22 Budget by Program Area



# Table B.1.2 COP22 Budget by Program Area

| Table B.1.2 COP22 Budget by Program Area | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | Metrics | Proposed COP22 Budget | | | Percent of Proposed COP 22 Budget | | |
| Program | Sub-Program | Non Service Delivery | Service Delivery | Total | Non Service Delivery | Service Delivery | Total |
| **Total** | | **$147,801,867** | **$309,812,650** | **$457,614,517** | **32%** | **68%** | **100%** |
| | **Total** | **$21,483,411** | **$195,523,833** | **$217,007,244** | **10%** | **90%** | **100%** |
| | HIV Clinical Services | $3,593,000 | $130,191,549 | **$133,784,549** | 3% | 97% | **100%** |
| | HIV Laboratory Services | | $597,535 | **$597,535** | | 100% | **100%** |
| C&T | Not Disaggregated | $17,890,411 | $64,734,749 | **$82,625,160** | 22% | 78% | **100%** |
| | **Total** | **$1,170,000** | **$3,673,286** | **$4,843,286** | **24%** | **76%** | **100%** |
| | Community-based testing | | $2,837,711 | **$2,837,711** | | 100% | **100%** |
| HTS | Not Disaggregated | $1,170,000 | $835,575 | **$2,005,575** | 58% | 42% | **100%** |
| | **Total** | **$15,279,281** | **$94,508,058** | **$109,787,339** | **14%** | **86%** | **100%** |
| | Comm. mobilization, behavior & norms change | | $422,305 | **$422,305** | | 100% | **100%** |
| | Medication assisted treatment | | $480,600 | **$480,600** | | 100% | **100%** |
| | Not Disaggregated | $7,388,406 | $20,215,450 | **$27,603,856** | 27% | 73% | **100%** |
| | PrEP | | $18,179,036 | **$18,179,036** | | 100% | **100%** |
| | Primary prevention of HIV and sexual violence | | $33,370,978 | **$33,370,978** | | 100% | **100%** |
| PREV | VMMC | $7,890,875 | $21,839,689 | **$29,730,564** | 27% | 73% | **100%** |
| | **Total** | **$2,593,707** | **$16,107,473** | **$18,701,180** | **14%** | **86%** | **100%** |
| SE | Not Disaggregated | $2,593,707 | $16,107,473 | **$18,701,180** | 14% | 86% | **100%** |
| | **Total** | **$32,558,244** | | **$32,558,244** | **100%** | | **100%** |
| | HMIS, surveillance, & research | $13,261,265 | | **$13,261,265** | 100% | | **100%** |
| | Human resources for health | $500,000 | | **$500,000** | 100% | | **100%** |
| | Laboratory systems strengthening | $2,928,001 | | **$2,928,001** | 100% | | **100%** |
| | Not Disaggregated | $3,252,803 | | **$3,252,803** | 100% | | **100%** |
| | Policy, planning, coordination & management of disease control programs | $7,333,400 | | **$7,333,400** | 100% | | **100%** |
| | Procurement & supply chain management | $3,772,275 | | **$3,772,275** | 100% | | **100%** |
| ASP | Public financial management strengthening | $1,510,500 | | **$1,510,500** | 100% | | **100%** |
| | **Total** | **$74,717,224** | | **$74,717,224** | **100%** | | **100%** |
| | IM Closeout costs | $530,000 | | **$530,000** | 100% | | **100%** |
| | IM Program Management | $51,335,735 | | **$51,335,735** | 100% | | **100%** |
| PM | USG Program Management | $22,851,489 | | **$22,851,489** | 100% | | **100%** |

## Table B.1.3 COP22 Total Planning Level

### Table B.1.3 COP22 Total Planning Level

| Metrics | Proposed COP22 Budget | Proposed COP22 Budget | Proposed COP22 Budget |
|---|---|---|---|
| Operating Unit | Applied Pipeline | New | Total |
| **Total** | **$29,394,857** | **$428,219,660** | **$457,614,517** |
| South Africa | $29,394,857 | $428,219,660 | **$457,614,517** |

*Data included in Table B.1.3 should match FACTS Info records and total applied pipeline amount required in PLL guidance.

# Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

**Table B.1.4: COP22 Resource Allocation by Program and Beneficiary**

| Operating Unit | Metrics | Proposed COP22 Budget | | | | | | | Percent to Total | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Beneficiary | C&T | HTS | PREV | SE | ASP | PM | Total | C&T | HTS | PREV | SE | ASP | PM | Total |
| South Africa | **Total** | **$217,007,244** | **$4,843,286** | **$109,787,339** | **$18,701,180** | **$32,558,244** | **$74,717,224** | **$457,614,517** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |
| | Females | $135,000 | | $44,910,565 | | $600,000 | $9,828,462 | **$55,474,027** | 0% | | 41% | | 2% | 13% | **12%** |
| | Key Pops | $6,584,507 | $2,766,683 | $8,141,304 | | $1,090,010 | $1,382,292 | **$19,964,796** | 3% | 57% | 7% | | 3% | 2% | **4%** |
| | Males | | | $29,730,564 | | $92,000 | | **$29,822,564** | | | 27% | | 0% | | **7%** |
| | Non-Targeted Pop | $209,612,737 | $2,076,603 | $21,160,883 | | $29,460,234 | $60,388,890 | **$322,699,347** | 97% | 43% | 19% | | 90% | 81% | **71%** |
| | OVC | | | $5,844,023 | $18,701,180 | $600,000 | $3,117,580 | **$28,262,783** | | | 5% | 100% | 2% | 4% | **6%** |
| | Pregnant & Breastfeeding Women | | | | | $356,000 | | **$356,000** | | | | | 1% | | **0%** |
| | Priority Pops | $675,000 | | | | $360,000 | | **$1,035,000** | 0% | | | | 1% | | **0%** |

