

**Country Operational Plan
(COP/ROP) 2021
Strategic Direction Summary
3 May 2021**



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***Military PSNU data are non-public**

A portion of PEPFAR data relates to foreign military sites, such as bases, barracks, or military hospitals. Data originating at these sites are aggregated to each respective OU's Military PSNU and are non-public. When developing graphics for the SDS, do not include the Military PSNU, which you can find in PSNU dropdowns in Panorama. These services may be funded through a variety of implementing agencies or mechanisms, so the Military PSNU designation is not equivalent to DOD as an implementing agency.

List of Acronyms

Acronym	Definition
ACC	Advanced Clinical Care
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APR	Annual Program Results
ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
ASP	Above Site Portfolio
BAS	Basic Accounting System
BMGF	Bill & Melinda Gates Foundation
C/ALHIV	Children and Adolescents Living with HIV
CAPs	Corrective Action Plans
CBO	Community Based Organizations
CCM	Country Coordinating Mechanism
CCMDD	Central Chronic Medicine Disease Dispensing and Distribution Programme
CDC	U.S. Centers for Disease Control and Prevention
CFSW	Children of Female Sex Workers
CHAI	Clinton Health Access Initiative
CHW	Community Health Worker
CLHIV	Children Living with HIV
CODB	Cost of Doing Business
COP	Country Operational Plan (PEPFAR)
COP18	2018 Country Operational Plan
COP19	2019 Country Operational Plan

COP20	2020 Country Operational Plan
COP21	2021 Country Operation Plan
COVAX	Covid-19 Vaccines Global Access
CQI	Continuous Quality Improvement
CrAG	Cryptococcal Antigen
CSE	Comprehensive Sexuality Education
CSF	Civil Society Forum
DBE	Department of Basic Education
DDD	Decentralized Drug Distribution
DHIS2	Digital Health Information Software 2
DMOC	Differentiated Models of Care
DoH	Department of Health
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DR	Drug Resistant
DSD	Direct Service Delivery
DSP	District Service Partner
DTG	Dolutegravir
EFV	Efavirenz
eGK	Electronic Gate Keeping (code)
EID	Early Infant Diagnosis
EQA	External Quality Assurance
FBO	Faith-Based Organizations
FSW	Female Sex Workers
FTE	Full-Time Equivalent
FY	Fiscal Year
G2G	Government to Government

GBV	Gender-Based Violence
GDP	Gross Domestic Product
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GHSA	Global Health Security Agenda
GoSA	Government of South Africa
HAST	HIV/AIDS, STIs, and TB (Directorate)
HEI	HIV Exposed Infants
HIV	Human Immunodeficiency Virus
HIVSS	HIV Self Screening
HPRS	Health Patient Registration System
HMIS	Health Management Information Systems
HRH	Human Resources for Health
HRID	Human Resources Inventory Database
HRIS	Human Resources Information System
HROE	Human Resources Overseas Employment
HSRC	Human Sciences Research Council
HSS	Health Systems Strengthening
HTA	High Transmission Area
HTS	HIV Testing Services
IAS	International AIDS Society
I-ACT	Integrated Access to Care and Treatment
ICASS	Internal Continuous Assessment
IEC	Information Education Communication
IM	Implementing Mechanism
IP	Implementing Partner
IPC	Infection Prevention and Control

IPV	Intimate Partner Violence
ITS	Index Testing Services
KP	Key Populations
LAM	Lipoarabinomannan Assay
LES	Locally Employed Staff
LIVES	Listen, Inquire, Validate, Enhance Safety and Support (approach)
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex People
MDR	Multi-Drug Resistant
MER	Monitoring, Evaluation, and Reporting
MINA	For Men. For Health. “me” in the context of “my community” (Campaign)
MH	Mental Health
MMD	Multi-Month Dispensing
MSF	Medicines Sans Frontiers
M&O	Management and Operations
MLHIV	Men Living with HIV
MOU	Memorandum of understanding
MPR	Minimum Program Requirements
MSM	Men Who Have Sex with Men
NDoH	National Department of Health
NGO	Non-Governmental Organization
NHLS	National Health Laboratory Service
NHI	National Health Insurance
NSP	South Africa National Strategic Plan for HIV, TB, and STIs, 2017-2022
NVP	Nevirapine
OGAC	Office of Global AIDS Coordinator
OVC	Orphans and Vulnerable Children

PBFW	Pregnant and Breastfeeding Women
PCO	PEPFAR Coordination Office
PEPFAR	President's Emergency Plan for AIDS Relief
PEP	Post Exposure Prophylaxis for HIV
PI	Protease Inhibitor
PFIP	Partnership Framework Implementation Plan
PICT	Provider Initiated Counseling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	HIV Pre-exposure Prophylaxis
PT	Proficiency Testing
PWID	People Who Inject Drugs
POC	Point-Of-Care
POPI	Protection of Personal Information (act)
PPL	Program Planning Letter
PUP	Pick-up Point
RPCs	Repeat Prescription Collection Strategies
RFA	Results for Action
SA	South Africa
SAG	South African Government
SAHPRA	South Africa Health Projects Regulatory Authority
SANAC	South African National AIDS Council
SFLA	Spaced and Fast-Lane Appointments
SI	Strategic Information
SID	Sustainability Index Dashboard
SIMS	Site Improvement Monitoring Systems

SMS	Short Message Service
SNU	Sub-National Unit
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
StatsSA	Statistics South Africa
STI	Sexually Transmitted Infections
SW	Sex Workers
SyNCH	Synchronized National Communication in Health
TAT	Turn Around Time
TB	Tuberculosis
TG	Transgender
TLD	Tenofovir/Lamivudine/Dolutegravir fixed-dose combination (ARV)
TEE	Tenofovir Disoproxil Fumarate/Emtricitabine-Efavirenz (ARV)
TPT	Tuberculosis Preventive Therapy
TVET	Technical and Vocational Education and Training College
TDY	Temporary Duty Travel
U.S.	United States
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
USD	U.S. Dollars
USDH	U.S. Direct Hire
USG	United States Government
USPSC	U.S. Personal Service Contract
U=U	Undetectable = Untransmittable
VL	Viral Load

VMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZAR	South African Rand

1.0 Goal Statement

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

PEPFAR SA will focus heavily on improving case finding approaches, returning clients to care, linkage and retention on ART, and viral suppression through expanding access to patient-centered retention strategies, including improved appointment systems and decanting stable patients to adherence clubs, external pick up points, and facility pick up points (including spaced and fast-lane appointments (SFLA)). In addition, PEPFAR SA will continue to support patient-centered interventions such as case management for all patients with unsuppressed viral loads. PEPFAR SA will support the national roll out of Multi-Month Dispensing (MMD) from the current 2-3 month supply to a 6-month supply. Pediatric focused approaches will include scale-up of postnatal and adolescent clubs, pediatric case management, expanded differentiated models of care (DMOC) for children, and optimization of pediatric ART regimens.

