2017 Sustainability Index and Dashboard Summary: South Africa

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 89 questions, the SID assesses the state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Dark Green Score (8.50-10 points) **(sustainable and requires no additional investment at this time)**
Light Green Score (7.00-8.49 points) **(approaching sustainability and requires little or no investment)**
Yellow Score (3.50-6.99 points) **(emerging sustainability and needs some investment)**
Red Score (<3.50 points) **(unsustainable and requires significant investment)**

Country Overview: In support of the 2017-2022 South Africa National Strategic Plan for HIV, Tuberculosis (TB), and Sexually Transmitted Infections (STIs) (hereafter referred to as the NSP), the Government of South Africa (GoSA) works in partnership with donor agencies and civil society to implement public health and social programs aimed at epidemic control. Core to the new NSP is ***Focus for Impact***, both geographically—where the 27 highest-burden districts have been prioritized—and based on populations—where adolescent girls and young women and key populations (sex workers, men who have sex with men, transgender people, people who inject drugs, and prisoners) have been prioritized. Provincial and District Implementation Plans are used to better implement the NSP through South Africa's decentralized government structures. The SID 2017 findings highlight GoSA's leadership and the collaboration with multiple stakeholders. Multi-sectoral coordination structures are in place at national, provincial, district, and local levels. These structures are increasingly using data for priority setting, program management, and decision-making. Budgets are in place at national and provincial levels to implement policies and programs. Whilst many key public health policies are in place, there is a need for increased focus on policy operationalization and implementation strengthening.

SID Process: A key part of the SID process took place on 6 November 2017 in Pretoria, South Africa. A total of 45 participants representing GoSA, the South Africa National AIDS Council (SANAC) secretariat, civil society groups, and donor organizations (PEPFAR, UNAIDS, GIZ) convened together for a one-day workshop to discuss sustainability issues and complete the tool. Participants were asked to join one of four groups, which related to the different SID domains. Participants were grouped according to the various sector/program areas they were primarily involved in to meaningfully contribute towards the consultative assessment.

Sustainability Strengths:

The results of the 2017 SID exercise clearly show continued strong national leadership and control over the HIV response, indicated by eight out of 15 domains receiving a score of nine and above (dark green) and another three scored eight and above (light green). Amongst the sustainability elements with the highest scores, two are worth being briefly highlighted here:

1. Planning and coordination (Score 9.17)

The SID indicated highlighted GoSA's commitment to ensuring multi-stakeholder consultations occur in the development of strategic policy guidelines. This was most evident in the drafting of the 2017-2022 South Africa NSP, where consultations were documented to ensure inclusion in this important strategic plan. The NSP

development processes included national, provincial, and district consultations. These efforts have been supported by the GoSA ensuring that budgets are in place at national, provincial, and district levels.

12. Technical and allocative efficiencies (Score 9.28)
In 2016, the SANAC and National Department of Health (NDoH), with support from key South African organizations and development partners, prepared the South African HIV and TB Investment Case which identified the programmatic areas and activities of highest return on investment towards achieving epidemic control. To accelerate treatment and retention programs in South Africa, the NDoH continues to improve data quality and use for priority setting, program management, and decision making. This is most reflective in the recent initiatives by the NDoH to develop and implement a Treatment and Retention Acceleration Plan and Standard Operating Procedures which provide guidance and accountability processes to enforce province, district, and facilities' improved program reporting, data review, analysis, and use for remediation actions.

Sustainability Vulnerabilities: Despite progress towards sustainability, there are four elements where the score falls below seven and is highlighted in yellow. Two of the sustainability vulnerabilities are:

6. Service Delivery (6.71)
Provision and financing of services for key populations is a vulnerable area, as South African institutions rely often on external partners to deliver those services and only a minor part of those services have been financed through domestic resources.

7. Human Resources for Health (6.16)
HRH is one of the other key vulnerabilities that present a challenge to sustainability of the national response. While the vast majority of the health workers salaries are being provided by the GoSA, there is concern about the supply of trained health care workers, vacancies, and transition plans for the limited number of donor-funded health care workers.

Additional Observations: South Africa's HIV response is led and in large part financed by the GoSA; however, there is a need for more investment in effective and efficient delivery of HIV prevention interventions to considerably reduce the number of new infections. South Africa has the world's largest HIV treatment program and the longer-term continuation of this programme for decades to come needs full integration of the HIV care and treatment program into the national health insurance scheme.

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Sustainability Analysis for Epidemic Control: South Africa

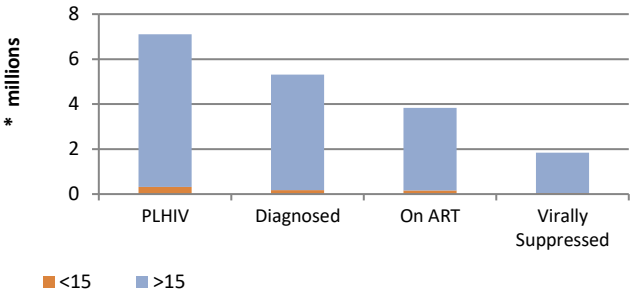
Epidemic Type: Generalized
Income Level: Upper middle income
PEPFAR Categorization: Long-term Strategy (Co-finance)
PEPFAR COP 17 Planning Level: $483 million (+ $51 million central VMMC funds)

SUSTAINABILITY DOMAINS and ELEMENTS

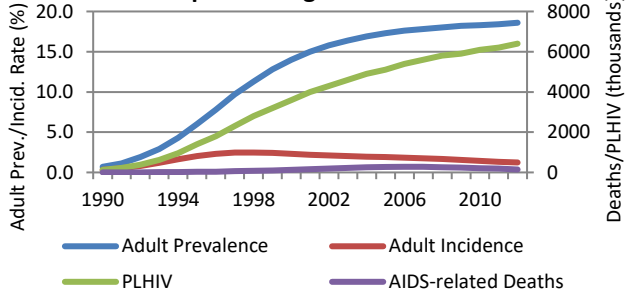
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.67	9.17		
2. Policies and Governance	8.45	8.87		
3. Civil Society Engagement	7.33	9.04		
4. Private Sector Engagement	6.50	9.17		
5. Public Access to Information	10.00	8.00		
National Health System and Service Delivery				
6. Service Delivery	7.69	6.71		
7. Human Resources for Health	6.97	6.16		
8. Commodity Security and Supply Chain	4.67	6.92		
9. Quality Management	8.38	8.00		
10. Laboratory	6.67	9.58		
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	8.61	8.53		
12. Technical and Allocative Efficiencies	8.61	9.28		
Strategic Information				
13. Epidemiological and Health Data	6.77	6.90		
14. Financial/Expenditure Data	9.58	8.33		
15. Performance Data	8.73	8.83		

