Narrative Cover Sheet –South Africa, SID 2019

Another round of PEPFAR SA's National Sustainability Profile was completed in September 2019 using the Sustainability Index and Dashboard (SID) 4.0. The process was led by the South African National AIDS Council (SANAC), GoSA, UNAIDS and PEPFAR SA, and included multisectoral partners from government and non-governmental organizations (NGOs) and civil society. The group completed the review of the index's critical sustainability elements. The SID 2019 summary will be approved through the bilateral Partnership Framework Implementation Plan (PFIP) Management Committee, and the results will be presented in various stakeholders' meetings including through the PFIP, Health Partners Forum, SANAC Civil Society Forum, and UN Joint Team.

The SA SID 4.o demonstrated a high level of sustainability (score of 7 or higher) in twelve of the 17 critical elements, and a score of 8 or higher in an additional four elements. Six elements were identified with vulnerabilities to sustainability: civil society engagement; human resources for health (HRH); quality management; epidemiological and health data; and data for decision-making ecosystem.

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

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

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

Gates Foundation that has invested in important formative research that informs PEPFAR investments as well as HIV-related information systems.

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

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

Sustainability Analysis for Epidemic Control: South Africa

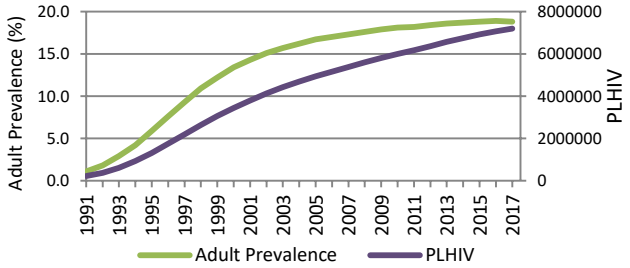
Epidemic Type: Generalized
Income Level: Upper middle income
PEPFAR Categorization: Long-term Strategy (Co-finance)
PEPFAR COP 19 Planning Level: $732,896,249

SUSTAINABILITY DOMAINS and ELEMENTS

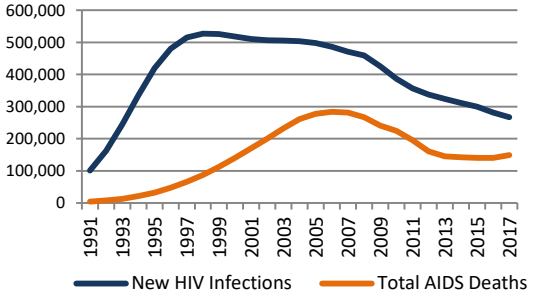
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.67	9.17	7.50	
2. Policies and Governance	8.45	8.87	7.62	
3. Civil Society Engagement	7.33	9.04	6.00	
4. Private Sector Engagement	6.50	9.17	9.17	
5. Public Access to Information	10.00	8.00	9.33	
National Health System and Service Delivery				
6. Service Delivery	7.69	6.71	7.00	
7. Human Resources for Health	6.97	6.16	6.39	
8. Commodity Security and Supply Chain	4.67	6.92	7.51	
9. Quality Management	8.38	8.00	5.67	
10. Laboratory	6.67	9.58	8.89	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	8.61	8.53	8.41	
12. Technical and Allocative Efficiencies	8.61	9.28	9.28	
13. Market Openness	N/A	N/A	8.13	
Strategic Information				
14. Epidemiological and Health Data	6.77	6.90	6.69	
15. Financial/Expenditure Data	9.58	8.33	9.17	
16. Performance Data	8.73	8.83	7.80	
17. Data for Decision-Making Ecosystem	N/A	N/A	5.33	

CONTEXTUAL DATA

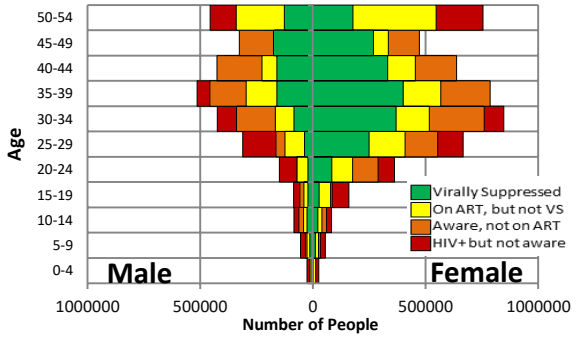
Adult Prevalence & PLHIV



New Infections & Total AIDS Deaths

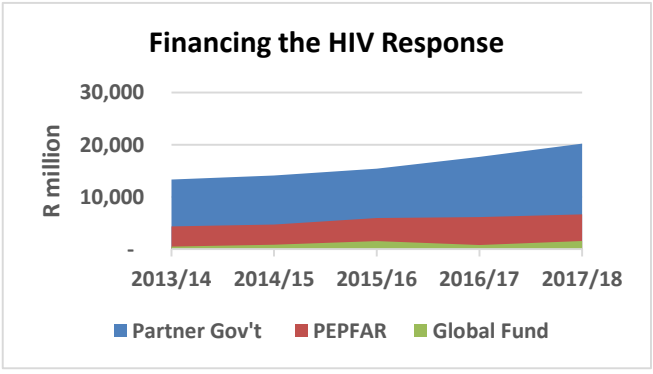


Clinical Cascade

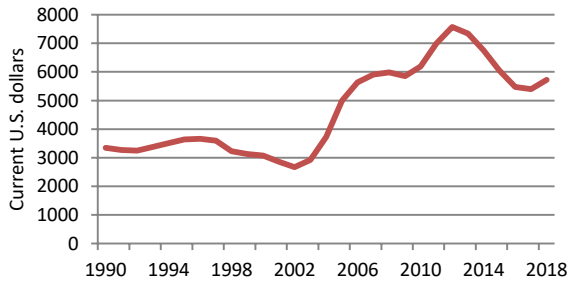


CONTEXTUAL DATA

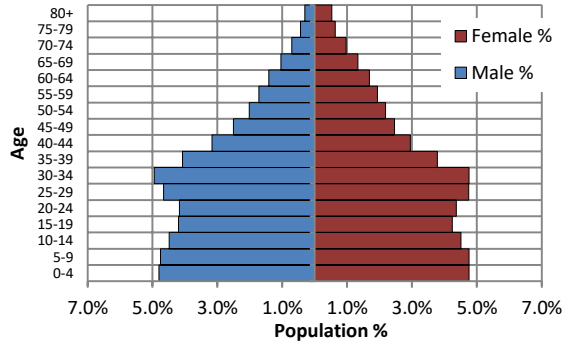
Financing the HIV Response



GNI Per Capita (Atlas Method)