Within PEPFAR SA-supported districts, overall viral load (VL) suppression was reported at 93% by the end of Fiscal Year (FY) 20, and it is expected the program will achieve 95% VL suppression across all populations/sex bands by the end of COP21. The roll-out of Tenofovir Lamivudine Dolutegravir (TLD) will continue to scale during COP21, with a focus on informed choice and patient literacy, and is expected to provide an additional boost to both ART coverage and VL suppression rates.

PEPFAR SA will use HIV rapid recency testing (confirmed by VL test) in the four highest burden districts. Data will be collected on demographics (e.g., age, sex,) residence, risk profile, and HIV testing history to help identify hot-spots, and results can be used to prioritize tracing of partners of persons with recent infection. HIV prevention efforts will continue through DREAMS support to 24 districts, increasing focus on VMMC coverage among males aged >15years, and surging the pre-exposure prophylaxis (PrEP) services.

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

PEPFAR SA has focused for impact both geographically and programmatically. During COP21, PEPFAR SA will continue to co-invest in South Africa's 27 highest HIV burden districts—accounting for nearly 80% of PLHIV. Within these districts, COP21 will further focus on the four largest metropolitan districts (accounting for 35% of PLHIV) and populations with largest treatment gaps.

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

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

SA is an upper-middle income country, with many cultures, languages, ethnic groups, and religions. In 2021, the population was estimated at 59.6 million, of which approximately 51% (30 million) were female. Life expectancy at birth was estimated to be 67.7 years for females (72.7 without HIV/AIDS) and 61.5 years for males (65.6 without HIV/AIDS), and the infant mortality rate was estimated at 22.1 per 1,000 live births.¹

*Please note: Some income data is not available as efforts on the Resource Alignment Tool were paused per S/GAC guidance.

In 2021, SA's HIV disease burden was an estimated 7,805,790 PLHIV,² of which more than 4.6 million were women over the age of 25 years. The estimated number of new infections among adults declined by 28% from 2001 to 2021, yet incidence remained high, with an estimated 157,145 new infections in 2021.³

South Africa's HIV epidemic is largely driven by heterosexual transmission, with underlying behavioral, socio-cultural, economic, and structural factors influencing HIV transmission risk. These factors include national and regional population mobility and migration; economic and educational status; lack of knowledge of HIV status; alcohol and drug use; early sexual debut; sexual and gender-based violence (GBV); incomplete coverage of male circumcision; intergenerational sex; multiple and concurrent sexual partners; inconsistent condom use, especially in longer-term relationships and during pregnancy/post-partum; discrimination and stigmatization; and gender dynamics, including unequal power relations between men and women.

The SA National Department of Health (NDoH) and the Departments of Health (DoH) at provincial and district levels lead the public-sector HIV treatment and biomedical prevention efforts to achieve epidemic control. As of 2020, there were 5.5 million people on ART in the public sector, including 160,395 children (<15 years) and 5,320,408 adults.⁴ SA manages the largest national treatment program in the world, although with universal ART eligibility, overall treatment coverage is 70%.⁵ ART coverage is higher among adult females (≥25 years, 77%) than among adult males (≥25 years, 71%), and higher among adolescent girls and young women (15–24 years, 73%) than adolescent males (15–24 years, 66%). ART coverage among children (<15 years) is estimated to be 61% (Table 2.1.2).

¹ Statistics South Africa [StatsSA], Mid-year population estimates, 2020 Statistical Release P0302, Statistics South Africa: Pretoria Accessed Jan 20, 2021 at <http://www.statssa.gov.za/publications/P0302/P03022020.pdf>

² Thembisa 4.3 (2020). Johnson LF, May MT, Dorrington RE, Cornell M, Boule A, Egger M and Davies MA. (2017) Estimating the impact of antiretroviral treatment on adult mortality trends in South Africa: a mathematical modelling study. *PLoS Medicine*. 14(12): e1002468. Thembisa 2020 estimates reflect mid-year 2020 for point estimates (like prevalence) and mid-year 2020 to mid-year 2020 for flow estimates (like number of new infections). The COP21 SDS data tables were generated using Thembisa 4.3, the most recent model that was available at the time the SDS was drafted. Thembisa 4.4 was published in April 2021; please visit Thembisa.org for the most updated estimates

³ Ibid.

⁴ Johnson LF, Dorrington RE (2020) Thembisa 4.3: A model for estimating the impact of HIV/AIDS in South Africa.

⁵ Johnson, *op. cit.*

HIV prevalence and incidence vary significantly across geographic areas; over half of PLHIV are concentrated in the Gauteng and KwaZulu-Natal provinces.⁶ Tables 2.1.1 and 2.1.2 below summarize the key HIV epidemiological data and provide a national view of the 95–95–95 cascade.

The South Africa Human Sciences Research Council (HSRC) issued results the Fifth South Africa National HIV Prevalence, Incidence, Behavior and Communications Survey (SABSSM V) in 2018.⁷ Overall, the survey demonstrated a marked decrease in new infections from 2012 to 2017, with a 56% decline among women. Incidence was higher for women than men, and in the important age group of 15–24 years, incidence was three times higher among young women than young men. An estimated 38% of new HIV infections were among those aged 15–24 years of age.

According to the HSRC 2017 survey, SA had reached 85–71–88 toward the UNAIDS 95–95–95 targets. South Africa has made considerable progress toward testing and identifying PLHIV. Approximately 92% of HIV-positive South Africans aware of their status in 2019. However, South Africa has a significant gap to reach these PLHIV with HIV treatment and keep them virally suppressed.

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

South Africa's plan to put an additional two million PLHIV on ART, announced by President Ramaphosa in the State of the Nation Address in February 2018, was the start of an increasingly targeted effort designed to accelerate epidemic control in SA. The GoSA and PEPFAR SA developed a treatment surge plan, and the roll-out began in COP18 with substantial PEPFAR SA investments in direct service delivery (DSD) in the 27 priority districts that accounted for 82% of the HIV burden in SA. The plan also included high-impact technical assistance and above-site interventions that support the national ART program.