CONTEXTUAL DATA

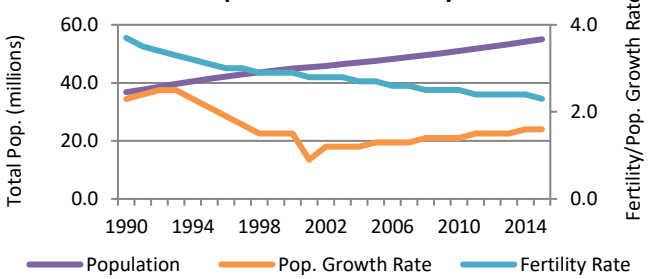
National DoH Clinical Cascade (3/17)



Epidemiological Data

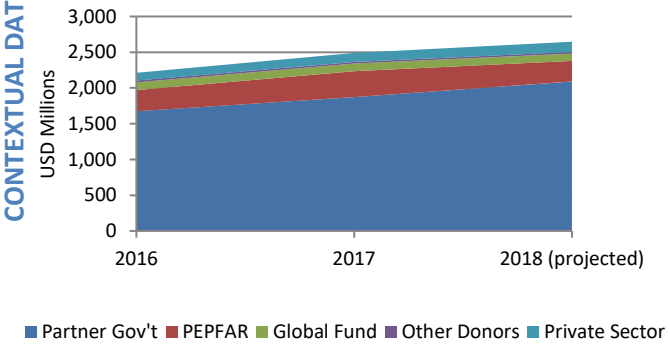


Population and Fertility

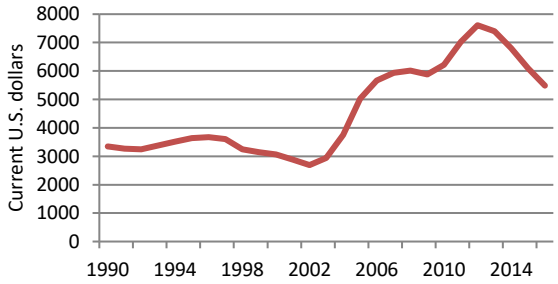


CONTEXTUAL DATA

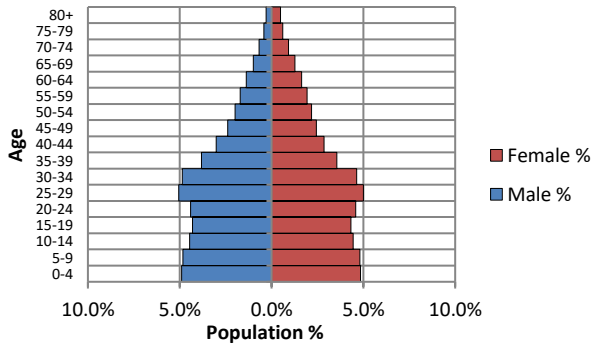
Financing the HIV Response



GNI Per Capita (Atlas Method)



Population Pyramid (2017)



Domain A. Governance, Leadership, and Accountability

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, provides accurate information and education on HIV/AIDS, and supports mechanisms for eliciting feedback. Relevant government entities take actions to create an enabling policy and legal environment, ensure good stewardship of HIV/AIDS resources, create space for and promote participation of the private sector, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.			**Data Source**	**Notes/Comments**
1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. There is no national strategy for HIV/AIDS ◉ B. There is a multiyear national strategy. Check all that apply: ☑ It is costed ☑ It has measurable targets. ☑ It is updated at least every five years ☑ Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics) ☑ Strategy includes explicit plans and activities to address the needs of key populations. ☑ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children ☑ Strategy (or separate document) includes considerations and activities related to sustainability	1.1 Score: 2.50	NSP 2017 -2022	There needs to be a separate document on sustainability with granular data.
1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?	○ A. There is no national strategy for HIV/AIDS ◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply): ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy ☑ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy ☑ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR) ☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy	1.2 Score: 2.50	NSP 2017 -2022	Broader private sector was consulted. Stakehodlers invited to make comments on the draft NSP. Some private health sector companies provided input. Consultations were precisely documented. Workshops and meeting reports are available, as well as written feedback from different spaces.

1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Check all that apply: ☑ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc. ☑ The host country government routinely tracks and maps HIV/AIDS activities of: ☐ civil society organizations ☐ private sector (including health care providers and/or other private sector partners) ☑ donors ☑ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes. ☑ Joint operational plans are developed that include key activities of implementing organizations. ☐ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 1.67	DIPS & MDIPS	DSD tracks NPOs through the NPO Registration process: these inlude NPO's that are contracted and monitored at different levels of government, through various procurement processess. DOH also tracks funding given to organisations. Structure for reporting is in place with routine tracking and monitoring. For She Conquers, reviewing areas for duplication and assessing the scope of activities and services provided challenging. This is an area that we need to work on in the future. Routine tracking should be improved. SANAC as the coordinating mechanism should take on this responsibility.The South African govenment continues to update on information on what NGOs are supported to do, and what their contributions are. In addition, Civil society is requesting for specific funding so govt is asking what are we paying for.
1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for either checkbox under option B)	○ A. There is no formal link between the national plan and sub-national service delivery. ◉ B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.) ☑ Sub-national units have performance targets that contribute to aggregate national goals or targets. ☐ The central government is responsible for service delivery at the sub-national level.	1.4 Score: 2.50	Annual Performance Plan	We ticked B1 but there is scope for improvement. The question is interpreted as the national government is not responsible for service delivery, it has been decentralised to the provincial level.
		Planning and Coordination Score: 9.17		

2. Policies and Governance: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Data Source**	**Notes/Comments**
2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current WHO guidelines for initiation of ART, i.e. Test and START for all populations?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines for each of the following: A. Adults (>19 years) ☑ Yes ☐ No B. Pregnant and Breastfeeding Mothers ☑ Yes ☐ No C. Adolescents (10-19 years) ☑ Yes ☐ No D. Children (<10 years) ☑ Yes ☐ No	2.1 Score: 1.11	WHO guidelines; NDOH guidelines - Test & Treat Guidelines; Option B+, PMTCT Guidelines,	

2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery? Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.	Check all that apply: ☑ A national public health services act that includes the control of HIV ☑ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☐ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits ☑ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) ☑ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) ☑ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☑ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS ☑ Policies that permit HIV self-testing ☑ Policies that permit pre-exposure prophylaxis (PrEP) ☑ Policies that permit post-exposure prophylaxis (PEP) ☑ Policies that allow HIV testing without parental consent for adolescents, starting at age 15 ☐ Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent	2.2 Score: 0.93	NIMAART, CCMDD, Childrens Act; HTS guidelines	Provision for self screening is in the HTS guidelines.