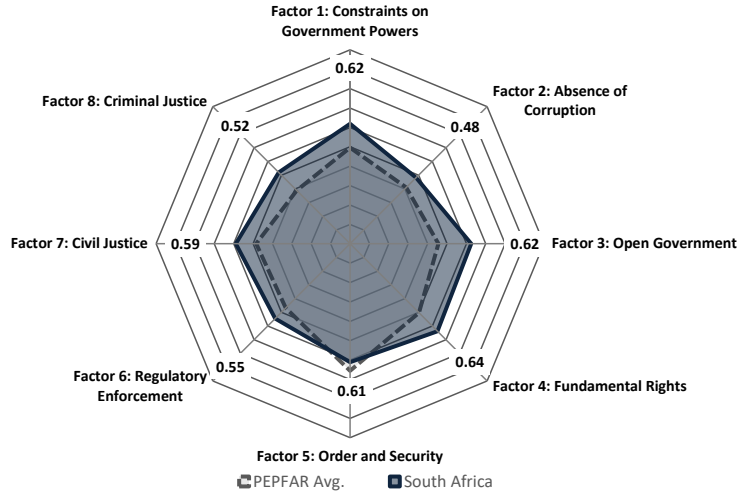
Population Pyramid (2019)

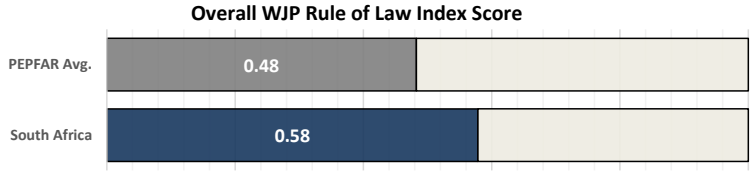


Sustainability Analysis for Epidemic Control: South Africa

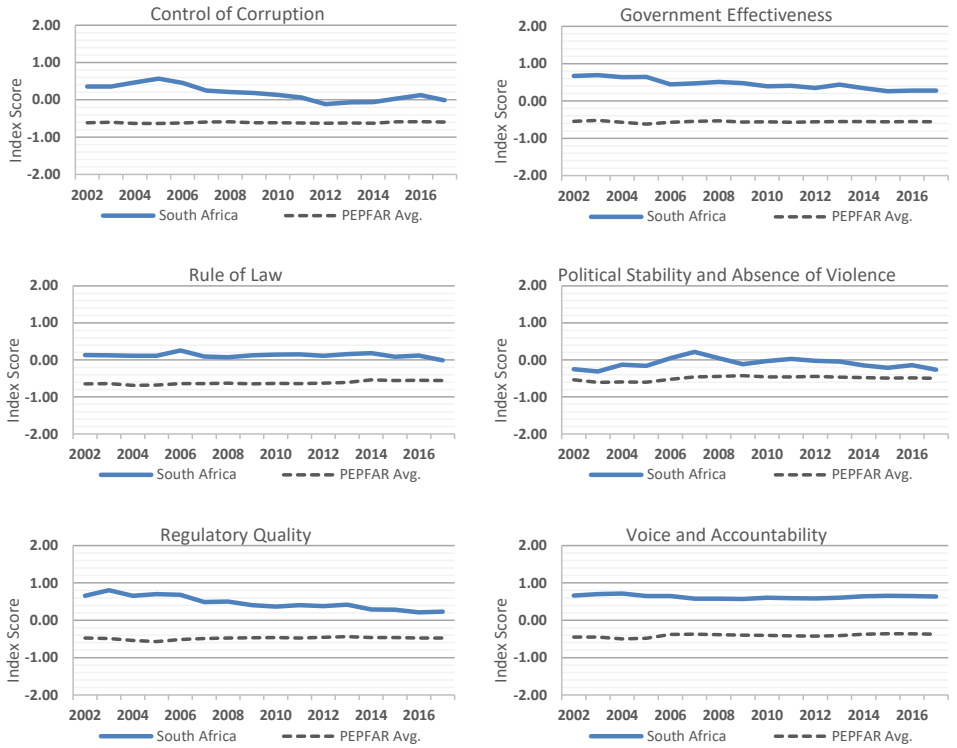
Contextual Governance Indicators

Rule of Law Index (World Justice Project)





Worldwide Governance Indicators (World Bank)



WJP's Rule of Law Index measures the general public's experience and perception across eight 'factors':

1. Constraints on Government Powers: Governmental powers are limited by both internal and external checks, including auditing and review. Governmental officials are subject to the law and sanctioned for misconduct.

2. Absence of Corruption: Government officials in all branches of government do not use public office for private gain.

3. Open Government: Citizens have open access to government information and data, complaint mechanisms, and civic participation.

4. Fundamental Rights: There is equal treatment of citizens and absence of discrimination. The rights to freedom of expression, security of the person, and due process are effectively guaranteed.

5. Order and Security: Crime and civil conflict are effectively limited. Personal grievances are not redressed through violence.

6. Regulatory Enforcement: Government regulations are effectively applied and enforced without improper influence. Due process is respected in administrative proceedings.

7. Civil Justice: Civil justice is accessible and free of discrimination, corruption and improper government influence.

8. Criminal Justice: Criminal justice is impartial, timely and effective, and free from corruption or improper government influence. There is due process of law and rights of the accused.

More information can be found at: https://worldjusticeproject.org/our-work/research-and-data/wjp-rule-law-index-2019

The World Bank Worldwide Governance Indicators (WGI) score countries based on six dimensions of governance:

1. Control of Corruption: captures perceptions of the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as 'capture' of the state by elites and private interests.

2. Government Effectiveness: measures the quality of public services, the quality of the civil service and its independence from political pressure, the quality of policy formulation and implementation (including the efficiency of revenue mobilization and budget management), and the credibility of the government's commitment to its stated policies.

3. Rule of Law: captures perceptions of the extent to which agents have confidence in and abide by the rules of society, and in particular the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence.

4. Political Stability and Absence of Violence: measures perceptions of the likelihood of political instability and/or politically-motivated violence, including terrorism.