## B.2 Resource Projections

All COP22 budget planning was completed using the Funding Allocation to Strategy Tool (FAST). The overall funding envelope reflects a return to pre-HIV Surge investment levels. Within the portfolio, resources are planned to focus on sustaining momentum toward 95-95-95 HIV treatment coverage levels, while maintaining investments in DREAMS and related prevention activities to address continued new infections among adolescent girls and young women. Above site programming, which accounts for roughly 7.1% of total PEPFAR SA programming, was further prioritized towards achieving 95-95-95 targets and promoting greater sustainability of domestic resources.

Resource projections were made using estimated service package unit costs for service delivery activities and activity-based budgeting for above-site activities. Prevention, care and treatment budget unit cost estimates were formulated for broad packages of programming and reviewed against Expenditure Analysis data and unit expenditures to help develop budgets. DREAMS, PrEP, Key Population and OVC programming followed a similar approach carrying forward agreed interagency methodology from previous COPs.

During FY 22, teams reviewed National AIDS Spending Assessment (NASA) data and results from the most recent NASA to inform resource planning to complement GOSA and International Funding resources. The NASA was one of the primary data sources used to populate the Resource Alignment Tool.

# APPENDIX C – Tables and Systems Investments for Section 6.0

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# APPENDIX D– Minimum Program Requirements

Core content is addressed in the narrative sections above. In this section, findings succinctly note if the program is meeting or not meeting the minimum program requirement. This table provides an assessment of the MPRs for South Africa providing detail on the proportion of sites meeting standards, as applicable. The minimum requirements for continued PEPFAR SA support include:

| Minimum Program Requirement | Status |
|---|---|
| **Care and Treatment** | |
| 1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. | **Status**: **In-process**<br><br>Overall proxy linkage in FY21 (Oct 2020 – Sep 2021) was 92% which was 3% improvement from the previous year.<br><br>**Issues or Barriers**:<br>• Direct community linkage still poses a challenge as some community testing partners do not initiate treatment within the community.<br>• Initiation of those who are medically ineligible to initiate treatment same day still remains a challenge as some of those patients are lost in the system.<br>• Although improving, linkage of the younger population continues to be sub-optimal due to multiple reasons; reluctance of caregivers to bring children to the facility due to the COVID-19 pandemic, fear of stigma and discrimination due to disclosure, and high mobility of the young population due to school closures/change in caregivers/caregiver job losses etc. |
| 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 who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens. | **Status**: **In-process**<br><br>For adults and children ≥30kg, TLD transition is ongoing. For children ≥4weeks of age, the DTG based regimen transition will extend into FY23. Removal of all EFV based ART regimens will be challenging because EFV-based regimens are still clinically indicated for some populations in National ART Guidelines.<br><br>**Issues or Barriers**:<br>• South Africa is expecting to get pediatric DTG approval by end of FY22 Q3. It goes onto tender in July 2022, transitioning of treatment will take up to 6-12 months<br>• EFV based regimens are still being used for TB/HIV coinfected clients as well as diabetic clients on high dose Metformin. (SA National ART guidelines 2019)<br>• NVP-based regimen is used to initiate CLHIV <4 weeks of age (SA National ART guidelines 2019) |
| 3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to | **Status: In-process**<br><br>The new Central Chronic Medicines Dispensing and Distribution (CCMDD) tender for decanting will come into effect at the beginning of FY22Q3. This will see an introduction of more 90 count packs and optimization of 3 month dispensing (3MD). Growth |

| | |
|---|---|
| improve identification and ART coverage and continuity for different demographic and risk groups. | in 3MD uptake across comorbidities over the last three quarters has led to more than 600,000 registered clients having received 90-day supplies of medicines, supporting CCMDD's continued roll-out of multi-month dispending (MMD).<br><br>**<u>Issues or Barriers</u>:**<br>• During COP 22 discussions, the Government of South Africa agreed to revisit the 6 months dispensing (6MD) pilot and has subsequently engaged the Affordable Medicines Directorate to discuss preliminary needs. Two- and three-month dispending remain the standard NDoH policy as per the National Adherence Strategy, which is readily supported by robust stocks of both TLD and TEE.<br>• The 12 month-scripting policy expired at the end of FY21Q4. The South African government has not held further discussions about renewing it or making the policy permanent.<br>• The provision of 3-month dispensing is not uniform across the country, and scale up is at the discretion of the provincial DOH.<br>• Limited access to real time data from the HIV Program confounds AMD's ability to accurately determine quantities dispensed at service delivery points (i.e., only aggregated total volumes dispensed over a known time frame is calculated, which is an implied retrospective volume). |
| 4) All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. | **<u>Status</u>**: **In-process**<br><br>Overall TPT completion rate in FY21 was 66% which was a 3% improvement from that of FY20. We now have a shorter course of a weekly rifapentine and isoniazid (3HP) therapy taken over three months, which has the potential to improve completion rates.<br><br>**<u>Issues or Barriers</u>:**<br>• The number of isoniazid preventive treatment (IPT) initiations have increased substantially over time; however, completion rates remain very low due to the longer duration of IPT.<br>• The SARS-CoV-2 pandemic resulted in devastating effects on TPT provision, including reversal of a positive trend observed from FY19 to FY21.<br>• Reaching all eligible ART patients who are new and already on ART requires intensified efforts to identify and overcome barriers to TB screening, TPT initiation and completion of treatment. |
| 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. | **<u>Status</u>**: **In-process**<br><br>The Diagnostic Network Optimization for VL/EID, TB and other coinfections has been completed; there is currently sufficient lab capacity for testing, and specimen transportation routes and results delivery mechanisms have been optimized. A Data Command Center facilitates monitoring of programmatic and operational needs for VL support in the laboratory resulting in 91% of results being returned within 96 hours and specimen rejection rates consistently <5%. eLABS, a technology to improve VL coverage and suppression, was expanded from 496 facilities at the beginning |