2.3 Data Protection: Does the country have policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS?	The country has policies in place that (check all that apply): ☑ Govern the collection of patient-level data for public health purposes, including surveillance ☐ Govern the collection and use of unique identifiers such as national ID for health records ☑ Govern the privacy and confidentiality of health outcomes matched with personally identifiable information ☑ Govern the use of patient-level data, including protection against its use in crimincal cases	2.3 Score: 0.83	The Protection of Personal Information (POPI) act, Public Health Act	Second option: lots of discussion around UPI - just not completed yet. POPI is not specific to health. UPI still under discussion
2.4 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?	Check all that apply: Transgender people (TG): ☑ Constitutional prohibition of discrimination based on gender diversity ☑ Prohibitions of discrimination in employment based on gender diversity ☐ A third gender is legally recognized ☐ Other non-discrimination provisions specifying gender diversity (note in comments) Men who have sex with men (MSM): ☑ Constitutional prohibition of discrimination based on sexual orientation ☑ Hate crimes based on sexual orientation are considered an aggravating circumstance ☑ Incitement to hatred based on sexual orientation prohibited ☑ Prohibition of discrimiation in employment based on sexual orientation ☐ Other non-discrimination provisions specifying sexual orientation Female sex workers (FSW): ☑ Constitutional prohibition of discrimination based on occupation ☐ Sex work is recognized as work ☐ Other non-discrimination protections specifying sex work (note in comments)	2.4 Score: 0.69	Constitution of SA; Labour Relations Act; Employment Equity Act; Basic Conidtions of Employment, National LGBTI plan. Sexworker plan. Criminal procedures Act. National Drug Master Plan	LGBTI plan and sex worker plan availalbe but not legislated.

	People who inject drugs (PWID): ☐ Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments) ☑ Explicit supportive reference to harm reduction in national policies ☐ Policies that address the specific needs of women who inject drugs			
2.5 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?	The country has the following to protect key populations and people living with HIV (PLHIV) from violence: ☑ General criminal laws prohibiting violence ☑ Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population ☑ Programs to address intimate partner violence ☑ Programs to address workplace violence ☑ Interventions to address police abuse ☑ Interventions to address torture and ill treatment in prisons ☐ A national plan or strategy to address gender-based violence and violence against women that includes HIV ☑ Legislation on domestic violence ☑ Criminal penalties for domestic violence ☑ Criminal penalties for violence against children	2.5 Score: 1.00	Constitution, National Prosecuting Authority programmes, Independent Police Directorate (IPD), National Strategic Plan on Gender Based Violence Shadow Framework. Judicial Inspectorate for Correctional Services. 2013 Prevention and combating of torture Act - implemented by IPID; Childrens Act	National Strategic Plan on Gender Based Violence Shadow Framework. - government not consulted

2.6 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services?	**For each question, select the most appropriate option:** Are transgender people criminalized and/or prosecuted in the country? ☐ Both criminalized and prosecuted ☐ Criminalized ☐ Prosecuted ☑ Neither criminalized nor prosecuted Is cross-dressing criminalized in the country? ☐ Yes ☐ Yes, only in parts of the country ☐ Yes, only under certain circumstances ☑ No Is sex work criminalized in your country? ☑ Selling and buying sexual services is criminalized ☐ Selling sexual services is criminalized ☐ Buying sexual services is criminalized ☐ Partial criminalization of sex work ☐ Other punitive regulation of sex work ☐ Sex work is not subject to punitive regulations or is not criminalized. ☐ Issue is determined/differs at subnational level	2.6 Score: 0.97	Sexual Offenses Act		

Does the country have laws criminalizing same-sex sexual acts?

- ☐ Yes, death penalty
- ☐ Yes, imprisonment (14 years - life)
- ☐ Yes, imprisonment (up to 14 years)
- ☐ No penalty specified
- ☐ No specific legislation
- ☐ Laws penalizing same-sex sexual acts have been decriminalized or never existed

Does the country maintain the death penalty in law for people convicted of drug-related offenses?

- ☐ Yes, with high application (sentencing of people convicted of drug offenses to death and/or carrying out executions are a routine and mainstreamed part of the criminal justice system)
- ☐ Yes, with low application (executions for drug offenses may have been carried out in recent years, but in practice such penalties are relatively rare)
- ☐ Yes, with symbolic application (the death penalty for drug offenses is included in legislation, but executions are not carried out)
- ☐ No

Does the country have laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission?

- ☐ Yes
- ☐ No, but prosecutions exist based on general criminal laws
- ☐ No

Does the country have policies restricting the entry, stay, and residence of people living with HIV (PLHIV)?

- ☐ Yes
- ☐ No

	Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people? ☐ Yes, promotion ("propaganda") laws ☐ Yes, morality laws or religious norms that limit LGBTI freedom of expression and association ☑ No			
2.7 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	There are host country government efforts in place as follows (check all that apply): ☑ To educate PLHIV about their legal rights in terms of access to HIV services ☑ To educate key populations about their legal rights in terms of access to HIV services ☑ National law exists regarding health care privacy and confidentiality protections ☑ Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	2.7 Score: 1.11	IEC materials; HTA programme;The Protection of Personal Information (POPI) Act; Legal Aid	
2.8 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?	○ A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. ○ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. ◉ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.	2.8 Score: 1.11	Annual audit reports	
2.9 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?	○ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. ○ B. The host country government does respond to audit findings by implementing changes as a result of the audit. ◉ C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.	2.9 Score: 1.11		
	Policies and Governance Score:	**8.87**		

3. Civil Society Engagement: Local civil society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.			**Data Source**	**Notes/Comments**
3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. ○ B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen. ◉ C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.	3.1 Score: 1.67		Civil Society was not in the room to input into answers for this set of questions but the rest of the team had consensus on the answers.
3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. There are no formal channels or opportunities. ○ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. ◉ C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☑ In joint annual program reviews ☑ For policy development ☑ As members of technical working groups ☐ Involvement on government HIV/AIDS program evaluation teams ☐ Involvement in surveys/studies ☑ Collecting and reporting on client feedback ☑ Service delivery	3.2 Score: 1.25	LGBTI plan; Test&Treat; New Department of Basic Education policy; She Conquers; Self Testing policy; through SANAC Structures	

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply): ☑ In policy design ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☐ In HIV/AIDS basket or national health financing decisions	3.3 Score: 1.33	NSP 2017-2022; She Conquers; The South African Government participates on the CCM of the Global Fund; Through the AIDS Councils (reflected in the SANAC Procedural Guidelines)	
3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)	○ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources. ○ B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ◉ E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).	3.4 Score: 3.33	Through Department of Social Development and Department of Health, Conditional Grant	
3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)? Note: This sometimes referred to as "social contracting" or "social procurement."	○ A. There is no law, policy, ore rgulation which permits CSOs to be funded from a government budget for HIV Services through open competition (not to include Global Fund or other donor funding to government that goes to CSOs). ◉ B. There is a law, policy or regulation which permits CSOs to be funded from a government budget for HIV services. Check all that apply: ☑ Competition is open and transparent (notices of opportunities are made public) ☑ Opportunities for CSO funding are made on an annual basis ☑ Awards are made in a timely manner (within 6-12 months of announcements) ☐ Payments are made to CSOs on time for provision of services	3.5 Score: 1.46	Central Treasury database	Payments not always made in time, but they are usually made.
		Civil Society Engagement Score:	**9.04**	