In March 2019, PEPFAR SA and DoH expanded an intensive facility-based support to cover high-volume facilities providing HIV treatment through a program known as "Siyenza!" ("We are doing it!" in Nguni). Siyenza has since been absorbed by the NDoH "Operation Phuthuma" initiative. The Siyenza approach is based on repeated site visits by PEPFAR SA, DoH, and implementing partner staff, with the goal of using quality improvement strategies to ensure full implementation of HIV testing and treatment policies with a focus on improving ART coverage and retention on ART. Guided by the Minister of Health's 10 point plan that defined and outlined performance standards and expectations for DoH staff, facility staff and managers work to ensure that PLHIV are linked to care, PLHIV who miss appointments are immediately called and/or

⁶ Johnson, *op. cit.*

⁷ South Africa Human Sciences Research Council (HSRC), Fifth South Africa National HIV Prevalence, Incidence, Behavior and Communications Survey. Accessible: <https://www.hsrcpress.ac.za/books/south-african-national-hiv-prevalence-incidence-behaviour-and-communication-survey-2017>

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

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

Table 2.1.1 Host Country Government Results

Table 2.1.1 Host Country Government Results															
	Total		<15 years				15-24 years				r				Source, Year
	N	%	Female		Male		Female		Male		Female		Male		
			N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	59 622 350	100%	8,424,597	14.10%	8,626,358	14.50%	4,769,858	8.00%	4,819,371	8.10%	17,299,020	29.00%	15,674,429	26.30%	Statistics South Africa (StatsSA), Mid-year population estimates, 2020 [1]
HIV Prevalence (%)		13.10%		1.60%		1.60%		8.60%		3.60%		26.60%		15.00%	Thembisa 4.3 2020 [2]
AIDS Deaths (per year)	59,101		AIDS deaths in male & female children <15 years= 2365				N/A		N/A		AIDS deaths in female adults ≥15 years= 23,325		AIDS deaths in male adults ≥15= 33,412		Thembisa 4.3 2020 [2]
# PLHIV	7,805,790		131,980		131,980		492,075		170,901		4,605,860		2,354,724		Thembisa 4.3 2020 [2]
Incidence Rate (Yr)		0.30%		0.06% (10-14)		<0.06% (10-14)		0.97%		0.23%					Thembisa 4.3 2020 [2]
New Infections (Yr)	157,145		6,702 (1,615 ages 10-14)		5,141 (54 ages 10-14)		42,230		10,613		54,777		38,988		Thembisa 4.3 2020 [2]
Annual births	1,181,420	100%													StatsSA, 2020 [1]
% of Pregnant Women with at least one ANC visit	N/A	98%	DHS has age disaggregations <20 (94.7%), 20-34(93.5%) and 35-49 (93.4%).												DHS (3)
Pregnant women needing ARVs	91,652	8.20%													DHS
Orphans (maternal, paternal, double)	2,763,000 (523878 maternal; 1520935 paternal; 405583 double)		N/A		N/A		N/A		N/A		N/A		N/A		General Household Survey, 2019? [4] StatsSA, 2019 [12]
Notified TB cases (Yr)	222,350		N/A		N/A		N/A		N/A		N/A		N/A		WHO, 2020 [5]
% of TB cases that are HIV infected	104,010	58%	NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	WHO, 2020 [5]
% of Males Circumcised	4,330,000 (medical; 15+)	61.65% (all)			1,064,835	13.4% (all)			1,773,689	70.2% (all)			6,948,082	59.9% (all)	SABSSM V, 2017 [6]

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Estimated Population Size of MSM*	357,876	1.4- 2.2%														UCSF, 2020 [7]
MSM HIV Prevalence	112,048	24%														UCSF, 2020 [7]
Estimated Population Size of FSW	127,190	0.5 - 1.0%														UCSF, 2020 [7]
FSW HIV Prevalence	68,913	51%														UCSF, 2020 [7]
Estimated Population Size of PWID	75,700	NA														SANAC, 2015 [8]
PWID HIV Prevalence	NA	14%*														Scheibe [9]
Estimated Size of Priority Populations: Black African Females 15-34 years	74,508	100%														South African Department of Defence, 2019 [10]
Estimated Size of Priority Populations: Black African Males 25-49 years	8,596,218	100%														StatsSA, 2020 [1]
	9,338,737	100%														StatsSA, 2020 [1]

*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources

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

The COP21 SDS data tables were generated using Themبisa 4.3, the most recent model that was available at the time the SDS was drafted. Themبisa 4.4 was published in April 2021; please visit Themبisa.org for the most updated estimates

[1] S+29:39Statistics South Africa [StatsSA], Mid-year population estimates, 2020 Statistical Release P0302, Statistics South Africa: Pretoria Accessed Jan 20,2021 at <http://www.statssa.gov.za/publications/P0302/P03022020.pdf>

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

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

[4] Statistics South Africa [StatsSA], General Household Survey, 2019. Statistical Release P0318, Statistics South Africa: Pretoria.

[5]Global tuberculosis report 2020. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO. *Tuberculosis Country Profiles (South Africa 2020)*. Accessed Jan 25, 2021 at <https://tbsouthafrica.org.za/sites/default/files/2020%20WHO%20Global%20Tuberculosis%20Report%20-%20South%20Africa%20Profile.pdf>

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

[7] University of California, San Francisco. (2020). Consensus Cascades. [Dataset]

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

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

[10] South African Department of Defence Annual Report 2017/2018. Accessed Jan 26 2021 at https://www.gov.za/sites/default/files/gcis_document/202002/dod-annual-report-fy2018-19-final-web-layout.pdf