5. Regulatory Quality: Measures perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development.

6. Voice and Accountability: captures perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media.

More information can be found at: https://info.worldbank.org/governance/wgi/

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	Country has plans by province and district

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. Midterm review of NSP is underway and stakeholder engagement is taking place at all levels to be completed by December 2019
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: 2.50	Based on discussion with stakeholders during SID workshop	

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:	0.00	Annual Performance Plan, MDIPs and PIPs	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.The Accountability scorecard has been finalised for all stakekholders. National and provinces.
		Planning and Coordination Score:	**7.50**		

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., optimal ART regimens for all populations (including TLD as recommended)?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines on optimal ART regimens 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: 0.91	WHO guidelines; NDOH guidelines e.g.Test & Treat Guidelines; Option B+, PMTCT Guidelines, TLD as recommended	

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: 0.76	NIMART, CCMDD, Childrens Act; HTS guidelines, updated PREP guidelines	Provision for self screening is in the HTS guidelines. Updated PREP guidelines which is still under discussion

2.3 User Fees for HIV Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any HIV services in the public sector: clinical, laboratory, testing, prevention and others? Note: "Formal" user fees are those established in policy or regulation by a government or institution.	Check all that apply: ☐ No, neither formal nor informal user fees exist. ☑ Yes, formal user fees exist. ☐ Yes, informal user fees exist.	2.3 Score: 0.23	Uniform patient fee schedule Available at www.health.gov.za/index.php/shortcodes/2015-03-29-10-42-47/2015-04-30-09-10-23/uniform-patient-fee-schedule/category/558-uniform-patient-fee-sched	Implementation varies according to provinces and walk-inns to hospital
2.4 User Fees for Other Health Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any non-HIV services in the public sector, such as MCH/SRH, TB, outpatient registration, hospitalizations, and others? Note: "Formal" user fees are those established in policy or regulation by a government or institution.	Check all that apply: ☐ No, neither formal nor informal user fees exist. ☑ Yes, formal user fees exist. ☐ Yes, informal user fees exist.	2.4 Score: 0.23	Uniform patient fee schedule Available at www.health.gov.za/index.php/shortcodes/2015-03-29-10-42-47/2015-04-30-09-10-23/uniform-patient-fee-schedule/category/558-uniform-patient-fee-sched	Implementation varies according to provinces and walk-inns to hospital
2.5 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	2.5 Score: 0.68	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 Health Patient system has been ruled out

2.6 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)	2.6 Score: 0.57	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. 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 available and implemented but not legislated Need to define THIRD GENDER as it is unclear Cannot discriminate against a sex worker working but the act of sex work is not legalised

	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			
2.7 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	2.7 Score: 0.73	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. 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 The draft national GBV and Femicide strategic plan 2020-2030 has been developed The Human Rights plan launched in June has a section on GBV and gender inequality	National Strategic Plan on Gender Based Violence Shadow Framework. There is a lack of urgency to act on GBV and leadership implementation An multi-billion amount has been allocated towards GBV

2.8 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	2.8 Score: 0.80	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question.	ENFORCEMENT IS SUBJECTIVE IN FAVOUR OF THE BUYER. Converstion has commenced with law enforement (Dignity and Diversity programme for Police)

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			
2.9 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, adolescents, 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	2.9 Score: 0.91	IEC materials; HTA programme;The Protection of Personal Information (POPI) Act; Legal Aid South Africa, Patient Rigths Charter, Human Rights Plan	
2.10 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.	2.10 Score: 0.91	Annual audit reports	
2.11 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.	2.11 Score: 0.91	Annual report to the Auditor-General	
	Policies and Governance Score:	**7.62**		

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	LGBTI plan; Test&Treat; New Department of Basic Education policy; She Conquers; Self Testing policy; through SANAC Structures, SANAC pleanary and Civil Society Forum NPO Act and NPC policies and companies Act, SANAC procedural guidelines, Civil Society terms of reference.	The Plans enable measuring of accountability and oversight. There is a limitation of disability in the implementation of the policies. There is conflict of policies for sex workers as the Act limit participation or implementation of HIV/AIDS policies. Cant seperate civil society from social justice and in South Africa, policies implementation is highly skewed support to civil society. USG restrictions (GAG rule) on actions that the South African law recognises
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: 1.67	Provincial AIDS Council, District AIDS Councils, Checka Impilo/Nerve Centers	There are formal platforms however Civil Society lacks the capacity to engage. Capacity means research and strategic data management and resources. Fundamental flaws in supporting the Civil Society response through the PFIP process as it is a bilateral agreement excluding Civil Society.Another key vunerable groups eg Disability Sector are once again excluded. Civil Society in South Africa wants to emphasise that Capacity to participate meaningfully in these platforms is severeley challenged. There fore the scoring for this domain is not accurately depicting the true situation. PEPFAR influence in the Country leads to neglect of the remaining 25 deprioritised/ low burden districts in South Afric

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: 1.00	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)	Civil Society influences policies. Although Civil Society is consulted on program and decision making however there are limited capacity, support, broader consultation and influence on the ultimate decisions. The inequalities of open market in South Africa have a negative impact to these elements.
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: 0.83	Conditional Grants (minimial support) are ring fenced	There is lack of transparency of how much of government or private sector funding supports Civil Society. Government support to Civil Society is negligable. Most Civil Society work is not funded or is with self funding. Government is not accountable to civil society on the conditional grant allocations
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, or regulation 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: 0.83	Based on discussion with stakeholders during SID workshop	Failure of policies implementation. Some provinces try to implement policies however it is poorly executed.
		Civil Society Engagement Score: 6.00		

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: 2.22	Private sector engagement strategy; ILO workplace programming documents	Private sector engagement needs to be improved. Current structure is more focused on implementation, but coordination could be enhanced

	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	abour Relations Act (LRA), Basic Conditions of Employment Act (BCEA), Companies Act, 2013 (Corporate Social Responsibility)	All of the checked items are available however their implementation is weak

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. ☐ Private Banks or lenders provide access to low interest loans prioritizing private health sector small and medium-sized enterprise (SME) development and expansion.	4.3 Score: 1.94	Based on discussion with stakeholders during SID workshop	

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	Based on discussion with stakeholders during SID workshop	
		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 Data Transparency: Does the host country government ensure that national HIV/AIDS surveillance 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 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 data available to stakeholders and the general public within 6-12 months. ◉ C. The host country government makes HIV/AIDS surveillance data available to stakeholders and the general public within six months.	5.1 Score: 2.00	Based on discussion with stakeholders during SID workshop	
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	NDOH website; published 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 . At what level of detail is this performance data reported? [CHECK ALL THAT APPLY] ☑ National ☑ District ☑ Site-Level	5.3 Score: 1.33	Annual and audit reports from each government department (with published dates)	
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	Treasury regulation website and other government websites	Certain threshold (above 500,000 rand) goes through Treasury.