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| | of COP20 to 2088 facilities currently in COP21, including 6 Key Population sites. Test volumes increased by 4% for VL and 11% for EID from COP19 to COP20, respectively, whereas, VL coverage remained consistent at 77% each quarter in COP20.<br><br>**Issues or Barriers**:<br>• SARS-CoV-2 again resulted in limited patient mobility to access health services. Furthermore, facility closures and staff absenteeism, and gaps remain in reaching the required VL coverage rates at facility level.<br>• Capturing of VL results onto Tier.Net and DHIS remains a challenge with lack of interoperability with the NHLS Laboratory Information System. |
| **Case Finding** | |
| 6) 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 should be offered testing for HIV. | **Status: In-process**<br><br>PEPFAR SA will continue to scale-up index testing in accordance with the PEPFAR Guidance on Implementing Safe and Ethical Index Testing and the GoSA SOPs for HIV Index Testing. Full implementation of facility-based index testing is in-process, targeting all new HIV positive clients, clients who have unsuppressed viral loads, STI patients, patients with presumptive and diagnosed TB, PLHIV with biological children, and adolescent girls.<br><br>**Issues or Barriers:**<br>• LIVES training and IPV/Adverse Events protocols are not up-to-date at all facilities offering Index Testing.<br>• Not all districts/provinces are accepting of offering HIV Self-Screening as a secondary distribution option.<br>• Focus on case-finding in certain age and sex groups need to be optimized further to reach children, adolescents and men that do not know their status or know their status and are not yet on treatment. |
| **Prevention and OVC** | |
| 7) 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) | **Status:** In-process<br><br>PEPFAR SA will continue to implement PrEP as part of the core package of DREAMS interventions within comprehensive sexual reproductive health services packages. PEPFAR will continue to support the DoH to institutionalize the provision of PrEP services in health facilities and continue to accelerate the services in community-based settings through mobile vans and ensure PrEP is prioritized for the most at-risk/vulnerable AGYW, including pregnant breastfeeding women (PBFW), GBV survivors, and sero-discordant couples. New PrEP initiations have continued to be scaled-up among MSM and inmates.<br><br>**Issues or Barriers:**<br>• Continued stigma and misunderstanding among communities and high-risk populations surrounding risk behaviours, and PrEP as a prevention technology and its effectiveness. |

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| | • Access to, and resources for, post-violence care services at public health facilities using the Decentralized Approach remains limited.<br>• Understanding of, demand creation for, and active linkage to comprehensive Sexual and Reproductive Health Services for AGYW and men remains limited and unintegrated.<br>• High unemployment and poor economic outlook in South Africa for the foreseeable future will severely limit employment opportunities for key and vulnerable populations. |
| 8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17 years, 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 10-14 yearold girls and boys in regard to primary prevention of sexual violence and HIV. | **Status: In-process**<br><br>The PEPFAR SA OVC Program will continue to provide service delivery for children and families across the three OVC models: OVC Comprehensive, OVC Preventive, and OVC/DREAMS Family Strengthening. In COP22, the PEPFAR SA OVC Comprehensive Program will build on COP21 successes and continue the provision of family-centered comprehensive case management for priority sub-populations at highest risk, including, but not limiting to, HIV-exposed infants, newly diagnosed C/ALHIV and new on treatment or failing treatment, Children of Female Sex Workers (CoFSW), children with an HIV+ caregiver, adolescent mothers living with HIV, children who have experienced sexual and gender-based violence, AGYW, as well as double orphans. The OVC Preventive Program will continue to implement structured evidence-based interventions to prevent sexual violence and HIV amongst at-risk very young adolescent girls and boys aged 10-14 years through youth facilitator-led curricula. The OVC Family Strengthening Program will ensure that the right adolescent girls and their parents/caregivers are reached as part of the secondary package of interventions through strengthened active linkages between the primary package implementing partners and OVC implementing partners.<br><br>**Issues or Barriers:**<br>• COVID-19 restrictions impacted program implementation:<br>• Limited referral completion for HIV testing, treatment initiation and VL testing<br>• Relocation of beneficiaries as a result of hard restrictions and reduced employment opportunities<br>• Group-based interventions for 10-14 year old girls and boys had limited implementation during FY21 and impacted target achievement |
| **Policy & Public Health Systems Support** | |
| 9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV | **Status: In-process**<br><br>Considerable attention has been paid by South Africa's National Department of Health and Civil Society and the PLHIV sector to improve quality of HIV services for all clients, as well as reducing stigma and discrimination for vulnerable groups.<br><br>**Issues or Barriers:** |