4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.			**Data Source**	**Notes/Comments**
4.1 Government Channels and Opportunities for Private Sector Engagement: Does the host country government have formal channels and opportunities for diverse private sector entities (including service delivery, corporations, and private training institutions) to engage and provide feedback on its HIV/AIDS policies, programs, and services? (If option B is true, check all subsequent boxes that apply.)	○ A. There are no formal channels or opportunities for private sector engagement. ◉ B. There are formal channels or opportunities for private sector engagement. i. The following private sector stakeholders formally contribute input into national or sub-national processes for HIV/AIDS planning and strategic development (check all that apply): ☑ Corporations ☑ Employers ☑ Private training institutions ☑ Private health service delivery providers ii. Stakeholders contribute in the following ways (check all that apply): ☑ The private sector contributes technical expertise into HIV program planning ☑ Data and strategic input into supply chain management for HIV commodities ☐ Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning ☑ Data on staffing in private health service delivery providers ☑ Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning ☑ For technical advisory on best practices and delivery solutions	4.1 Score: 2.08	SANAC Procedural Guidelines; NSP 2017-2022; SANAC Private Sector Strategy	

	iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply): ☑ The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response. ☑ A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan ☐ The government and private sector effectively coordinates and executes a total market approach for HIV service delivery, which accounts for whether people are able and/or willing to pay for HIV services.			
4.2 Enabling Environment for Private Corporate Contributions to HIV/AIDS Programming: Does the host country government have systems and policies in place that allow for private corporate contributions to HIV/AIDS programming?	Check all that apply: ☑ Tax policies and incentives are designed to encourage corporate social responsibility efforts from companies who are contributing financial commitments and/or non-financial resources (including, but not limited to, product donations, expertise, and employee staff time). ☑ The host country government has in-house expertise in contracting services to private sector corporations when appropriate and necessary (e.g., transportation and waste management). ☑ The host country government has standards for reporting and sharing data across public and private sectors. ☑ Regulations help ensure that workplace programs align with the national HIV/AIDS program (e.g., medical leave policies, on-site testing, on-site prevention and education, anti-discrimination policies). ☑ There are strong linkage and referral networks between on-site workplace programs and public health care facilities.	4.2 Score: 2.50	Labour Relations Act (LRA), Basic Conditions of Employment Act (BCEA)	

4.3 Enabling Environment for Private Health Service Delivery: Does the host country government have systems and policies in place that allow for private health service delivery? Note: Full score possible without checking all boxes.	○ A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services. ○ B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years. ◉ C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply): ☑ Policies are in place to ensure that private providers receive, understand, and adhere to national guidelines/protocols for ART, and appropriate quality standards and certifications. ☑ Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting. ☐ Joint (i.e., public-private) supervision and quality oversight of private facilities. ☐ The government offers tax deductions for private facilities delivering HIV/AIDS services. ☑ The government offers tax deductions for private training institutions. ☐ The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores ☑ The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services. ☐ HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes ☑ There are open competitions for private health care providers to compete for government service contracts ☐ There is a systematic and timely process for private company registration and/or testing of new health products (e.g., drugs, diagnostic kits, medical devices, etc.) that support HIV/AIDS programming ☑ The government effectively regulates the flow of subsidized commodities into the private sector.	4.3 Score: 2.08	HTS policy, other health policies	Guidelines to report from private facilities is not formalised. In certain sectors eg mining, enter into MOU with DOH. But not all sectors have MOUs.

4.4 Private Sector Capability and Interest: Does the private sector possess the capability to support HIV/AIDS services, and do private sector stakeholders demonstrate interest in supporting the national HIV/AIDS response?	○ A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response. ○ B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response. ◉ C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply): ☑ Market opportunities that align with and support the national HIV/AIDS response ☑ Opportunities to contribute financial and/or non-financial resources to the national response (including business skills, market research, logistics, communication, research and development, product design, brand awareness, and innovation)	4.4 Score:	2.50		
		Private Sector Engagement Score:	**9.17**		

5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.			**Source of Data**	**Notes/Comments**
5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data and analyses are made available to stakeholders and general public in a timely and useful way?	◉ A. The host country government does not make HIV/AIDS surveillance and survey data available to stakeholders and the general public, or they are made available more than one year after the date of collection. ○ B. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within 6-12 months. ○ C. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within six months.	5.1 Score: 0.00		Until 2015 South Africa was doing well. Currently, we are still analysing 2015 ANC prevalence study. Current HSRC study was supposed to release a fact sheet on 01 Dec 17 but they just announced a delay.
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data available to stakeholders and the public in a timely and useful way?	○ A. The host country government does not track HIV/AIDS expenditures. ○ B. The host country government does not make HIV/AIDS expenditure data available to stakeholders and the general public, or they are made available more than one year after the date of expenditures. ○ C. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within 6-12 months after date of expenditures. ◉ D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures.	5.2 Score: 2.00	Annual reports	
5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data available to stakeholders and the public in a timely and useful way?	○ A. The host country government does not make HIV/AIDS program performance and service delivery data available to stakeholders and the general public or they are made available more than one year after the date of programming. ○ B. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within 6-12 months after date of programming. ◉ C. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within six months after date of programming .	5.3 Score: 2.00	Annual reports	

5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. The host country government does not make any HIV/AIDS procurements. ○ B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ○ C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ◉ D. The host country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score: 2.00		
5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for providing scientifically accurate education to the public about HIV/AIDS?	○ A. There is no government institution that is responsible for this function and no other groups provide education. ○ B. There is no government institution that is responsible for this function but at least one of the following provides education: ☐ Civil society ☐ Media ☐ Private sector ◉ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.	5.5 Score: 2.00		Department of Health plays this key role.
		Public Access to Information Score: 8.00		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving prevention, treatment, and care services and interventions. There is a high demand for HIV/AIDS services, which are accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and/or are affected by the HIV/AIDS epidemic.