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	Conferences; social media; GCIS; RTCs	Question is not clear. There is not only one government agency that is responsible. Different government agencies provide scientifically accurate information. For Health, it is through the regional training centers, GCIS, educational institutions. Government agencies have health campaigns, which include HIV/AIDS information. There are other educational campaigns.
		Public Access to Information Score:	**9.33**		

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: 0.95	DHP, ICSM Manual NSP DHIS Program reports and Minister's 90-90-90 circular (12 August 2019)	- Q1 Facilities have the ability to adapt plans. There is need to ensure implementation thereof accross all facilities. - Q2 Facility targets are set to ensure that high burden faciities meet their demands - The CHW program has increased in
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: 0.95	NSP, CCMDD, Aherence Guidelines, War Rooms, Community Health Care Worker Policy Conditional Grant, Community Outreach Services Grant (COS), Minister's 90-90-90 circular (12 August 2019) Program Reports Ideal Clinic Manual PHC ReEngineering	COS conditional grant established to fund the CHW program - CHWs have MOU or SLA at a local with CBOs and DOH - Referral policy and manuals in place. A revised policy is undergoing review.
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 HIV Conditional Grant Community Outreach Services Grant (COS) NSP outlines budget sources PFIP Framework reports, PEPFAR COP 2019 DORA 2019	The investment from donors in direct service delivery has increased

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: 0.63	nvestment Case HIV Conditional Grant Community Outreach Services Grant (COS) NSP outlines budget sources PFIP Framework reports, PEPFAR COP 2019	The investment from donors in direct service delivery 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, or information is not available. ○ 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	Investment Case HIV Conditional Grant Community Outreach Services Grant (COS) NSP outlines budget sources PFIP Framework reports, PEPFAR COP 2019 DORA 2019	
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: 0.32	Investment Case HIV Conditional Grant Community Outreach Services Grant (COS) NSP outlines budget sources PFIP Framework reports, PEPFAR COP 2019	
6.7 Management and Monitoring of HIV Service Delivery: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV service delivery activities including practice standards, quality, health outcomes, and information monitoring across all sectors. Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget. ○ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ◉ D. Yes, there is an entity with authority and sufficient staff and budget.	6.7 Score: 0.95	Investment Case HIV Conditional Grant	

6.8 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	6.8 Score: 0.63	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. - 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. Additional investments are needed to strengthen effective civil society engagement
6.9 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.	6.9 Score: 0.48	DHPs DHIS Conditional Grant Business Plans Program Reports	Data is available, but not used efficiently - Use of epi and programmatic data needs to be strengthed at district and facility level - Civil Society engagementand coordination occurs but needs strengthening at each level of care - Provincial program and expenditure perfomance is closely monitored.
		Service Delivery Score	**7.00**	

7. Health Workforce: Health workforce staffing decisions for those working on HIV/AIDS are based on use of workforce 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 Health Workforce 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: 0.24	CHW Validation exercise PEPFAR HRH Assessment NDOH has approved and operationalized the Rural Retention Scheme Human Resources for Health Strategy	CHW Validation exercises revealed 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: 0.95	National CHW Strategy PEPFAR's Human Resource Inventory Database (HRID)	- CHWs now have set remuneration of 3,500 ZAR. Data available on request, but team is not aware of data accessible to the public. - PEPFAR supporting national CHW database. - While there is a broad scope of work for CHWs to support HIV self-screening, referrals and linkages, there is an opportunity to broaden their scope to HIV testing and TB [illegible]
7.3 Health Workforce 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 and timeline for transition.	○ 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: 0.24	Global Fund's Sustainability Review of Interventions Supported by the Global Fund in South Africa (July, 2018)	No official plan at this time. - For many Global Fund interventions, formal sustainability and transition plans do not exist

7.4 Domestic Funding for Health Workforce: 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 Training: 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: 0.83	Curricula	NEPI submitted national nursing curricula to national bodies for roll-out which included stigma and discrimination content. Cadres: Clinical associates, nurses, pharmacists
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: 0.60	Based on discussion with stakeholders during SID workshop	Donor funded organizations provide in-service for their Direct Service Providers, and TA to facility and district staff. - Unsure of % of SA government implementation/support for in-service training, so keeping as-is

7.7 Health Workforce 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:	0.71	**Based on discussion with stakeholders during SID workshop**	While national HRIS is in development, need to roll-out for increased use and program planning, including all partners.
7.8 Management and Monitoring of Health Workforce Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for health workforce activities in HIV service delivery sites, including training, supervision, deployments, quality assurance, and others across all sectors. Select only ONE answer.	○ A. No, there is no entity. ◉ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ○ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	7.8 Score:	0.32	**t the request of the NDOH, PEPFAR has seconded staff to support the HR unit.**	
		Health Workforce Score:	**6.39**		

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	NDoH (COP development commodity procurement profile)	A small proportion (~3%) of funds for ARVs are provided by the Global Fund for strategic buffer. 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	Based on discussion with stakeholders during SID workshop	
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	Based on discussion with stakeholders during SID workshop	

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: 1.52	National Strategy to Improve Access to Medicines	The SIMA is due for a revision within the next SAG fiscal year
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: 1.48	National Surveillance Centre NDoH IMAT initiative	
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: 0.83	Global Fund Suply Chain Transformational review GHSC-TA PMPU readiness assessments	
8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities including forecasting, stock monitoring, logistics and warehousing support, and other forms of information monitoring across all sectors? Select only ONE answer.	○ A. No, there is no entity. ◉ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ○ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	8.8 Score: 0.56	NDoH Affordable Medicines Directorate	There is an existing team which is currently overburdened with the scope of work required of them. Additional staff are needed to effectively manage tenders as well as implementation of Supply Chain Reforms in preparation for the NHI
		Commodity Security and Supply Chain Score:	**7.51**	

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	At National level it exits, but at subnational (provincial , district and subdistrict) varies in functionality or even existence.
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	The QM/QI National Plan has not been updated in the last two years. It is been partially utilized.
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: 0.67	HIS Acceleration Plan Dashboard Reports	Performance meassures are being aggregated and analyzed at the national level , but not at the local/site level to inform quality improvement.