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| prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups. | • Continued mentorship and training is needed for health care providers at all levels to ensure that HIV care is provided equitably throughout the country. |
| 10) 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. | **Status: Completed**<br><br>South Africa prohibits, through legislation, informal and formal user fees for HIV, TB, antenatal care, and all primary level care in the public sector. PEPFAR SA continues to work at the national, provincial, and district levels to ensure that this policy is implemented in facilities and that all people have access to HIV services. |
| 11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy. | **Status**: **In-process**<br><br>PEPFAR Operation Phuthuma Support (Siyenza) in South Africa is being implemented at 408 facilities as of January 2022. PEPFAR South Africa continues its hybrid model of support including virtual and in-person site-visits involving from PEPFAR, DSPs, and DoH. Focal areas for site-level improvement include retention, viral load coverage, viral load suppression and more specifically, the pediatric program, as well as ensuring that adequate social distancing measures are in place and PPE is available for all staff. In addition, PEPFAR SA has supported NDoH's COVID-19 vaccination efforts at public health facilities and within communities. |
| 12) Evidence of treatment literacy 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. | **Status: In-process**GoSA, with support from PEPFAR South Africa, has implemented several campaigns to improve treatment and viral load literacy including 1) the MINA brand to promote treatment adherence & U=U among men; 2) the Dablapmeds brand to promote differentiated models of care; 3) the eLABS platform to provide viral load counseling and results; 4) a pediatric surge targeting children and their caregivers; and 5) plans are underway to expand The New Status as the new messaging approach to promote U=U in SA. All PEPFAR-supported partners and provinces are implementing these campaigns in COP21 and will continue into COP22 to improve ART retention, viral load suppression, and treatment adherence. |
| 13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses | **Status: In-process**<br><br>PEPFAR SA continues to expand support directly to key population led organizations including the Sex Workers Education and Advocacy Taskforce (SWEAT), Sisonke, OUT Wellbeing (one of the oldest MSM-led organizations in South Africa, and the South African Network of People who Use Drugs (SANUPD). The program continues to exceed the target of 70% of PEPFAR SA funding be awarded to local, indigenous partners. At the start of COP21, PEPFAR SA was at 82%, which is an increase from 79% in COP20. PEPFAR SA adheres to COP guidance recommending that the majority of prime partners are local/indigenous (86 of 106). |
| 14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year | **Status: In-process**<br><br>PEPFAR SA will continue to collaborate with GoSA to identify additional domestic resources and efficiencies in HIV spending to maximize HIV-related health outcomes at the national-, provincial-, |

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| after year increased resources expended | and district-levels and support sustainable, host government-led initiatives to maintain progress in the HIV and SARS-CoV-2 epidemics.<br><br>**<u>Issues or Barriers</u>:**<br>• There is clear commitment by the GoSA to increase budgetary support for the HIV response, although the SARS-CoV-2 pandemic has resulted in significant budget cuts, including reductions in DOH staffing. |
| 15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. | **<u>Status</u>: In-process**<br><br>South Africa's national morbidity and mortality reporting system is supported by a range of data sources and institutions, including the District Health Information System, Birth and Death Registries, Census and cause- specific data reporting systems. PEPFAR SA has and will continue investing in systems to improve cause of death information for HIV/TB. PEPFAR SA will also continue supporting expansion of effective national HIV/TB patient-level data reporting systems that allow for real-time analysis and monitoring for program improvement. |
| 16) Scale-up of case surveillance and unique identifiers for patients across all sites. | **Status: In-Process**Case surveillance in South Africa has been piloted in four districts in KwaZulu-Natal since COP20. Under an approved protocol with NDoH and NICD Primary Investigators, electronic medical records from over 50 facilities with over 72,000 patient records of PLHIV are linked to lab results and then national mortality data to de-duplicated using a one trial algorithm. Once validated, case surveillance will integrate national mortality data and enable epidemiological data manipulation to identify critical sentinel events and other program outcomes along the continuum of care from diagnosis, establishment of recency status, up until death. The pilot will expand in the next fiscal year to include over 1,000 facilities in all districts of KwaZulu-Natal and Gauteng Provinces.<br><br>The PEPFAR SA funded and managed CHISA system (formerly InfoHubs) provides a platform for case surveillance by creating linked, longitudinal records for Tier.net data. Case surveillance would be a use case for CHISA, particularly given its potential to provide linked clinical and lab data to the NICD and NDoH for further integration of other data sources including mortality, and this functionality will be evaluated in the context of the developing National Digital Health Strategy.<br><br>As of November 2020, South Africa's unique identifier register the Health Patient Registration System (HPRS) has been deployed in 3,059 health facilities, representing 83% of NDOH-supported health facilities, and has registered 45.3 million individuals representing 78% of the total population of South Africa.<br><br>**<u>Issues or Barriers:</u>**<br>• Changes in HMIS oversight at the NDOH have shifted the lines of reporting and centers of decision making. This presents both challenges and opportunities |
| 17) Improved access to data for Patient and Program Management | **<u>Status</u>: In-process** |