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

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data				HIV Treatment and Viral Suppression				HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#) [1]	HIV Prevalence (%) [2]	Estimated Total PLHIV (#) [2]	PLHIV Diagnosed (#) [2]	On ART (#) [2]	ART Coverage (%) [2]	Viral Suppression (%) [2,5]	Tested for HIV (#) [3]	Diagnosed HIV Positive (#) [3]	Initiated on ART (#) [3]
Total population	59,622,350	13.10%	7,805,790	7,333,419	5,480,800	70%	66%	12,612,764	564,425	504,286
Population <15 years	1,050,955	1.60%	288,768	212,113	160,395	61%	44%	1,003,641	11,637	11,422
Men 15-24 years	4,828,088	3.60%	170,901	145,151	103,568	66%	68%	3,589,994	198,082	173,510
Men ≥25 years	15,674,429	15.02%	2,354,724	2,198,220	1,552,146	71%	84%			
Women 15-24 years	4,769,858	8.60%	410,335	339,106	241,367	73%	78%			
Women 25+ years	17,299,020	26.62%	4,605,860	4,438,829	3,423,327	77%	88%	7,993,057	353,648	319,353
MSM [2,4,6]	357,876	24%	112,048	47,167	32,183	53%	63%	36,313	2,897	2,116
FSW [2,4,6]	127,190	51%	68,913	52,108	34,999	70%	76%	25,852	3,567	2,994
PWID [7,8,9]	75,000	21%	15,750	N/A	N/A	N/A	N/A	1,157	512	449
(People in prisons)								15,033	1,169	993
HIV: Human Immunodeficiency Virus; PLHIV: People Living with HIV; ART: Antiretroviral Therapy										
MSM: Men who have Sex with Men; FSW: Female Sex Workers; PWID: People Who Inject Drugs										
[1] Statistics South Africa [StatsSA]. Mid-year population estimates, 2020. Statistical Release P0302, Statistics South Africa: Pretoria										
[2] Johnson LF, Dorrington RE (2020) Thebisa 4.3: A model for estimating the impact of HIV/AIDS in South Africa.										
[3] PEPFAR reported data (APR 2020). PEPFAR SA partners have used TIER.Net for HIV testing and treatment reporting from FY17Q3 onward. Viral suppression results are patient-level viral suppression rates at the most recent test done within the past year, as reported in TIER.Net.										
[4] University of California, San Francisco. (2020). Consensus Cascades. [Dataset]										
[5] NHLS Viral Load dashboard										
[6] Naomi South Africa district estimation model										
[7] UNAIDS. Do no harm. Health, human rights and people who use drugs. Report. Geneva: UNAIDS; 2016. Available from: http://www.unaids.org/sites/default/files/media_asset/donoharm_en.pdf .										
[8] Scheibe, A., Young, K., Moses, L. et al. Understanding hepatitis B, hepatitis C and HIV among people who inject drugs in South Africa: findings from a three-city cross-sectional survey. Harm Reduct J 16, 28 (2019). https://doi.org/10.1186/s12954-019-0298-2 .										
[9] No new data on PWID; data from previous sources used										

Figure 2.1.3 National and PEPFAR South Africa Trends for Individuals Currently on Treatment

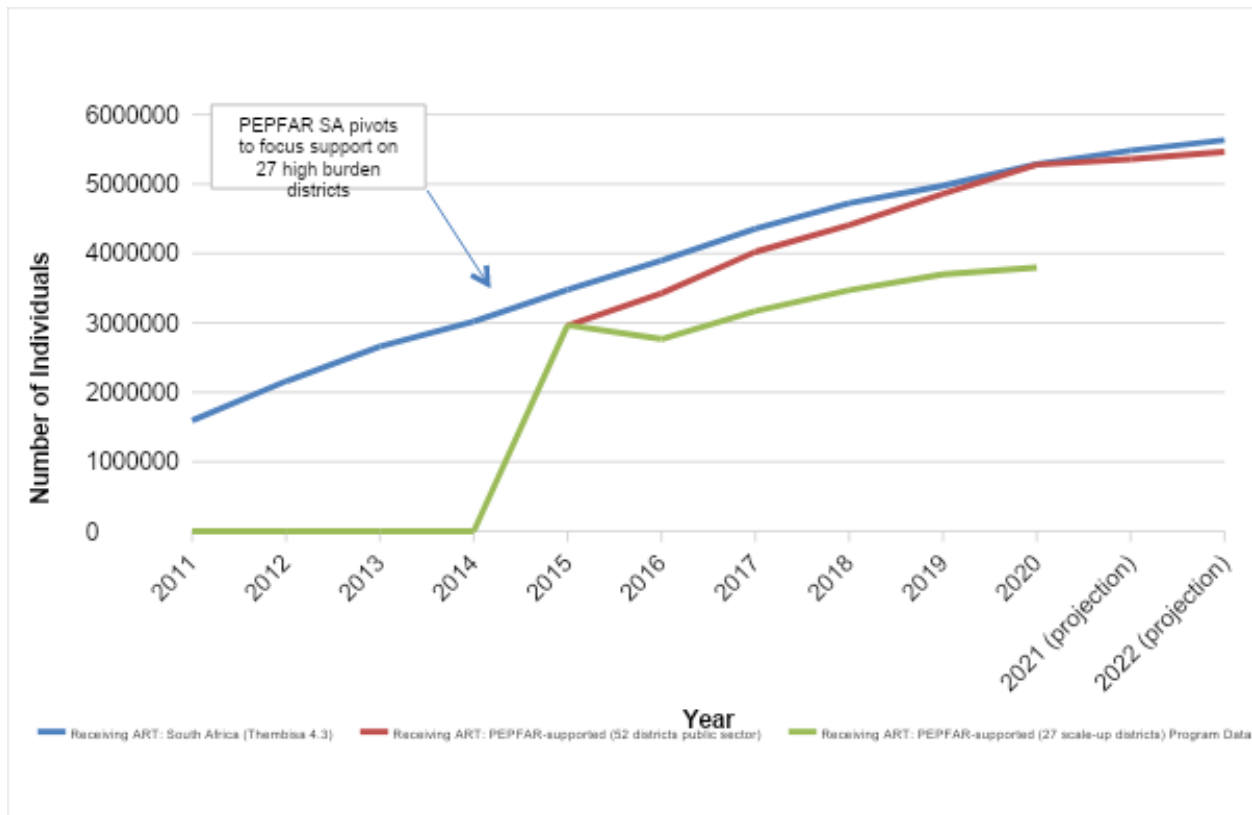


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among People Living with HIV/AIDS