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.			**Data Source**	**Notes/Comments**
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	☑ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) ☑ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☑ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 1.11	DIPs, DHP, ICSM Manual NSP DHIS program reports	- When plans are done at facility, there is a target setting process for services. These are linked to resources, then go up to province and NDOH. - Funding from Conditional Grants - In 27 priority districts, there is extra staff for service delivery - Q2. Truck Stop & border programs, WBOTs are in some places, not in other places. Needs to scale-up.
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.)	The host country has standardized the following design and implementation components of community-based HIV/AIDS services through (check all that apply): ☑ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services ☑ National guidelines detailing how to operationalize HIV/AIDS services in communities ☐ Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities ☑ Providing financial support for community-based services ☑ Providing supply chain support for community-based services ☑ Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness)	6.2 Score: 0.93	NSP, CCMDD, Aherence Guidelines, War Rooms, Community Health Care Worker Policy Conditional Grant, Business Plan Program Reports Ideal Clinic Manual PHC ReEngineering	- Policy and Framework developed, implementation just started - CHWs have MOU or SLA at a local with CBOs and DOH - Bidirectional Referral Manual is final; policy is under development. Implemenation of guidelines is a challenge.
6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services (i.e. excluding any external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services ◉ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services	6.3 Score: 1.25	Investment Case Conditional Grant NSP outlines who pays for what NHI	Refer to NSP for actual %

6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services without external technical assistance from donors?	○ A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions. ○ B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance. ◉ C. Host country institutions deliver HIV/AIDS services with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.	6.4 Score: 0.74	NSP Partner Reports	DSD has increased
6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations (i.e. without external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations. ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations. ◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.	6.5 Score: 0.83	NSP Conditional Grant	DOH facilities provide HIV services as part of their holistic approach to care. - Need to ID COP & GF funding for KP and calculate accring
6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations without external technical assistance from donors?	○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.37	COP, SDS Program Reports (Tato) Global Fund Concept Note	Key Pops service are supported by Government of South Africa, PEPFAR & Global Fund. DSPs support facility staff to provide high quality KP services in DOH facilities.
6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	National health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☐ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engage with civil society in program planning and evaluation of services. ☐ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.7 Score: 0.74	Annual Performance Plan NSP, Conditional Grant, DHIS	- HIV services integrated into comprehensive approach to service delivery, which is reflected in the SA Primary Health Care model. - Staffing needs are not routinely assessed based on program goals. WISN has been utilized, but has not yet received full potential. - National and Provincial DOH work to understand needs and effectively allocate resources. - Civil Society part of South African National AIDS Commity (SANAC). SANAC leads NSP development. - National performance plans are developed by Department of Public Service & Administration (DPSA). Working to revive clinical mentorship program. Facility (PHC) Supervisory Manual is currently under review.

6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Sub-national health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☐ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engage with civil society in program planning and evaluation of services. ☐ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.8 Score:	0.74		- Data is available, but not used as frequently as necessary. - Use of epi and programmatic data can be enhanced at the district level - Payment challenges w/ NHLS reflect financial payement systems challenges -Province develops business plans, costs activities, and develops budgets - Engagement with Civil Society noted throughout the country, but with various levels of maturity. - Performance management at provincial and district level needs to be improved to reflect individual staff needs
		Service Delivery Score	**6.71**		

7. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Data Source**	**Notes/Comments**
7.1 HRH Supply: To what extent is the clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level?	Check all that apply: ☐ The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers ☐ The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☑ The country has developed retention schemes that address clinical health worker vacancy or attrition in high HIV burden areas ☐ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children	7.1 Score: 0.28	WISN Retention Strategy	- Joint Health, Education & Training Committee that addresses these needs, but planning is currently not part of the agenda. Nothing to inform the pipeline. - WISN results showed that there may be adequate staff in a given district, but there is a need to ensure that staff are deployed appropriately - Retention is supported by on-boarding retention program, rural allowance and Community Service (required post-graduation bonding).
7.2 Role of Community-based Health Workers (CHWs): To what extent are community-based health workers' roles and responsibilities specified for HIV/AIDS service delivery?	Check all that apply: ☑ There is a national community-based health worker (CHW) cadre that has a defined role in HIV/AIDS service delivery (e.g., through a national strategy or task-sharing framework/guidelines). ☐ Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors. ☑ The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services.	7.2 Score: 0.74		- CHW SOW has identified 95% to be focussed on HIV/AIDS service delivery (on average). - CHW financial and worker allocation has not yet been done. - CHWs are recognized and renumerated but not salaried.
7.3 HRH transition: What is the status of transitioning PEPFAR and/or other donor supported HIV/AIDS health worker salaries to local financing/compensation? Note in comments column which donors have transition plans in place.	○ A. There is no inventory or plan for transition of donor-supported health workers ◉ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support ○ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented ○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	7.3 Score: 0.28		No official plan at this time. In the past, there was an agreed upon transition plan, but because of new DSD model and increased funding, they are no longer in effect.

7.4 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) health worker salaries ○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries ○ C. Host country institutions provide some (approx. 10-49%) health worker salaries ◉ D. Host country institutions provide most (approx. 50-89%) health worker salaries ○ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries	7.4 Score: 2.50	Estimates on National Expenditure (ENE) Estimates of Provincial Revenue & Expenditure (from APR and their targets and how they will be delivered)	
7.5 Pre-service: Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years? Note: List applicable cadres in the comments column.	○ A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years) ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☐ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☑ Institutions maintain process for continuously updating content, including HIV/AIDS content ☐ Updated curricula contain training related to stigma & discrimination of PLHIV ☐ Institutions track student employment after graduation to inform planning	7.5 Score: 0.69	Notes, training modules, national memos, SkillSmart	- Medical schools have updated their curricula. Colleges of Nursing are working to modify curricula. Updated guidelines and policy guidelines are shared w/ all pre-service institutions.
7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (if exact or approximate percentage known, please note in Comments column)	Check all that apply among A, B, C, D: ☑ A. The host country government provides the following support for in-service training in the country (check ONE): ☐ Host country government implements no (0%) HIV/AIDS related in-service training ☐ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training ☑ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training ☐ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training ☐ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training ☐ B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS ☑ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians ☑ D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)	7.6 Score: 0.69		DSPs provide a good amount of in-service for their Direct Service Providers, and TA to facility and district staff. Information systems to track training needs and link to training is being by DOH. The server is maintained by PEPFAR Partners.

7.7 HR Data Collection and Use: Does the country systematically collect and use health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?	○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management ○ B. There is no HRIS in country, but some data is collected for planning and management ☐ Registration and re-licensure data for key professionals is collected and used for planning and management ☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used ☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites ◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: ☐ The HRIS is primarily financed and managed by host country institutions ☑ There is a national strategy or approach to interoperability for HRIS ☑ The government produces HR data from the system at least annually ☑ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)	7.7 Score: 0.97		Monitoring, verificaiton and planning of re-licensure is a sub-optimum. HRH Assessment at a facility level are needed quarterly.
	Human Resources for Health Score	**6.16**		

8. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Data Source**	**Notes/Comments**
8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○A. This information is not known. ○B. No (0%) funding from domestic sources ○C. Minimal (approx. 1-9%) funding from domestic sources ○D. Some (approx. 10-49%) funded from domestic sources ○E. Most (approx. 50 – 89%) funded from domestic sources ◉F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.83	SA Annual Report Investment Case	If there are shortfalls, SA government goes to Treasury to advocate additional funds
8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○A. This information is not known ○B. No (0%) funding from domestic sources ○C. Minimal (approx. 1-9%) funding from domestic sources ○D. Some (approx. 10-49%) funded from domestic sources ○E. Most (approx. 50-89%) funded from domestic sources ◉F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.83	APR Investment Case	If there are shortfalls, SA government goes to Treasury to advocate additional funds
8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs. (if exact or approximate percentage known, please note in Comments column)	○A. This information is not known ○B. No (0%) funding from domestic sources ○C. Minimal (approx. 1-9%) funding from domestic sources ○D. Some (approx. 10-49%) funded from domestic sources ○E. Most (approx. 50-89%) funded from domestic sources ◉F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.83	APR Investment Case	If there are shortfalls, SA government goes to Treasury to advocate additional funds