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| | • **<u>Issues or Barriers</u>:** Prior to June 2020, PEPFAR SA partners and facilities had access to patient-level reports from the TIER.Net system that were critical in providing timely and efficient patient management and program monitoring activities. Patient- and facility-level electronic data allowed partners and facilities to rapidly develop and manage real-time, daily, or weekly lists of patients who required urgent clinical or laboratory actions such as tracing and tracking activities, receiving SMS/calls reminders for upcoming clinical/laboratory appointments, identifying virally unsuppressed patients, or pre-identifying and flagging patients eligible for specific services such as DMOC enrollment, TLD transitioning, TPT initiations, or viral load tests.<br><br>• As noted above, recent changes in information systems oversight at the national level present challenges and opportunities in terms of access to data. It presents opportunities for dialogue. In COP21 and continuing into CO22, PEPFAR SA will work with the new NHI Digital Health Unit to explore opportunities for supporting the country's vision of electronic medical records and greater access to data to ensure program progress and accountability while complying with the POPIA. |
| 18) Improved data access (to facilitate person centered services) | **<u>Status</u>: In-process**<br><br>**<u>Issues or Barriers</u>:**<br>• The timelines for TIER.Net dispatch collection at the end of each reporting period are quite tight; facilities are given 5-10 days to complete data capture and cleaning activities which has proven to be inadequate for many facilities/ districts. This leads to submission of incomplete datasets. The timeline is in accordance with the DoH's District Health Management Information (DHMIS) policy that prescribes for dispatches to be submitted to the sub-districts by the 10th of next month following the end of the quarter. Increased frequency of data collection and submission per reporting period would provide more complete and higher quality data. This would enable District and Provincial DOHs to review data more frequently and identify data quality and performance challenges for action. In COP22, PEPFAR SA will explore opportunities for addressing these challenges. |

# APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

During COP22 planning, the country team reviewed the SID and South Africa Resource Allocation results to provide insights into where there may be potential opportunities to increase domestic responsibility for the HIV response. This document outlines proposed actions that will be taken during COP22 implementation (FY23) to facilitate the shift towards greater domestic resources, responsibility, and ownership as part of a broader, long-term approach to achieving sustainable control of the HIV/AIDS epidemic. The narrative, below, describes specific, detailed answers to the following questions:

- Are there misalignments or gaps between investments in program areas required for achieving epidemic control and a sustainable response and related outcomes?
- Are there elements of the response that would be relatively easy and straightforward for the partner country government and/or local partners to take on greater responsibility?
- How will country teams begin engaging with the partner country government during COP22 implementation (FY23) to ensure sustainability of core elements of the HIV response?

## 1. Misalignments between Investments and Outcomes

Based on the LAST analysis (Table S1, Investment Profile) conducted in February 2022, PEPFAR SA has downward funding trends across most program areas and flatline budgets for the care and treatment program. However, due to continuous efforts to review and refine programming, PEPFAR SA activities are generally well-aligned in terms of how investments target local needs and the outcomes achieved. The sections above document in detail how target setting and prioritization of activities have taken place with local needs and data in mind. Below is additional information on investment/outcome alignment for a few key areas, including where shifts will be necessary in coming years.

*Above-site investments*

PEPFAR SA's above-site budget is limited. Budget for above-site activity has decreased significantly since 2018 (Figure E.1.3). Thus, activities for COP22 have been selected to address the most critical health systems components, including: Human Resources for Health (HRH) strategy, planning and coordination; support for policy advances, governance, and coordination; strengthening of laboratory systems; further development of the supply chain; fit-for-purpose health financing processes; and interoperable Health Information Management Systems (HMIS) with movement toward electronic patient records—all of which are taking into account the shifting environment as the country moves to National Health Insurance (NHI). The above-site portfolio also supports all strategic marketing activities, which provide cross-cutting support to the care and treatment program. Expected outcomes of all above-site support include: improved program efficiencies and effectiveness; gains in technical and allocative efficiency with regard to budgeting and expenditure; progress toward key policy advances necessary to facilitate the country's achievement of epidemic control; and ultimately, the resiliency and capacity to sustain epidemic control over time. However, it is important to keep in

mind that these investments require long-term commitment in order to fully realize their potential.

*Key Populations*

As noted above, modeling predicts that approximately 40% of new infections in South Africa could be attributable to Key Populations (KP) and their partners.[40] Acknowledging the importance of addressing KP needs, PEPFAR SA has provided increases in year-on-year funding in this area. Moving toward sustainability will require that the GoSA likewise increases its investment and overall responsibility for prevention and treatment services targeting KP. As noted above, some of this is already occurring, with the GoSA launching Centers of Excellence. Additionally, PEPFAR SA will conduct KP population size estimation and assist the GoSA in the development of a National M&E Framework for Key Populations.

*Private sector engagement*

The launch of the Private Sector HIV Response Strategy Framework (PSRF) in March 2022 will be an important milestone in advancing and strengthening the national response and work of the South African National AIDS Council (SANAC) to better monitor and report on the progress of the National Strategic Plan (NSP). The PSRF will facilitate the establishment of provincial Private Sector Forums; the NSP alignment and catch-up plans for HIV, TB and STI services in provincial forums; and support for resource mobilization committees. Through these activities and partnership with the government, PEPFAR SA anticipates a gradual increase of domestic resource allocation as PEPFAR SA support declines.

[40] Stone J et al. Estimating the contribution of key populations towards HIV transmission in South Africa. J Int AIDS Soc. 2021 Jan;24(1):e25650. doi: 10.1002/jia2.25650. PMID: 33533115; PMCID: PMC7855076.