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: 1.00	Pre-service nursing curriculum	Two years ago an effort was done to train DOH staff in QI method but nolonger in practice.. New nursing curriculum integrates QI training but not in national in-service training
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	DHS ART 90-90-90 DHIS Dashboard	Implementation remains a challenge due to HR constraints & governence
		Quality Management Score:	**5.67**	

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: 1.33	NHLS Strategic plan document	
10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, purchase, and provide guidance - laboratory services at the regional and district level across all sectors? Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ◉ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	10.2 Score: 0.89	Based on discussion with stakeholders during SID workshop	
10.3 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).	10.3 Score: 1.00	NHLS HR department	HIV- rapid test is performed in the facilities that are not under NHLS authorities, but the provinces. Lay counselors and nurses are performing the test. Counselors are most of the time trained, but nurses are not.
10.4 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	10.4 Score: 1.00		

10.5 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 out ☑ Adequate specimen transport system and timely return of results	10.5 Score: 1.33	NHLS Reports/Guidelines Viral Load dashboard is used to generate results for action Reports for all VL > 1000 copies on a weekly basis, allowing HCW to call patients back before set appointment	Challenges in VL access for 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 and delayed equipment service and maintenance
10.6 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.	10.6 Score: 3.33	NSP 2017-2022 HIV conditional Grant	
		Laboratory Score:	**8.89**	

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Financing and Market Openness

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. Finally, having and effectively implementing policies that ensure leveraging markets (both nonprofit and for profit) where appropriate and enabling their participation and competition will be critical for a sustained HIV response.

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?	14%		2019 Budget Review	Average over the 2020 MTEF (2019/20 - 2021/22 fiscal years). This is % of non-interest expenditure (i.e. the denominator excludes debt service costs)
2. What is the per capita health expenditure all sources?	$549		National Treasury Calculations (2018/19 financial year	USD exchange rate $1=R 14.6
3. What is the total health care expenditure all sources as a percent of GDP?	9,10%		National Treasury Calculations (2018/19 financial year	
4. What percent of total health expenditures is financed by external resources?	2.30%		National Treasury Calculations (2018/19 financial year)	Used R10.5bn donor / R460bn total. In 2019-2020, it is expected that percent of health
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%		Global Health Expenditure Database (WHO) (2016)	Most recent published estimate. Fairly consistent with National Treasury calculations of 7.3% and National Health Accounts report of 8% in 2012/14

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 (specify in comments). ☐ It includes public subsidies for the affordability of care.	11.1 Score: 0.32	**Based on discussion with stakeholders during SID workshop**	

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: 0.83	National Estimates of National Expenditures, conditional grants ; Provincial Estimates for Revenue and Expenditure (EPR)	
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	Estimates of National Expenditure, conditional grants business plans; Provincial Estimates for Revenue and Expenditure (EPR); 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), 2017/18	

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	
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	Based on discussion with stakeholders during SID workshop	
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.	
	Domestic Resource Mobilization Score:	**8.41**		

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 ART Cost Model	Most recent utilization was COP19 development, including site-level targeting.
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	

12.3 Information on cost of service provision: Does the host country government have a system that routinely produces information on the costs of providing HIV/AIDS services, and is this information used for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	○ A. The host country DOES NOT have a system that routinely produces information on the costs of providing HIV/AIDS services. ○ B. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services, but this information is not used for budgeting or planning. ◉ C. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services AND this information is used for bugeting or planning purposes for the following services (check all that apply): ☑ HIV Testing ☑ Laboratory services ☑ ART ☑ PMTCT ☑ VMMC ☐ OVC Service Package ☑ Key population Interventions ☑ PrEP	12.3 Score: 2.00	Based on discussion with stakeholders during SID workshop	
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)	12.4 Score: 1.78	RT35 Tenders National Treasury; Integrated Chronic Services Management Model	

	☑ 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 (e.g., multi-month scripting, testing modalities targeted to the population profile, etc. - specify in comments)			
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**		

13. Market Openness: Host country and donor policies do not negatively distort the market for HIV services by reducing participation and/or competition.			Data Source	Notes/Comments
13.1 Granting exclusive rights for services or training: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies grant exclusive rights for the government or another local provider to provide HIV services?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) polices: A. Restrict the provision of any one aspect of HIV prevention, testing, counseling, or treatment services to a single entity (i.e., creating a monopoly arrangement for that service)? ☐ Yes ☑ No B. Mandate that only government facilities have the exclusive right to provide any one aspect of HIV prevention, testing, counseling, or treatment services? ☐ Yes ☑ No C. Grant exclusive rights to government institutions for providing health service training? ☐ Yes ☑ No	13.1 Score: 0.36	**Based on discussion with stakeholders during SID workshop**	**Subtle exclusivilty criteria that removes and divides civil society. Financing of the response has been monopolised by donors and government. The historical apartheid system laid the foundation for this system adopted by donors and has enabled continuation. PFIP is excluding the voice of Civil Society. PEPFAR and other donors processes of appointing Implementing Partners are not transparent. The Donors internal and exclusive process deligitemises the accountability aspect of IP to the broader structures of HIV response.**
13.2 Requiring license or authorization: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies establish a license, permit or authorization process as a requirement of operation?	A. Are health facilities required to obtain a government-mandated license or accreditation in order to provide HIV services? [SELECT ONE] ☐ No ☐ Yes, and the enforcement of the accreditation places equal burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) and government facilities. ☑ Yes, and the enforcement of the accreditation places higher burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) than on government facilities. B. Are health training institutions required to obtain a government-mandated license or accreditation in order to provide health service training? [SELECT ONE] ☐ No ☑ Yes, and the enforcement of the accreditation places equal burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) and government institutions. ☐ Yes, and the enforcement of the accreditation places higher burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) than on government institutions.	13.2 Score: 0.18	**Based on discussion with stakeholders during SID workshop**	**The challenge is with Government lack of responsibility and accountability when it comes to Key Population. 25 years later Government is unable to deliver a competent Key populations services. 12% of LGBTI people are rejected by facilities, while 6% delay seeking health services due to stigma and discrminiation. The other challenge when it comes to PLHIV, the burden of care and support is led by CSOs for PLHIV, Gov is providing Treatment and relying on CSO for adherence and support.** **There are 2 types of training (Informal and formal). The CSOs at the local level must be capacitated. There is a need for parity and transformation Inequalities persist**