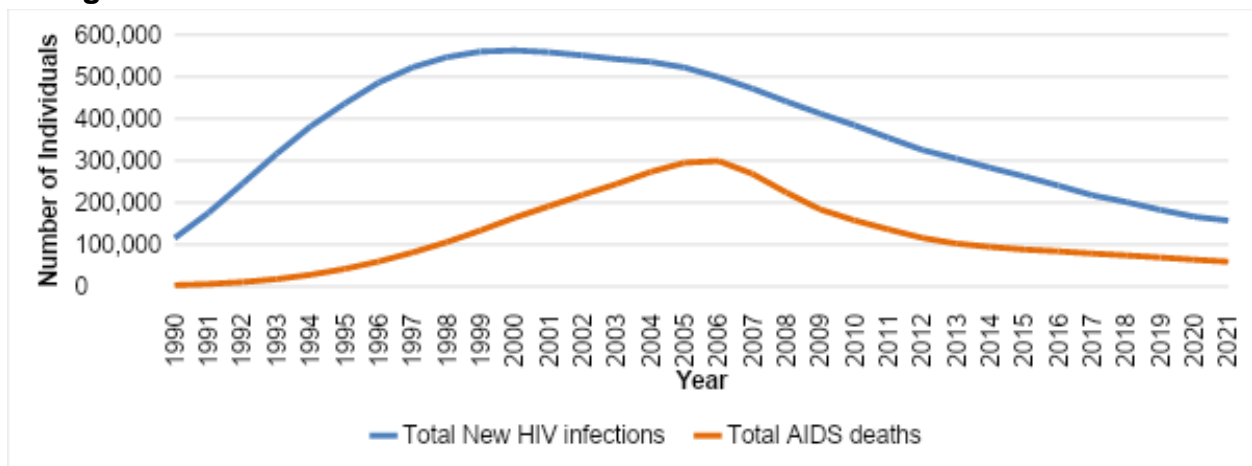


Figure 2.1.5 Progress Retaining Individuals in Lifelong Antiretroviral Treatment in FY20

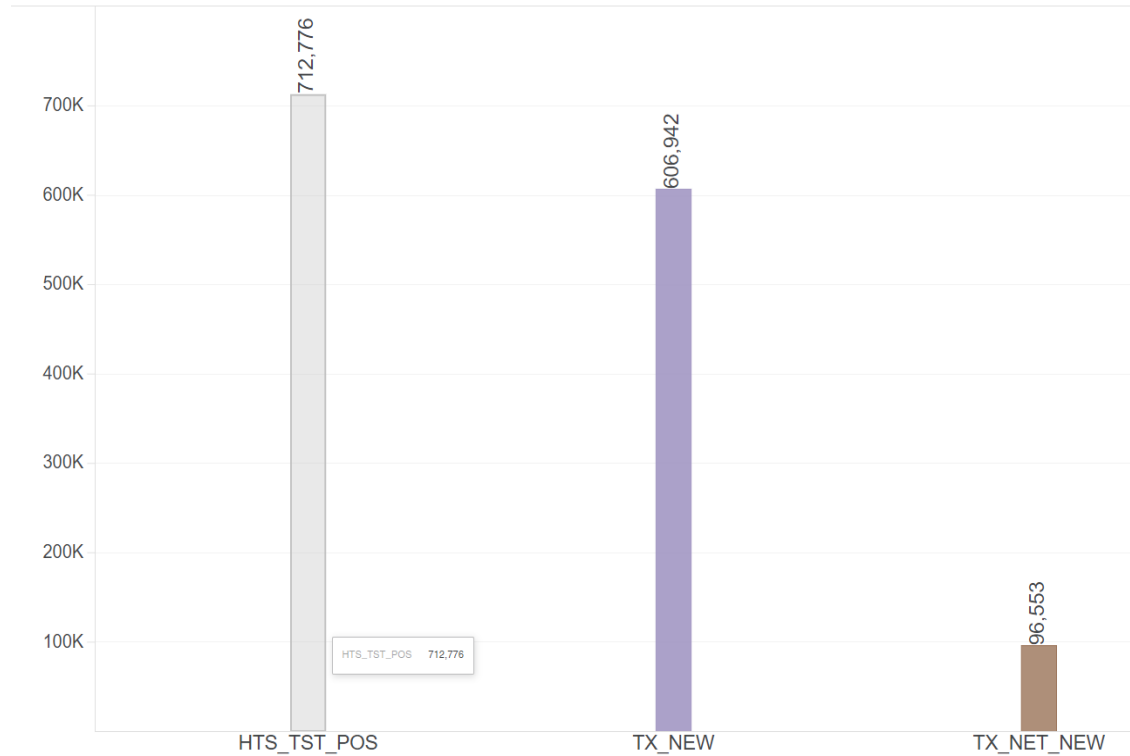


Figure 2.1.6 Clients Gained/Lost from Antiretroviral Treatment by Age/Sex, FY20 Q4