## Figure E.1.1. Trends in Investments and SID Scores for System-Related Elements

| SID Scores Reported in Table 6 | | | | | Above Site Activities and Budget Reported in Table 6 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| SID Score | | | | | | COP18 | COP19 | | COP20 | | |
| SID Element | Element | 2017 | 2019 | 2021 | SID Budget Element | Activities | Activities | Budget | Activities | Budget | |
| Governance, Leadership & Accountability | 1. Planning and Coordination Score: | 9.17 | 7.50 | 10.00 | Planning and Coordination | 3 | 1 | $ 220,000.00 | | | |
| | 2. Policies and Governance Score: | 8.87 | 7.62 | 6.96 | Policies and Governance | 3 | 1 | 440000 | 7 | $8,011,700 | |
| | 3. Civil Society Engagement Score: | 9.04 | 6.00 | 6.54 | Civil Society Engagement | | 1 | $ 3,220,000.00 | 2 | $405,000 | |
| | 4. Private Sector Engagement Score: | 9.17 | 9.17 | 8.68 | Public Access to Information | 5 | | | | | |
| | 5. Public Access to Information Score: | 8.00 | 9.33 | 7.00 | Service Delivery | 5 | 1 | $ 1,276,000.00 | | | |
| National Health System & Service Delivery | 6. Service Delivery Score: | 6.71 | 7.00 | 5.22 | Human Resources for Health | 3 | | | 5 | $10,078,996 | |
| | 7. Health Workforce Score: | 6.16 | 6.39 | 6.75 | Commodity Security and Supply Chain | 5 | 5 | $ 3,897,000.00 | 5 | $7,940,354 | |
| | 8. Commodity Security and Supply Chain Score: | 6.92 | 7.51 | 7.51 | Quality Management | 1 | | | | | |
| | 9. Quality Management Score: | 8.00 | 5.67 | 6.33 | Laboratory | 1 | 5 | $ 2,904,000.00 | 3 | $4,477,500 | |
| | 10. Laboratory Score: | 9.58 | 8.89 | 8.62 | Domestic Resource Mobilization | | | | 5 | $4,208,100 | |
| Strategic Financing & Market Openness | 11. Domestic Resource Mobilization Score: | 8.53 | 8.41 | 7.46 | Technical and Allocative Efficiencies | 3 | | | | | |
| | 12. Technical and Allocative Efficiencies Score: | 9.28 | 9.28 | 8.90 | Epidemiological and Health Data | 8 | 24 | $ 12,420,000.00 | 15 | $16,217,759 | |
| | 13. Market Openness Score: | | 8.13 | 9.58 | Financial/Expenditure Data | 1 | 2 | $ 1,001,066.00 | | | |
| Strategic Information | 14. Epidemiological and Health data Score: | 6.90 | 6.69 | 5.68 | Performance Data | 3 | 3 | 1155567 | | | |
| | 15. Financial/Expenditure data Score: | 8.33 | 9.17 | 9.17 | | | | | | | |
| | 16. Performance Data Score: | 8.83 | 7.80 | 6.58 | | | | | | | |
| | 17. Data for Decision-Making Ecosystem Score: | | 5.33 | 5.86 | | | | | | | |

**Figure E.1.2. Percent Responsibility Ratings from Responsibility Matrix**

| | % Primary Responsibility Ratings from Responsibility Matrix | | | |
|---|---|---|---|---|
| | | **Host Country** | **PEPFAR** | **Global Fund** |
| Dimensions of Support | Service Delivery | 90% | 6% | 4% |
| | Non-Service Delivery | 74% | 17% | 10% |
| Functional Elements | Strategy Formulation and Planning | 93% | 7% | 0% |
| | Site-Level Programs | 80% | 13% | 5% |
| | Commodities | 90% | 10% | 0% |
| | Health Workforce | 68% | 19% | 44% |
| | Above Site (Systems) Programs | 95% | 4% | 2% |
| | Program Management | 33% | 33% | 33% |

| | % Secondary Responsibility Ratings from Responsibility Matrix | | | |
|---|---|---|---|---|
| | | **Host Country** | **PEPFAR** | **Global Fund** |
| Dimensions of Support | Service Delivery | 0% | 68% | 32% |
| | Non-Service Delivery | 13% | 58% | 29% |
| Functional Elements | Strategy Formulation and Planning | 5% | 67% | 28% |
| | Site-Level Programs | 8% | 56% | 36% |
| | Commodities | 9% | 82% | 9% |

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| | Health Workforce | 0% | 33% | 67% |
| | Above Site (Systems) Programs | 2% | 70% | 28% |
| | Program Management | 33% | 33% | 33% |

| | % Nominal or None Responsibility Ratings from Responsibility Matrix | | | |
|---|---|---|---|---|
| | | **Host Country** | **PEPFAR** | **Global Fund** |
| Dimensions of Support | Service Delivery | 8% | 26% | 67% |
| | Non-Service Delivery | 2% | 26% | 72% |
| Functional Elements | Strategy Formulation and Planning | 0% | 16% | 84% |
| | Site-Level Programs | 4% | 0% | 96% |
| | Commodities | 0% | 4% | 96% |
| | Health Workforce | 11% | 56% | 33% |
| | Above Site (Systems) Programs | 0% | 45% | 55% |
| | Program Management | 0% | 0% | 0% |

Figure E.1.3. Assessing South Africa's PEPFAR Expenditure Trends by Interaction Type and Epidemic Control Status