8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	○ A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). ◉ B. There is a plan/SOP that includes the following components (check all that apply): ☑ Human resources ☑ Training ☑ Warehousing ☑ Distribution ☐ Reverse Logistics ☐ Waste management ☑ Information system ☑ Procurement ☑ Forecasting ☑ Supply planning and supervision ☑ Site supervision	8.4 Score: 1.82	National Strategy to Improve Access to Medicines	Approved by NHC in 2017
8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)? (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not available. ○ B. No (0%) funding from domestic sources. ○ C. Minimal (approx. 1-9%) funding from domestic sources. ○ D. Some (approx. 10-49%) funding from domestic sources. ◉ E. Most (approx. 50-89%) funding from domestic sources. ○ F. All or almost all (approx. 90%+) funding from domestic sources.	8.5 Score: 0.63	National Strategy to Improve Access to Medicines	

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Check all that apply: ☑ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities ☑ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time ☑ MOH or other host government personnel make re-supply decisions with minimal external assistance: ☑ Decision makers are not seconded or implementing partner staff ☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects ☐ Team that conducts analysis of facility data is at least 50% host government	8.6 Score: 1.98	Stock Visibility System Quarterly Wave Governence Meeting minutes	
8.7 Assessment: Was an overall score of above 80% achieved on the National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years? (if exact or approximate percentage known, please note in Comments column)	◉ A. A comprehensive assessment has not been done within the last three years. ○ B. A comprehensive assessment has been done within the last three years but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments ○ C. A comprehensive assessment has been done within the last three years and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score: 0.00		Global Fund plans to conduct a Diagnostic Assessment of the SA supply chain to be done within the next 6-months
	Commodity Security and Supply Chain Score:	**6.92**		

9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			**Data Source**	**Notes/Comments**
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	○ A. The host country government does not have structures or resources to support site-level continuous quality improvement ◉ B. The host country government: ☑ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement ☐ Has a budget line item for the QM program ☐ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions	9.1 Score: 0.67	Organograms of provincial, district and sub-districts have QI Coordinators	
9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)	○ A. There is no HIV/AIDS-related QM/QI strategy ○ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not utilized ◉ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized. ○ D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.	9.2 Score: 1.33	QI meeting minutes	
9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?	○ A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. ◉ B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): ☑ The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement ☑ There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities ☑ There is documentation of results of QI activities and demonstration of national HIV program improvement through sharing and implementation of best practices across HIV/AIDS sites at all levels	9.3 Score: 2.00	DHIS Acceleration Plan Dashboard Reports	

9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?	○ A. There is no training or recognition offered to build health workforce competency in QI. ◉ B. There is health workforce competency-building in QI, including: ☑ Pre-service institutions incorporate modern quality improvement methods in curricula ☑ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 2.00		
9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?	The national-level QM structure: ☑ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services ☑ Regularly convenes meetings that include health services consumers ☑ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☑ Regularly convene meetings that includes health services consumers ☑ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 2.00	DIPS Ideal Clinic Dashboard Acceleration Plans	Implementation remains a challenge due to HR constraints & governance.
		Quality Management Score:	**8.00**	

10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.			**Data Source**	**Notes/Comments**
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	○ A. There is no national laboratory strategic plan ○ B. National laboratory strategic plan is under development ○ C. National laboratory strategic plan has been developed, but not approved ○ D. National laboratory strategic plan has been developed and approved ○ E. National laboratory plan has been developed, approved, and costed ◉ F. National laboratory strategic plan has been developed, approved, costed, and implemented	10.1 Score: 1.67		
10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)	○ A. Regulations do not exist to monitor minimum quality of laboratories in the country. ○ B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). ○ C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated). ○ D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). ◉ E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). ○ F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).	10.2 Score: 1.25	look to SIMS for % NHLS reports	
10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?	○ A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control ◉ B. There are adequate qualified laboratory personnel to perform the following key functions: ☑ HIV diagnosis by rapid testing and point-of-care testing ☑ Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria ☑ Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays ☑ TB diagnosis	10.3 Score: 1.67		

10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	○A. There is not sufficient infrastructure to test for viral load. ◉B. There is sufficient infrastructure to test for viral load, including: ☑ Sufficient HIV viral load instruments ☑ All HIV viral load laboratories have an instrument maintenance program ☑ Sufficient supply chain system is in place to prevent stock outs ☑ Adequate specimen transport system and timely return of results	10.4 Score: 1.67	lab reports guidelines results for action dashboard provide NHLS Viral Load Reports	- Challenges in transportation and skills (eg. Dry Spot) in rural areas - Clinic lab interface is part of the the ICSM - Turn around time may be a challenge due to communication issues between facility and NHLS/patients.
10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)? (if exact or approximate percentage known, please note in Comments column)	○A. No (0%) laboratory services are financed by domestic resources. ○B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources. ○C. Some (approx. 10-49%) laboratory services are financed by domestic resources. ○D. Most (approx. 50-89%) laboratory services are financed by domestic resources. ◉E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.	10.5 Score: 3.33	NSP National Grant	
		Laboratory Score:	**9.58**	

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Investments, Efficiency, and Sustainable Financing

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

Fiscal Context for Health and HIV/AIDS This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.			**Data Source**	**Notes/Comments**
1. What percentage of general government expenditures goes to health?	13.5%		2017 Budget Review	
2. What is the per capita health expenditure all sources?	$467		National Treasury Calculations (2016/17 financial year)	
3. What is the total health care expenditure all sources as a percent of GDP?	8.90%		National Treasury Calculations (2016/17 financial year)	
4. What percent of total health expenditures is financed by external resources?	5.40%		Annual Planning Tool (CHAI/NDOH-2013/14)	
5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?	8%		Draft National Health Accounts report (2013/14)	

11. Domestic Resource Mobilization: The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability.			**Data Source**	**Notes/Comments**
11.1 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?	Check all that apply: ☑ A. Yes, there is a universal, comprehensive financing scheme that integrates social health insurance, public subsidies, and national budget provisions for public health aspects (e.g., disease surveillance). It includes the following (check all that apply): ☑ ARVs are covered ☑ Non-ARV care and treatment is covered ☑ Prevention services are covered ☐ B. Yes, there is an affordable health insurance scheme available (check one of the following). ☐ It covers 25% or less of the population. ☐ It covers 26 to 50% of the population. ☐ It covers 51 to 75% of the population. ☐ It covers more than 75% of the population. ☐ C. The affordable health insurance scheme in (B.) includes the following (check all that apply): ☐ ARVs are covered. ☐ Non-ARV care and treatment services are covered. ☐ Prevention services are covered. ☐ It includes public subsidies for the affordability of care.	11.1 Score: 0.32	Investment Case	