13.3 Limiting provision of certain direct clinical services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local providers to provide certain direct clinical services?	National government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local health service providers to offer the following HIV services: ☑ Prevention ☑ Testing and Counseling ☑ Treatment	13.3 Score: 0.00	Based on discussion with stakeholders during SID workshop	All the thematic areas are governed by national guidelines and can be restictive and prescriptive.
13.4 Limiting provision of certain clinical support services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed local providers to provide certain clinical support services?	A. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from providing essential HIV laboratory services? ☐ Yes ☑ No B. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly arrangements in lab testing (i.e., arrangements where effectively only one lab service provider is allowed to conduct a certain essential HIV lab service)? ☐ Yes ☑ No C. National government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from procuring or distributing the following HIV commodities and supplies [PLEASE SPECIFY TYPE IN NOTES]: ☐ ARVs ☐ Test kits ☐ Laboratory supplies ☐ Other D. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly supply chain arrangements for HIV commodities (i.e., arrangements where effectively only one entity is able to supply a certain essential HIV commodity)? ☐ Yes ☑ No	13.4 Score: 0.36	Based on discussion with stakeholders during SID workshop	

13.5 Limits on local manufacturing: Do national government policies limit the ability of the local manufacturing industry to compete with the international market?	A. Do national government policies restrict the production of HIV commodities and supplies by local manufacturers beyond international standards? ○ Yes ◉ No B. [IF YES] For which of the following is local manufacturing restricted? ☐ ARVs ☐ Test kits ☐ Laboratory supplies ☐ Other	13.5 Score: 0.36	Based on discussion with stakeholders during SID workshop	
13.6 Cost of entry/exit: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of entry or exit by a local provider?	Do local health service facilities face higher start-up or maintenance costs compared to government or donor (e.g., PEPFAR, GFATM, etc.) supported facilities (e.g., lack of access to funds, higher accreditation fees, prohibitive contracting costs, etc.)? ☑ Yes ☐ No	13.6 Score: 0.00	Based on discussion with stakeholders during SID workshop	Government and donor supported facilities are provided with technical experts and other resources to assist with start up processes which local facilities that are not supported do not have. This create a capacity divide which ultimately affects costs of entry.
13.7 Geographical barriers: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create geographical barriers for local providers to supply goods, services or labor, or invest capital?	A. Are certain geographical areas restricted to only government or donor-supported HIV service providers? ◉ Yes ○ No B. [IF YES] Which of the following are geographically restricted? ☑ Supplying HIV supplies and commodities ☑ Supplying HIV services or health workforce labor ☑ Investing capital (e.g., constructing or renovating facilities)	13.7 Score: 0.00	Based on discussion with stakeholders during SID workshop	PEPFAR and other donors limit their support to 27 priority districts and marginalise the remaining deprioritised 25 districts.
13.8 Freedom to advertise: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the freedom of local organizations to advertise or market HIV goods or services? [Note: "organizations" in this case can refer broadly to clinical service providers and also organizations providing advocacy and promotion services.]	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the freedom of nongovernment (e.g., FBOs, CBOs, or private sector) organizations to advertise or promote HIV services either online, over TV and radio, or in public spaces? ☐ Yes ☑ No	13.8 Score: 0.63	Based on discussion with stakeholders during SID workshop	Advertising that receives donor funding is per the donor guidelines which although may not be perceived as restrictive have their limitations

13.9 Quality standards for HIV services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality? [CHECK ALL THAT APPLY] ☑ Yes ☐ No, government service providers are held to higher standards than nongovernment service providers ☐ No, FBOs/CSOs are held to higher standards than government service providers ☐ No, private sector providers are held to higher standards than government service providers	13.9 Score: 0.63	Based on discussion with stakeholders during SID workshop	
13.10 Quality standards for HIV commodities: Do national government policies set standards for product quality that provide an advantage to some commodity suppliers over others?	Do national government policies set product quality standards on HIV commodities that advantage some suppliers over others? [IF YES, PLEASE EXPLAIN IN NOTES] ☐ Yes ☑ No	13.10 Score: 0.63	Based on discussion with stakeholders during SID workshop	
13.11 Cost of service provision: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of service provision for some local providers relative to others (especially by treating incumbents differently from new entrants)?	A. Do government HIV service providers receive greater subsidies or support of overhead expenses (e.g., operational support) as compared to nongovernment (e.g., FBOs, CBOs, or private sector) HIV service providers? ☑ Yes ☐ No B. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local HIV service providers over others? ☑ Yes ☐ No C. Do government health training institutions receive greater subsidies or support of overhead expenses as compared to nongovernment (e.g., FBOs, CBOs, or private sector) health training institutions? ☑ Yes ☐ No D. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local health service training institutions over others? ☑ Yes ☐ No	13.11 Score: 0.00 Based on discussion with stakeholders during SID workshop	(B.) DOH Conditional Grants	Subtle exclusivilty criteria that removes and divides civil society.
13.12 Self-regulation: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow for the creation of a self-regulatory or co-regulatory regime?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow HIV service providers—either groups of individuals or groups of institutions—to create structural barriers (e.g., closed network systems) that may reduce the incentive of other potential providers to provide HIV services? ☐ Yes ☑ No	13.12 Score: 1.25	Based on discussion with stakeholders during SID workshop	
13.13 Publishing of provider information: Do national government or donor (e.g., PEPFAR,	A. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require nongovernment (e.g., FBOs, CBOs, or private sector) health service facilities to publish more data than government facilities on the following [CHECK ALL THAT APPLY]: ☐ HIV service caseload ☐ Procurement of HIV supplies/commodities	13.13 Score: 1.25	Based on discussion with stakeholders during SID workshop	

GFATM, etc.) policies require or encourage information on local providers' outputs, prices, sales or costs to be published?	☐ Expenses B. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require HIV commodity suppliers to publish data on the following [CHECK ALL THAT APPLY]: ☐ Distribution ☐ Sales/Revenue ☐ Production costs			
13.14 Patient choice: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of patients to decide which providers or products to use?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of patients or specific groups of patients to choose: A. Which HIV service providers they use? ☐ Yes ☑ No B. Which HIV supplies/commodities they use (e.g., ARVs, PrEP, condoms, needles, etc.)? ☐ Yes ☑ No	13.14 Score: 1.25	Based on discussion with stakeholders during SID workshop	
13.15 Patient mobility: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies reduce mobility of patients between HIV service providers by increasing the explicit or implicit costs of changing providers?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies impose costs or other barriers that restrict a patient's ability to transfer from a government HIV service provider to a nongovernment (e.g., FBO, CBO, or private sector) HIV service provider? ☐ Yes ☑ No	13.15 Score: 1.25	Based on discussion with stakeholders during SID workshop	
	Market Openness Score:	**8.13**		

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.