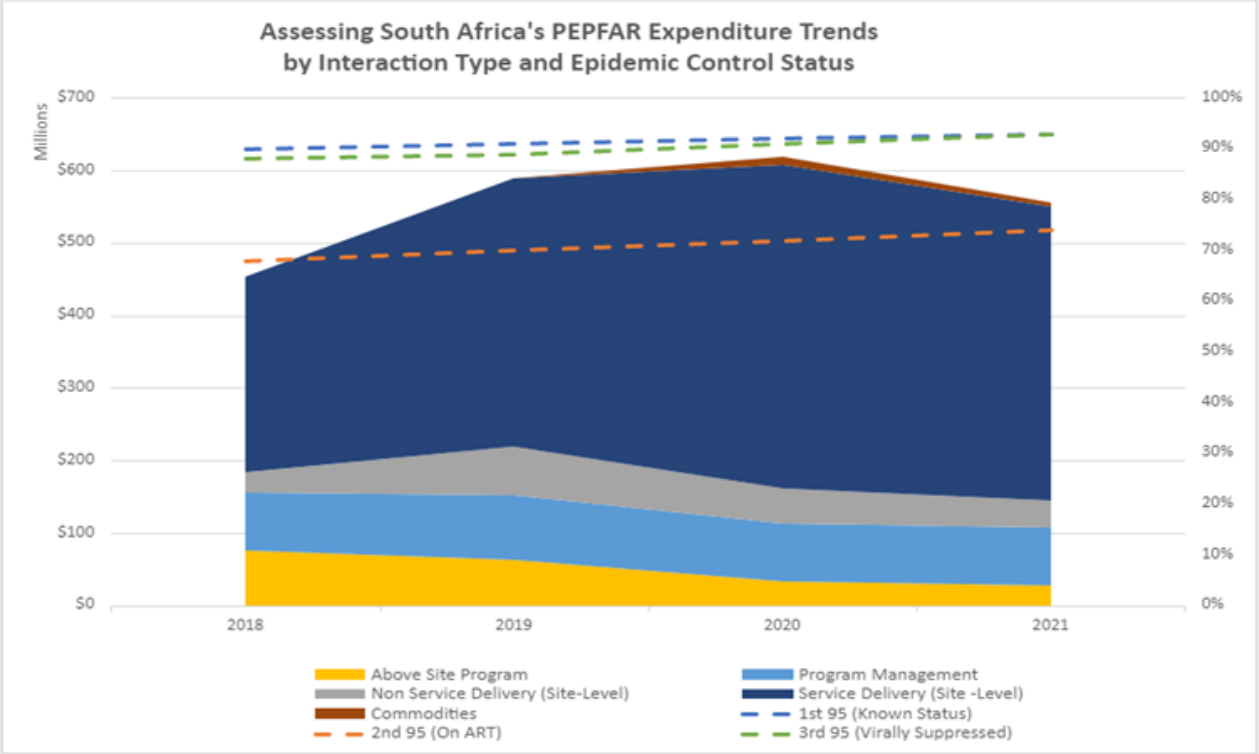
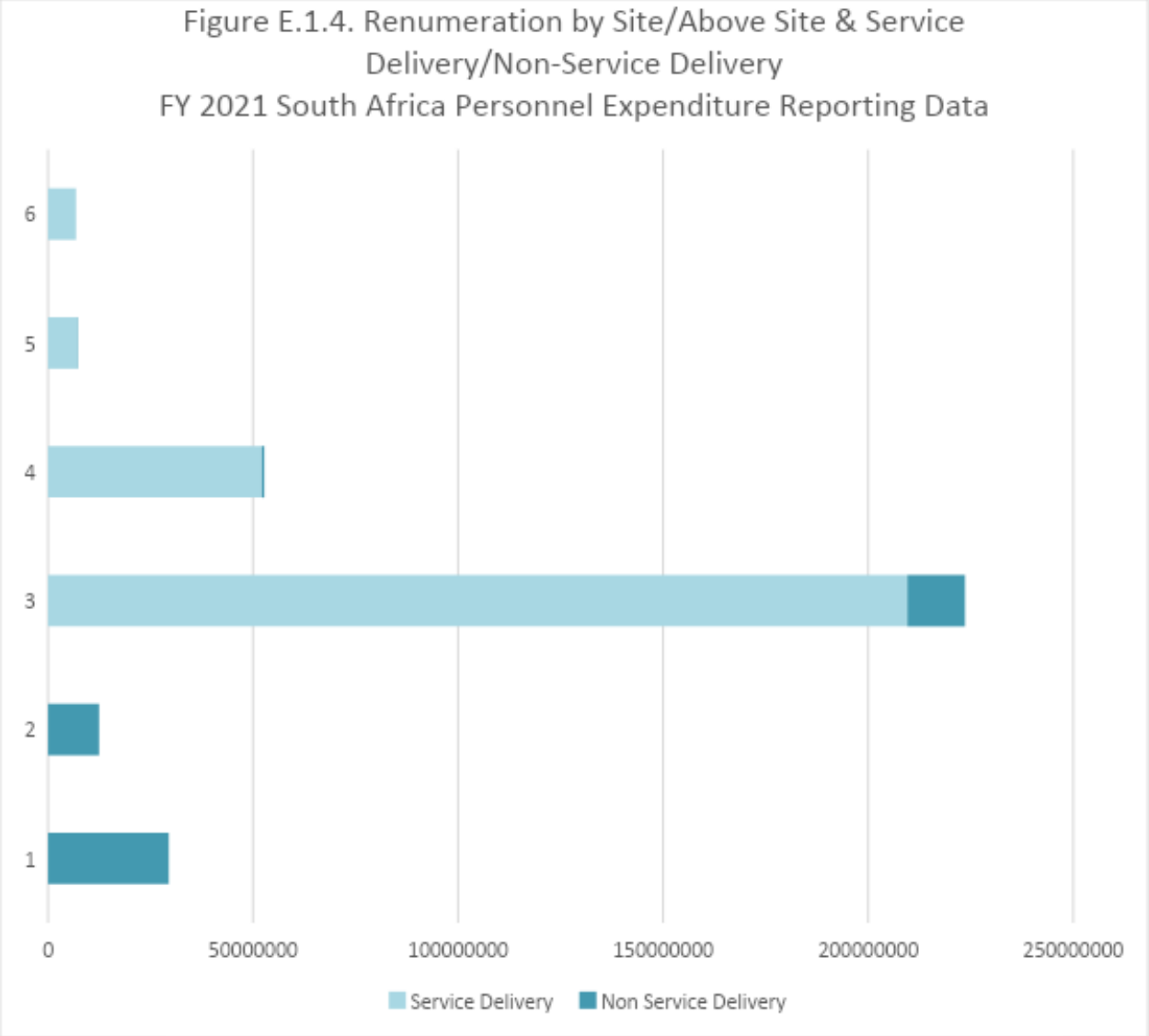