11.2 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?	○ A. There is no explicit funding for HIV/AIDS in the national budget. ◉ B. There is explicit HIV/AIDS funding within the national budget. ☑ The HIV/AIDS budget is program-based across ministries ☑ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals ☑ The budget includes specific HIV/AIDS service delivery targets ☑ National budget reflects all sources of funding for HIV, including from external donors	11.2 Score: 0.95	National Estimates of National Expenditures, conditional grants ; Provincial Estimates for Revenue and Expenditure (EPR) - 2017	
11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?	○ A. There are no HIV/AIDS goals/targets articulated in the national budget ◉ B. There are HIV/AIDS goals/targets articulated in the national budget. ☑ The goals/targets are measurable. ☑ Budget items/programs are linked to goals/targets. ☑ The goals/targets are routinely monitored during budget execution. ☑ The goals/targets are routinely monitored during the development of the budget.	11.3 Score: 0.95	National Estimates of National Expenditures, conditional grants ; Provincial Estimates for Revenue and Expenditure (EPR) - 2017; Annual Performance Plans (APP)	
11.4 HIV/AIDS Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level? (If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)	○ A. There is no HIV/AIDS budget, or information is not available. ○ B. 0-49% of budget executed ○ C. 50-69% of budget executed ○ D. 70-89% of budget executed ◉ E. 90% or greater of budget executed	11.4 Score: 0.95	Annual Financial Statements of All Relevant Departments (Annual Report)	

11.5 Donor Spending: Does the Ministry of Health or Ministry of Finance routinely, and at least on an annual basis, collect all donor spending in the health sector or for HIV/AIDS-specific services?	○ A. Neither the Ministry of Health nor the Ministry of Finance routinely collects all donor spending in the health sector or for HIV/AIDS-specific services. ○ B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services. ◉ C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.	11.5 Score: 0.95	National Estimates of National Expenditures, conditional grants ; Provincial Estimates for Revenue and Expenditure (EPR) - 2017; Annual Report	IDC Data Source will be forthcoming (from Treasury) ; Developmeny Cooperation Information System (DCIS)
11.6 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding? (Domestic funding excludes out-of-pocket, Global Fund grants, and other donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. None (0%) is financed with domestic funding. ○ B. Very liitle (approx. 1-9%) is financed with domestic funding. ○ C. Some (approx. 10-49%) is financed with domestic funding. ◉ D. Most (approx. 50-89%) is financed with domestic funding. ○ E. All or almost all (approx. 90%+) is financed with domestic funding.	11.6 Score: 2.50	Expenditure Tracking (NDoH, DSD, DBE)	
11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?	○ A. There is no budget for health or no money was allocated. ○ B. 0-49% of budget executed. ○ C. 50-69% of budget executed. ○ D. 70-89% of budget executed. ◉ E. 90% or greater of budget executed.	11.7 Score: 0.95	Annual Reports of various departments	
11.8 Data-Driven Reprogramming: Do host country government policies/systems allow for reprograming domestic investments based on new or updated program data during the government funding cycle?	○ A. There is no system for funding cycle reprogramming. ○ B. There is a policy/system that allows for funding cycle reprogramming, but is seldom used. ○ C. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, but not based on data. ◉ D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, and is based on data.	11.8 Score: 0.95	Medium Term Budget Policy Statements; Quarterly Reviews between Treasury and all departments.	In the medium term, evidence is based off of Medium Term Budget Statements (includes money for ART) ; short term, data sources derive from shifting of programming resources. Data is also derived from conditional grant reports. Reviews that are done between health and treasury are to validate the data, plan for remedial actions.
	Domestic Resource Mobilization Score:	**8.53**		

12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).			**Data Source**	**Notes/Comments**
12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources? If yes, please note in the comments section when the model was last used and for what purpose (e.g., for Global Fund concept note development) (note: full score achieved by selecting one checkbox)	○ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources. ◉ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply): ☐ Optima ☑ Spectrum (including EPP and Goals) ☐ AIDS Epidemic Model (AEM) ☐ Modes of Transmission (MOT) Model ☐ Other recognized process or model (specify in notes column)	12.1 Score: 2.00	Thembisa; Investment Case; National AIDS Costing Model	Thembisa replaces Spectrum. Investment case; National AIDS Costing Model
12.2 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)? (if exact or approximate percentage known, please note in Comments column)	○ A. Information not available. ○ B. No resources (0%) are targeting the highest burden geographic areas. ○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas. ○ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas. ◉ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas. ○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.	12.2 Score: 1.50	Proportion allocations are determined + conditional grants; Division Of Revenue Act	Proportion allocations are determined + conditional grants

12.3 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	○ A. The host country government does not have/use recent expenditure data or cost analysis to estimate unit costs ◉ B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply): ☑ HIV Testing ☑ Laboratory services ☑ ART ☑ PMTCT ☑ VMMC ☐ OVC Service Package ☑ Key population Interventions	12.3 Score: 2.00	SA has a database for unit costs (2017); National AIDS Costing Model	
12.4 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?	Check all that apply: ☑ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies ☐ Reduced overhead costs by streamlining management ☑ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. ☑ Improved procurement competition ☑ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) ☑ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) ☑ Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years) ☑ Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years) ☑ Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)	12.4 Score: 1.78	RT35 Tenders National Treasury; Integrated Chronic Services Management Model; Health Insurance Source: Prescribed minimum benefits	New models of HIV Service Delivery: CCMDD, national adherence guidelines; VMMC (281K)

12.5 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)	○ A. Partner government did not pay for any ARVs using domestic resources in the previous year. ○ B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen. ○ C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen. ○ D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen. ◉ E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.	12.5 Score:	2.00	RT35 Tenders National Treasury	
Technical and Allocative Efficiencies Score:			**9.28**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

What Success Looks Like: Using local and national systems, the host country government collects, analyzes and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

13.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.			**Data Source**	**Notes/Comments**
13.1 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ○ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ◉ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies	13.1 Score: 0.95	HSRC (population), NICD for ANC, Stats SA (DHS, Mortality), and Other National Institutions	NSP under goal 8 which is strengthening strategic information. The frst two are functional and NICD is leading in drug resistance survaillance.It is important to note that this study still in discussion. STATs SA important for Demographic estimates.
13.2 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ○ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ◉ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies	13.2 Score: 0.71	FW IBBS 2014, MSM IBSS 2015/2016	NSP under goal 3 on key populations and vulnerable populations. Need to expand the survey to provinces as they are city-specific at the momenet. There are planned IBSS for the following groups, SW, MSM, PWID and Inmates.
13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ◉ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	13.3 Score: 1.25	HSRC, NICD ldeading in ANC	

13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (approx. 90% +) is provided by the host country government	13.4 Score: 0.42	FW IBBS 2014, MSM IBSS 205/2016, Investment Case	NSP under goal 3 on key populations and vulnerable populations. Need to expand the survey to provinces as they are city specific at the momenet. There are planned IBSSS for the following groups, SW, MSM, PWID and Inmates. Donor funded from Global Fund and PEPFAR
13.5 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below. (A.) refers to prevalence data. (B.) refers to incidence data: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age (at coarse disaggregates) ☑ Age (at fine disaggregates) ☑ Sex ☑ Key populations (FSW, PWID, MSM, TG, prisoners) ☑ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ Sub-national units ☑ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☑ Age (at coarse disaggregates) ☑ Age (at fine disaggregates) ☑ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☑ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ Sub-national units	13.5 Score: 0.95	HSRC survey protocol	The most rescent HSRC has over samples in priority districts to allow precise measures for within the districts. Key to note not for all key populations. There will be a preliminary report by December 2017 that will help to review how age is reported.