14.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**
14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including: data collection, analysis and interpretation; data storage and retrieval; and quality assurance across all sectors. Select only ONE answer.	◉ No, there is no entity. ○ Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ○ Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ Yes, there is an entity with authority and sufficient staff and budget.	14.1 Score: 0.00	Based on discussion with stakeholders during SID workshop	There is no single entity that oversees all Surveillance and Epi responsibilities. Responsilities are diffused across multiple governmental, parastatal, and academic entities including: NICD, HSRC, SANAC, MRC, University of Cape Town. Surveillance activities pertain to general and key populations surveillance. Looking forward, SANAC is developing a strategic information task team that will encompass strategic planning around surveillance activities. National
14.2 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 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	14.2 Score: 0.83	Based on discussion with stakeholders during SID workshop	Agencies listed above carry out surveillance activities in collaboration with NDoH and other stakeholders. PEPFAR provides funding and at through that funding, provides technical input towards key surveillance activities.
14.3 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	14.3 Score: 0.63	Protocols for KP surveys UCSF cascades and triangulation activity report	Local partners conducted the most recent (2018 and 2019) key populations surveys. Workshops faciliatated by SANAC convened stakeholders for dissemination of BBS, PSE and HIV clinical cascades. PEPFAR funding and technical input from PEPFAR.

14.4 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	14.4 Score: 1.25	Donor contributed	SI funds toward surveys, surveillance, and monitoring activities, and data systems support for SI FY14-FY19 totals $27million.
14.5 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	14.5 Score: 0.42	Based on discussion with stakeholders during SID workshop	Implementation is supported by PEPFAR at >90%. Global Fund no longer provides funding for KP Surveys and Surveillance. SA Government plays a significant role in the coordiantation and dissemination of findings from KP survey activities.

14.6 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?	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	14.6 Score: 0.75	Based on discussion with stakeholders during SID workshop	Five rounds of general population surveys were conducted in South Africa in 2002; 2005; 2008; 2012 and 2017. Key populations prevalence data is collected in separate bio-behavioral surveys (BBS). Recency measures have not been collected as part of prior BBS surveys. Data for the listed priority populations is only available for AGYW. Age (fine disaggregate) is collected for age 15-24. Incidence reports are based on recency testing. SA does not conduct direct incidence measures in nationala surveillance. KEY GAP: KP surveillance is geographically focused, and not at a national level. <10% of KP surveillance comes from public funds. KEY GAP: The only priority population with data for the elements discussed in the SI tab is AGYW (comment applies to sections 14-17).

14.7 Comprehensiveness of Viral Load Coverage Data: To what extent does the host country government collect/report viral load coverage data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage is known, please note in Comments column)	○ A. The host country government does not collect/report viral load coverage data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load coverage data (answer both subsections below): Government collects/report viral load coverage data 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 does the government collect/report viral load coverage data (select one of the following): ☐ Less than 25% ☐ 25-50% ☐ 50-75% ☑ More than 75%	14.7 Score: 0.73	Based on discussion with stakeholders during SID workshop	Surveys and surveillance activitites include VL data by age, sex, and KP. Priority populations include only AGYW. Routine VL coverage data is available for general population, but not by KP. KP VL coverage data is collected only through special surveys. The NHLS reports capture >75% of PLHIV on ART. Tier and DHIS capture <75% of PLHIV on ART.
14.8 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct integrated behavioral surveillance (either as a standalone IBBS or integrated into other routine surveillance such as HSS+) and 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 (or other integrated behavioral surveillance) 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)	14.8 Score: 0.83	Based on discussion with stakeholders during SID workshop	The key populations surveys are limited in geographic coverage and PSE apply only to the areas in the IBBS. Most recent IBBS and size estimation studies are: FSW - 2018 (Cape Town, Durban and Johannesburg) MSM - 2019 (Cape Town, Johannesburg and Mahikeng) TGW - 2018 (Cape Town, Johannesburg and Buffalo City Metro) PWID - 2017 (Cape Town and Tswane) Prisoners - 2019 (two correctional facilities, one in Gauteng and the other in Limpopo) Modeled size esimations have been completed for FSW, MSM, and PWID. Program data (enumeration), not PSE, is used to measure population size of prisoners. AGYW are being accessed through general population surveys, and AGYW-specific surveys including DREAMS evaluation and HERStory.

14.9 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	14.9 Score: 0.83	Based on discussion with stakeholders during SID workshop	A national roadmap for Surveys and Surveillance activitities with timing and scope of activities exists, and was developed in conjunction with government and donor stakeholders.
14.10 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.	14.10 Score: 0.42	Based on discussion with stakeholders during SID workshop	Protocols for survey activities contain policies and procedures around data quality, IRB approval, and results dissemination. However no single entity is responsible for oversight of these activities at a national level. There are provincial research committees which reveiw protocols at provincial level. In addition, there are locatl instituional ethics committess. South Africa has strong IRB processes. (See note on 14.1)
	Epidemiological and Health Data Score:	**6.69**		

15. 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**
15.1 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	15.1 Score: 2.50	Based on discussion with stakeholders during SID workshop	SA collects expenditure data through NASA. UNAIDS and Global Fund provide funding and TA for the collection of this data. KEY GAP: Lack of National Health Account
15.2 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	15.2 Score: 3.33		Information is collected from treasury, PEPFAR, and Global Fund. At subnational level, this information is tracked through NDOH Conditional Grants.
15.3 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	15.3 Score: 3.33	Based on discussion with stakeholders during SID workshop	Information is collected from treasury, PEPFAR, and Global Fund. At subnational level, this information is tracked through NDOH Conditional Grants. Data is collected annually.
		Financial/Expenditure Data Score: 9.17		

16. Performance data: Government routinely collects, reports, 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, and viral load testing coverage and suppression.			**Data Source**	**Notes/Comments**
16.1 Who Leads Collection and Reporting of Service Delivery Data: To what extent is the routine collection and reporting of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government at the national level?	○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	16.1 Score: 1.00	Based on discussion with stakeholders during SID workshop	SA Govertment Health Information data for HIV/AIDS is intergrated and harmonized through DHIS. KEY GAP: Outside of the health sector, there are numerous systems that track service delivery which are not harmonized.
16.2 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	16.2 Score: 2.50	Based on discussion with stakeholders during SID workshop	PEPFAR provides financial support through secondees and a cooperative agreements with HMIS partners. Approximately 85% of the HIV response, including HMIS, is funded by the SA Government. There is additional financing for information systems outside of the health sector, e.g. KP is donor-funded; DSD & DBE systems are primarily financed through SA Government.