**Figure E.1.4. Remuneration by Site/Above-Site & Service Delivery/Non-Service Delivery**




## 2. Areas for Transition

*Patient-level HMIS*

The goal of the South African National Health Act, Section 74, is that the NDoH be able to fund, facilitate, and coordinate the development, implementation, and maintenance of a comprehensive national health information system that links provincial, district health council, municipal, and private health sector information systems. However, over the years, the patient-level HMIS space in the country has become characterized by vertical systems addressing specific health program needs. The country's three-tiered approach to government and lack of coordination in the donor space has also resulted in duplication, gaps, and challenges with interoperability between provincial and national systems. All of this has contributed to duplication and fragmentation of information and barriers to evidence-based decision-making in the health sector. A unified, interoperable information system would assist the NDoH and

provincial DOHs in making more informed decisions on all aspects of service provision, budgeting, and management.

PEPFAR SA has supported a number of patient-level information systems in South Africa over time. Recent efforts to transition financial responsibility for further development and operation of two systems in particular have been slow and plagued by challenges, including financial pressure from the SARS-CoV-2 pandemic. The two systems are: 1) the Synchronized National Communication in Health (SyNCH) system which supports CCMDD program monitoring and 2) Consolidated Health Informatics South Africa (CHISA), which contains longitudinal Tier.net clinical and demographic data for all HIV/TB patients nationally. New developments in the NDoH resulting from increased pressure to prepare for NHI, have presented opportunities for advancements in this space. As noted above in Section 5.0, the newly created NHI Digital Health Unit will conduct an HMIS audit in mid 2022 and has publicly stated a desire for the NDoH to have central responsibility in all further technological HMIS developments.

*HRH information systems*
Information systems for HRH planning and deployment are another area characterized by gaps and fragmentation. This is particularly true given the public-private divide in the health system. As the country approaches NHI, there is an urgent need for integrated tools. PEPFAR SA has supported the Human Resources Information System (HRIS) and KnowledgeHub for some time. The former brings together GoSA public sector data and data from a number of other sources. The latter is an online platform for self-directed training by health care workers. Transition efforts for KnowedgeHub are underway, and the same is required for HRIS in the near future. However, there are calls for integration of these two systems, and PEPFAR SA's role remains unclear.

*HIV self-testing*
Another potential area for greater responsibility on the part of the GoSA is the procurement of HIV self-test kits. HIV self-testing is a high priority intervention for PEPFAR, has high positivity yield in South Africa, and has proven to be accessible to most vulnerable populations. Plans for scale up at the community level are underway. The HIV Testing TWG has started a discussion with the NDoH on progressive responsibility. PEPFAR SA will supplement government purchases in COP22 while preparing the necessary projections, budget estimates, and processes for complete ownership and domestic responsibility during COP23.

## 3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

At the national level, PEPFAR SA engages directly with the NDoH, SANAC, and other sections of the GoSA. Quarterly meetings are held to discuss progress towards achieving the 95-95-95 goals. There are monthly engagements on Operation Phuthuma (Siyenza) data and many other routine meetings with GoSA for program and above-site activities, including with HIV/TB program teams at the various levels of GoSA, and in national expenditure assessment activities. Transition of support or activities are discussed in detail during workstream meetings including timelines. Leadership in the GoSA, including those representing NHI, and the National Treasury have recently proposed quarterly meetings on above-site supported activities.

PEPFAR SA representatives also actively participate in the technical working groups of SANAC, the GFATM Country Coordinating Mechanism, and other Civil Society engagement. These include Civil Society Forum Meetings, Provincial AIDS Council Meetings, and continued

community-led monitoring efforts. PEPFAR SA engages with SANAC on the development and monitoring of implementation of the NSP. Drafting of the new 2024-2029 NSP is underway, led by SANAC, and PEPFAR SA representatives are contributing.

Finally, the PEPFAR SA team in COP22 will continue to facilitate meetings with the PLHIV sector of SANAC to strengthen a community-led monitoring program (Ritshidze) which is used in multiple part of the heath system to identify service delivery challenges and mitigation strategies.

## 4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

All current and future agreements on data sharing will be evaluated to ensure alignment with the new NHI Digital Health Unit's data sharing framework in compliance with the Protection of Public Information Act (POPI Act). All data-related negotiations will be coordinated from the PEPFAR SA Coordinator's Office.