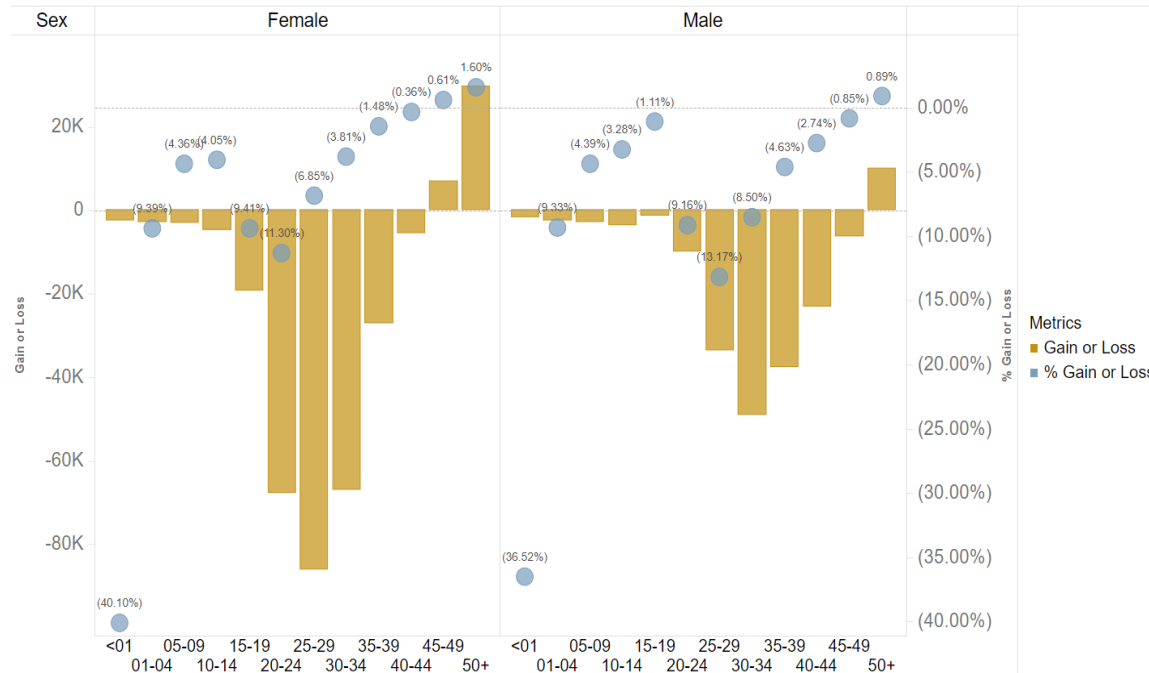
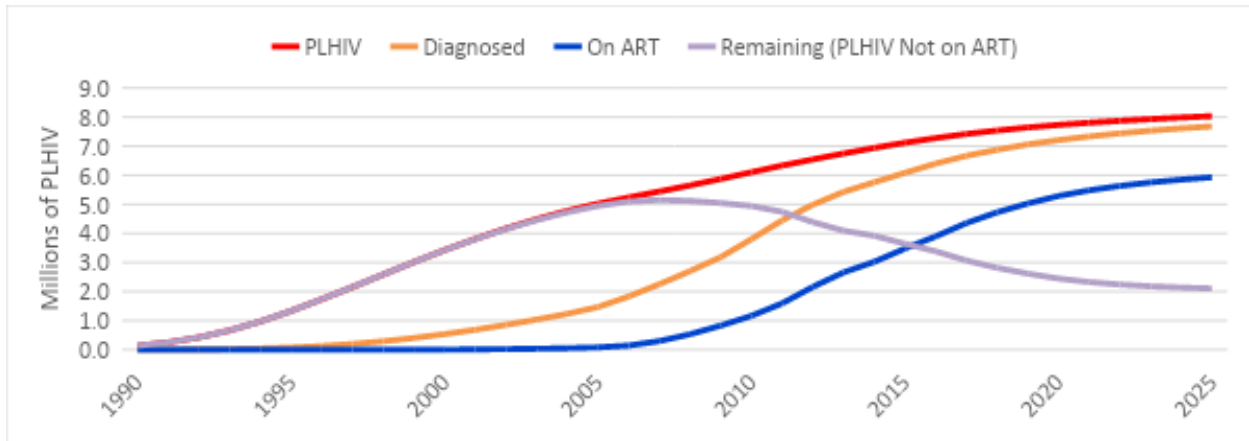
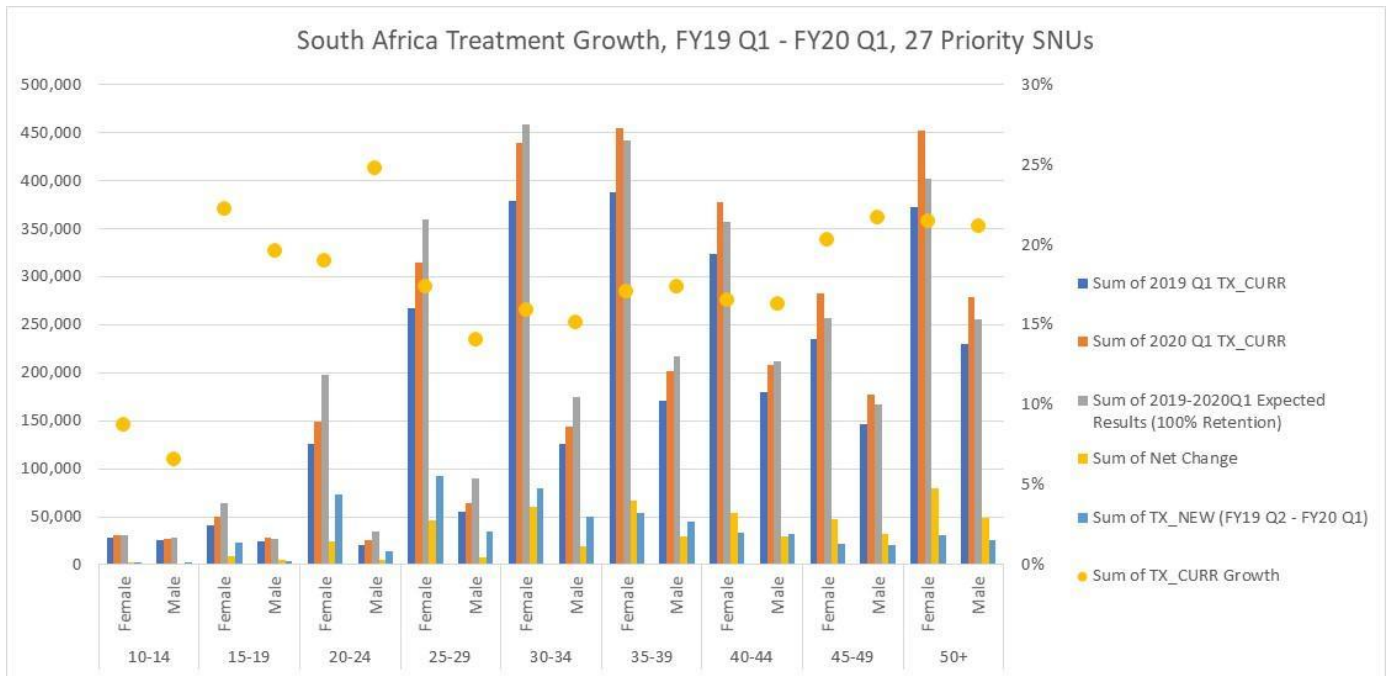


Figure 2.1.7 Projected Epidemiologic Trends and Program Response for your Country (Scaled)



Sources	Thembisa 4.3
Notes	PLHIV = Mean Total HIV infections estimates from Thembisa 4.3
	HTS_TST_POS replaced with Thembisa 4.2 derived Diagnosed volume
	Diagnosed Volume = % of HIV-positive individuals diagnosed * PLHIV
	On ART = Mean Total on ART

Figure 2.1.8 Net change in HIV treatment by sex and age bands 2019 Q4 to 2020 Q4



2.2 New Activities and Areas of Focus for COP21, Including Focus on Client ART Continuity

The COP21 approach focuses on client centered, age and gender tailored interventions to reach saturation across both genders and all age bands. PEPFAR SA will continue to provide substantial support to facility- and community-level human resource investments to enable HIV testing, same-day ART initiation, extended service hours, patient navigation, active linkage, peer-based case management, adherence and ART continuity, tracking and tracing, and repeat prescription collection strategies (RPCs) in districts with the highest number of PLHIV and the greatest gap to reaching UNAIDS 95–95–95 targets.