16.3 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.)	16.3 Score: 1.33	Based on discussion with stakeholders during SID workshop	For Part A; SA National Indicator Dataset (NIDS), inclusive of the CHW / WHBOT module, encompasses all program areas listed with the exception of AIDS-related mortality. AIDS-related mortality is collected as part of national vital record reporting and is reported through StatsSA; MRC also conducts activiteies pertaining to AIDS-related mortality. Most service delivery indicators are disaggregated by age only (<15/15+); However, a subset of indicators are also disaggregated by sex and reported quarterly as part of the cohort reports. All public-sector facilities report to the national system. Not all data from Private and Faith-Based Organizations is integrated into the national reporting system. PrEP provision data is collected, but is not currently intergrated into national HIV/AIDS service delivery reporting. For part B, KP program data is collected
16.4 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	16.4 Score: 1.33	Based on discussion with stakeholders during SID workshop	Service delivery data are collected, anlaysed, and disseminated monthy.

16.5 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, viral suppression, 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, and viral load ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention, and viral load ☑ Results against targets ☑ Coverage or recent achievements 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	16.5 Score: 0.83	Based on discussion with stakeholders during SID workshop	Population-specific cascades are developed for adult and pediatric populations only; not for all populations listed. Continuum of care cascades are developed for populations by specific programs, but is not part of a national activity.
16.6 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	16.6 Score: 0.80	Based on discussion with stakeholders during SID workshop	The data quality strategy is imbedded within the National HMIS strategy. KEY GAP: Routine collection, publication, and dissemination of data quality reports
		Performance Data Score: **7.80**		

17. Data for Decision-Making Ecosystem: Host country government demonstrates commitment and capacity to advance the use of data in informing government decisions and cultivating an informed, engaged civil society.			**Data Source**	**Notes/Comments**
17.1 Civil Registration and Vital Statistics (CRVS): Is there a CRVS system in place that records births and deaths and is fully operational across the country? Is CRVS data made publically available in a timely manner?	○ A. No, there is not a CRVS system. ◉ B. Yes, there is a CRVS system that... (check all that apply): ☑ records births ☑ records deaths ☑ is fully operational across the country [IF YES] How often is CRVS data updated and made publically available (select only one)? ☑ A. The host country government does not make CRVS data available to the general public, or they are made available more than one year after the date of collection. ☐ B. The host country government makes CRVS data available to the general public within 6-12 months. ☐ C. The host country government makes CRVS data available to the general public within 6 months.	17.1 Score: 1.00	Based on discussion with stakeholders during SID workshop	Data is made available from the CVRS sytsem, but routinely it is published through StatsSA >12 months after it is collected.
17.2 Unique Identification: Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? Do national polices protect privacy of Unique ID information?	Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? ◉ A. No, there is no national Unique Identification system used to track delivery of services for HIV/AIDS or other health services. ○ B. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS, but not other health services. ○ C. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS and other health services. [IF YES to B or C] Are there national policies, procedures and systems in place that protect the security and privacy of Unique ID information? ☐ Yes ☐ No	17.2 Score: 0.00	Based on discussion with stakeholders during SID workshop	The Health Patient Registration Number (HPRN) is the current national unique identifier for HIV/AIDS and other health services. However, integration of HPRN across systems is not completed and implemenation of the Health Patient Registration System (HRPS) is not completed in all districts. For this reason, at this time HPRN is not used to track service delivery at an individual level across HIV or other health services. KEY GAP: Univeral coverage and utilization of UID across all sectors is needed.

17.3 Interoperability of National Administrative Data: To fully utilize all administrative data, are HIV/AIDS data and other relevant administrative data sources integrated in a data warehouse where they are joined for analysis across diseases and conditions?	○ A. No, there is no central integration of HIV/AIDS data with other relevant administrative data. ◉ B. Yes, national HIV/AIDS administrative data is integrated and joined with administrative data on the following: ☑ a. TB ☐ b. Maternal and Child Health ☐ c. Other Health Data (e.g., other communicable and non-communicable diseases) ☐ d. Education ☐ e. Health Systems Information (e.g., health workforce data) ☐ f. Poverty and Employment ☐ g. Other (specify in notes)	17.3 Score: 0.33	Based on discussion with stakeholders during SID workshop	TB patient-level data is integrated iwith HIV data in Tier.net. At facility level, NIDS indicators capture TB, NCH, and Other Health Data. The district health baromoter includes independent analyses of these areas, but these results are not reported in an integrated matter. KEY GAP: Planning and policies around data system integration are needed, and development of dashboards, visualizations, and data feedback looks using integetrated data will also be needed.
17.4 Census Data: Does the host country government regularly (at least every 10 years) collect and publically disseminate census data?	○ A. No, the host country government does not collect census data at least every 10 years ○ B. Yes, the host country government regularly collects census data, but does not make it available to the general public. ◉ C. Yes, the host country government regularly collects census data and makes it available to the general public. [IF YES to C only] Data that are made available to the public are disaggregated by: ☑ a. Age ☑ b. Sex ☑ c. District	17.4 Score: 2.00	StatsSA	
17.5 Subnational Administrative Units: Are the boundaries of subnational administrative units made public (including district and site level)?	○ A. No, the country's subnational administrative boundaries are not made public. ○ B. Yes, the host country government publicizes district-level boundaries, but not site-level geocodes. ◉ C. Yes, the host country government publicizes district-level boundaries and site-level geocodes.	17.5 Score: 2.00	Based on discussion with stakeholders during SID workshop	Sub-district administrative unit boundaries are not always consistent across sectors (eg, education and health). KEY GAP: Misalignment of boundaries between health, eduction, possibly
	Data for Decision-Making Ecosystem Score:	**5.33**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D