13.6 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage known, please note in Comments column)	○ A. The host country government does not collect/report viral load data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load data (answer both subsections below): According to the following disaggregates (check ALL that apply): ☑ Age ☑ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) For what proportion of PLHIV (select ONE of the following): ☐ Less than 25% ☐ 25-50% ☐ 50-75% ☑ More than 75%	13.6 Score: 0.71	NNHLS (CCMT),	Data is collected by age and sex but CCMT report is not disaggregated by age and sex. Need to check with NHSL how they are collecting data. Colected for all people on treatment using WHO guidelines.
13.7 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.) Please note most recent survey dates in comments section.	○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM, TG, prisoners) or priority populations (Military, etc.). ◉ B. The host country government conducts (answer both subsections below): IBBS for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☐ Transgender (TG) ☑ People who inject drugs (PWID) ☑ Prisoners ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☐ Transgender (TG) ☐ People who inject drugs (PWID) ☐ Prisoners ☐ Priority populations (AGYW, clients of sex workers, miliitary, mobile populations, non-injecting drug users)	13.7 Score: 0.71	FW IBBS 2014, MSM IBSS 2015/2016	PWID, Priisoner are planned and AGYW is planned by NICD

13.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?	○ A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys ◉ B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups ○ C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups	13.8 Score: 0.48	NDoH and WHO	Strategy has been developed but needs to be approved by NDoH
13.9 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply): ☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data ☐ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance ☑ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection ☑ An in-country internal review board (IRB) exists and reviews all protocols.	13.9 Score: 0.71	NDoH and WHO	The current NSP gives guidance on the component. Strategy has been developed but needs to be approved by NDoH.
	Epidemiological and Health Data Score:	**6.90**		

14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.			**Data Source**	**Notes/Comments**
14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	○A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ○B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions ○C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance ◉D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance ○E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	14.1 Score: 2.50	NASA, Investment Case, Public expenditure reports - BAS	Commissioned with minimal technical assistance
14.2 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?	○A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ◉B. HIV/AIDS expenditure data are collected (check all that apply): ☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening ☑ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel ☐ Sub-nationally	14.2 Score: 2.50	Governmnnt Public - BAS, PEPFAR and Global Fund, BAS information collected from Treasury and PEPFAR and Global Fund	PEPFAR at subnationals
14.3 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	○A. No HIV/AIDS expenditure data are collected ○B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago ○C. HIV/AIDS expenditure data were collected at least once in the past 3 years ○D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures ◉E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	14.3 Score: 3.33	BAS expenditure report & provintial budget expenditure reports	
	Financial/Expenditure Data Score:	**8.33**		

15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.			**Data Source**	**Notes/Comments**
15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?	○A. No system exists for routine collection of HIV/AIDS service delivery data ○B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions ○C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution ◉D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution ○E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government	15.1 Score: 1.00	DHIS, Tier.net, ETR, NHLS,	They are all harmonised. Technical assistance is provided by external agencies. There are other department systems e.g DSD (CBIMS), DBE (EMIS)
15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)	○A. No routine collection of HIV/AIDS service delivery data exists ○B. No financing (0%) is provided by the host country government ○C. Minimal financing (approx. 1-9%) is provided by the host country government ○D. Some financing (approx. 10-49%) is provided by the host country government ◉E. Most financing (approx. 50-89%) is provided by the host country government ○F. All or almost all financing (90% +) is provided by the host country government	15.2 Score: 2.50		Largely government with external contract donor funded. Not sure how much cost is carried by Donors through their partners through support they provide through Tier.net and ETR.

15.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government routinely collects & reports service delivery data for: ☑ HIV Testing ☑ PMTCT ☑ Adult Care and Support ☑ Adult Treatment ☑ Pediatric Care and Support ☑ Orphans and Vulnerable Children ☑ Voluntary Medical Male Circumcision ☑ HIV Prevention ☑ AIDS-related mortality ☑ B. Service delivery data are being collected: ☑ By key population (FSW, PWID, MSM, TG, prisoners) ☑ By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ By age & sex ☑ From all facility sites (public, private, faith-based, etc.) ☑ From all community sites (public, private, faith-based, etc.)	15.3 Score: 1.33	Current FW IBBS, MSM, AGYW, Private Sector (CMS)	PreP collected at demonstration sites. SANAC is working on Key populations throught UCSF. Data on age and sex is collected but not in some reporting. ART Data is now collected for both public and private (Council of Medical AID Schemes (CMS)). However, the data needs to be included in DHIS and any other data collected form CMS.

15.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?	○ A. The host country government does not routinely collect/report HIV/AIDS service delivery data ○ B. The host country government collects & reports service delivery data annually ○ C. The host country government collects & reports service delivery data semi-annually ◉ D. The host country government collects & reports service delivery data at least quarterly	15.4 Score: 1.33	DHIMS Policy, QRS report, DORA reports, AG reports	Quartely review meetings are held with Provinces and feedback is provided. Data reports are shared with Treasury but there is still a gap in sharing reports to donors.
15.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	○ A. The host country government does not routinely analyze service delivery data to measure program performance ◉ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply): ☑ Continuum of care cascade for each identified priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users), including HIV testing, linkage to care, treatment, adherence and retention ☑ Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention ☑ Results against targets ☑ Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.) ☑ Site-specific yield for HIV testing (HTC and PMTCT) ☑ AIDS-related mortality rates ☑ Variations in performance by sub-national unit ☑ Creation of maps to facilitate geographic analysis	15.5 Score: 1.33	DHIS, Tier.net, ETR, NHLS, Stats SA Mid year populations	There are geographical locations and not by priority population. Site specific yeild for HIV testing for HTC and PMTCT is avaiable Sub districts and facilities especially on 27 pririoty districts. With Focus Impact this is evolving.
15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☑ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☑ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government ☑ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☑ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☑ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans	15.6 Score: 1.33	DHIMS Policy, QRS report, DORA reports, AG reports	Quartely review meetings are held with Provinces and feedback is provided. Data reports are shared with Treasury but there is still a gap in sharing reports to donors.
		Performance Data Score: **8.83**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D