In line with the success of the Siyenza/Phuthuma efforts, PEPFAR SA will continue its intensive partner management and support in COP21. PEPFAR SA staff will work closely with NDoH to accelerate the Phuthuma approach at both national and provincial levels cascading down to the district and facility levels through quality improvement forums that focus on the greatest area of need and are attended by technical leads from PEPFAR SA, GGFATM, UNAIDS, WHO, NDoH, and Civil Society. In addition, performance-based recognition rewarding high-performing facilities will be used to further bolster the NDoH-PEPFAR SA collaboration at the site-level. PEPFAR continues to seek ways to expand PLHIV peer led patient support leveraging off the success of the Coach Mpilo model which has realized success for men living with HIV (MLHIV). This intervention has been heralded for its empathetic approach.

Treatment Program Growth - Case Finding and New Initiations

For case finding, in COP 21, PEPFAR SA will continue to optimize high yield targeted testing with a special focus on index testing services (ITS). PEPFAR SA will achieve this through the new standardized NDoH data collection tools and ensuring that known positives not previously on ART are also linked to treatment and ITS. PEPFAR SA will intensify the distribution of HIV Self Screening (HIVSS) kits in pharmacies and online platforms, with a special focus on men, Key Populations, and others in communities who are unable or unwilling to utilize health facilities. PEPFAR SA will also aim to standardize the reporting of the HIVSS cascade to monitor yield and linkages. To decrease over-testing in facilities the use of the HIV risk screening tool for both adults and pediatrics will be intensified at all testing sites. A strategic mix of testing modalities will be implemented to increase the yield with support from Civil Society for community mobilization and education. To address issues and challenges with ITS recorded by Civil Society's Ritshidze platform, PEPFAR SA will continue to ensure that the risk of coercion is monitored through acceptance rates monitoring; clients are informed of their rights to refuse index testing without impact on regular clinic services; intimate partner violence (IPV) screening is done 100% of the time with ITS stopped when signs are recorded; adverse event monitoring with referrals to psychosocial services are recorded with outcomes; and that adverse events includes more than IPV screening, but also include loss of income, homes and relationships.

In COP21, PEPFAR SA will continue to strengthen direct facility and community linkage to sustain >95% linkage in all PEPFAR SA supported districts. Strategies to improve linkage and treatment initiation in COP21 will be tailored for each setting and include same-day ART initiation for all eligible clients. To improve community linkage, clients will be offered same-day ART and sustained community ART, where feasible. The community services provision

approach will not be limited to ART services but will be integrated to include TB, COVID-19, and other services. Linkage officers will facilitate the handshake model (escorting HIV positive patients directly from testing to the ART initiation room/officer) to strengthen community to facility linkage as well. Within facilities, clients will be offered same-day ART, and patient navigators and/or peer-based linkage officers will ensure linkage to care. In COP21, the PEPFAR team intends to continue to support direct placement of lay counselors, nurses, and linkage officers to focus on case finding and ART initiation. PEPFAR SA will also improve and adapt the case management approach and scale up what is working. This will include incorporating performance-based recognition and further trainings to improve quality counselling. PEPFAR SA will scale the use of “Expert Clients” and assign support to further scale-up of population-specific case manager cadres (such as Coach Mpilo for men and Mentor Mothers for pregnant women) expanding to key populations as far as possible. These case managers will work with each client to assess the risks and barriers to treatment initiation and ART continuity. All case management work will be continuously monitored, assessed, and improved.

PEPFAR SA will strengthen patient literacy on the importance of ART initiation upon HIV diagnosis, staying on treatment once initiated, and the key and liberating impact of knowing their viral load and achieving an undetectable status. Additionally, better and more efficacious treatment options will be scaled-up to improve treatment initiation and maintenance on treatment for all populations, especially children.

Retention of all Clients Over Time – Reducing Interruption in Treatment and Case Management

In COP19 and COP20, all PEPFAR SA-supported districts were grossly affected by the SARS-CoV-2 pandemic. Clients were lost during the COVID-19 lockdown period and mop up efforts were required to return clients to care and back capture all clients who received care but were not captured due to COVID-19 related factors (e.g. staff absenteeism, staff deaths, and clinic closures). The SARS-CoV-2 pandemic and lockdown in COP19 and COP20 led to significant decreases in clinic headcounts across the country with decreases as high as 50% in some high-volume facilities and districts, at the peak of the epidemic.

In COP21, PEPFAR SA will intensify and tailor back to care efforts, promoting self-health for re-initiation and staying on treatment, promoting behavior change through the improvement of knowledge, attitudes, and perceptions of HIV treatment and warmly welcome back clients to re-engage in client-centered services. Communications campaigns incorporating U=U messages for all populations will be used to strengthen patient literacy and demand for services and to improve provider knowledge regarding HIV treatment. The PLHIV/Civil Society sector will be engaged to promote patient health literacy efforts. PEPFAR SA will ensure that healthcare workers — including implementing partner staff and community healthcare workers — are providing accurate and easily understandable information on treatment adherence and the importance of an undetectable viral load when talking to PLHIV, through counselling, and through health talks at clinics. Spot checks on this will take place during site support visits.

Case management will be improved and scaled for continued peer-to-peer support. Population-focused approaches to strengthen retention will include continuing to scale-up postnatal clubs, pediatric-focused case management, and the Coach Mpilo model of case management for men.

PEPFAR SA will also continue to build on the successful efforts to increase the number of patients decanted into RPCs, including through the national CCMDD program, with a specific focus on expanding external pick-up points and restarting Adherence Clubs where feasible while ensuring IPC for COVID-19. RPCs include facility-based pick up points such as fast lanes, Adherence Clubs - both facility- and community-based(which were used as pick-up-points during COVID-19 lockdown), and external pick-up points (such as private pharmacies). Overall, retention among people established on treatment who have been decanted (enrolled into any of the RPCs) is high in SA. Demand creation for RPCs is being implemented in COP20 through the DapLap campaign and the PEPFAR SA team will aim to increase the total proportion of eligible patients decanted to 85% in COP21 with the majority (60%) decanted to external pick-up-points, and 20% from an Adherence Club. At the same time, the PEPFAR SA team will continue to scale up PLHIV-led support groups while exploring non-physical contact support measures in the setting of COVID-19 to ensure that newly diagnosed PLHIV, PLHIV returning to care, or PLHIV struggling with adherence are provided with the option to be linked to these support groups.

The PEPFAR SA team will continue to monitor the number of clients decanted into the CCMDD program on a quarterly basis overall and on a monthly basis at Siyenza sites—including monitoring enrollment through the SyNCH (CCMDD monitoring) program that the PEPFAR SA program developed, and is in the process of transition to NDoH for national ownership and oversight.

An enhanced focus in COP21, will be increasing the enrollment of children and adolescents into RPCs,, in alignment with recent updated guidance released by NDoH. PEPFAR SA will continue to support RPCs implementation at the national level, including through supporting CCMDD service providers, helping transition SyNCH ownership to the NDoH and providing technical assistance to the NDoH related to stock provisions. In addition, the PEPFAR SA team will work with the NDoH to support national roll out of MMD, with 3-MD formally initiated in COP19 and expected to be rolled-out nationally in COP20 and 6-MD expected to be initiated in COP20 and expanded in COP21 to all eligible PLHIV.

Systems will be put in place to ensure RPCs functionality, to ensure that they streamline ART refill collection to make it quicker, easier and increase overall patient satisfaction. A specific focus will be put on collaborating with Civil Society and implementing partners in order to audit and improve the quality of facility and community-based adherence clubs as outlined in the “People’s COP21”. Where possible, PLHIV will be recruited as Adherence Club facilitators to provide up to date adherence information at club meetings.

Prior to the COVID-19 pandemic and associated lockdown, PEPFAR SA Monitoring, Evaluation, and Reporting (MER) and Siyenza data showed a significant decline in the number of patients falling off of treatment after instituting more frequent monitoring and earlier follow-up of patients who missed appointments. In COP21, PEPFAR SA will continue to reduce the number of clients

disengaging from care through sending appointment reminders and immediate tracking of patients who miss appointments. PEPFAR SA will ensure that staff involved in this (including PEPFAR SA staff-funded staff) are provided with adequate equipment including phones, airtime, data and reliable transport to be able to implement this effectively. In addition, during COP20 and COP21, PEPFAR SA will focus on preventing treatment interruptions by better understanding the individual characteristics and reasons for disengaging from care and focusing on improving patient experience during clinic visits. Key strategies to do this include decanting people established on treatment to reduce queues and shorten waiting times, expanding hours of operation including weekends, offering scheduled visits with appointment times, re-training and sensitizing providers on friendly/compassionate services, ensuring organized/up-to-date/available patient records that are stored in confidential rooms inaccessible by other patients, and providing population-specific services like Men's Corner (e.g. specific spaces to provide services to male clients), youth-friendly services during after school and weekend hours, and community ART. PEPFAR SA will support GoSA to ensure that no PLHIV will be sent to the back of the queue if they miss an appointment.

PEPFAR SA will continue to provide enhanced support through text message (e.g. Short Message Service - SMS) reminders and early assignment of Case Managers to patients initiating therapy, as part of client centered services provision. Close follow-up of patients will begin from the time an individual is diagnosed (e.g. same day). We will also strengthen patient access to mental health services, working with NDoH at the national level improve processes for managing patients with mental health comorbidities. This will include capacitating district support partners (DSPs) and DoH staff to manage simple mental health problems and to identify and appropriately refer patients with more complex care needs.

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

ART Optimization

The PEPFAR SA team supported the NDoH to scale-up TLD in the latter part of COP19 and early part of COP20, with over half of ART patients in South Africa receiving TLD as of the end of the first quarter of COP20. In COP21, PEPFAR SA will continue to support the NDoH to further expand and monitor TLD access in South Africa. A greater focus will be placed on ensuring that all patients are offered TLD within the context of informed choice, by expanding

the availability of patient education materials (which will be further developed with inputs from PLHIV) and healthcare worker job-aids that clarify the risks and benefits. PEPFAR SA will specifically focus on strengthening transition of eligible children and adolescents living with HIV onto TLD and DTG-based regimens; fast tracking registration of DTG 5mg and 10mg dispersible tablets; and roll-out of other more child-friendly formulations. PEPFAR SA will support pharmacovigilance efforts to track side effects and support on-going training of health care workers, including side effect monitoring and appropriate regimen switch, in alignment with national guidelines. Although VL suppression rates are high among those currently on ARVs, the roll-out of TLD and DTG-based regimens during COP19 and COP20 is expected to further improve retention and VL suppression.

As per the SA ART Clinical Guidelines, PEPFAR SA will continue tracking BMI amongst PLHIV during clinical visits. Where problematic weight gain is identified, clinicians will refer the PLHIV to a dietician in order to properly support the individual or provide necessary counselling as necessary. Further PLHIV will be screened for other NCDs associated with obesity. In conjunction with meaningful inputs from PLHIV, people friendly materials and topics will be expanded to help people in diet and nutrition, to be rolled out across PEPFAR supported clinics, adherence clubs and support groups.

TB/HIV

In COP21, PEPFAR SA will support the GoSA to ensure that individuals with TB know their HIV status, to effectively link HIV-infected TB patients to appropriate HIV treatment, and to scale up Tuberculosis Preventative Therapy (TPT) initiation and completion among PLHIV. The COVID-19 pandemic has eroded the previous gains of the TB/HIV program. Therefore, PEPFAR SA will support the implementation of the National TB Recovery Plan to find the missing TB cases, support the integration of TB screening with COVID-19 testing, improve TB case notifications, ensure prompt TB treatment initiation, and monitor TB treatment completion. Priorities include integration of community-based TB/HIV service delivery, ensuring implementation of targeted universal TB testing at all PEPFAR-supported facilities, integration of TB services into Men's health programs, increased HIV testing among individuals with presumptive TB, and ensuring rapid ART initiation for TB/HIV co-infected individuals. Ensuring data quality for reporting on the TB cascade will be key. In addition, with PEPFAR SA's dedicated TB/HIV funding, partners will be expected to further scale-up TPT, including among those currently on treatment who have not previously received TPT and those in differentiated care models. A greater focus will be placed on ensuring TPT completion (currently 61%) through the roll-out of 3HP (Rifapentine and Isoniazid) and provision of dedicated adherence support focused on TB prevention and TB treatment

PEPFAR SA supports the implementation of the National TB recovery plan to mitigate TB losses and improve TB case notifications. As part of the PEPFAR SA support for TB/HIV, we are prioritizing interventions to improve TB case finding and increase case notification. We continue to focus on improving TB screening among PLHIV, promoting the use of mHealth solutions such as the TB mobile screening App, increasing access to Gene Xpert testing and Urine LAM testing and strengthen linkage to TB treatment. In COP21, we will continue to use the TB_STAT denominator as a proxy indicator to monitor TB case finding. PEPFAR SA will continue to

support facilities to increase the TB screening rate to 100%. Site-level staff will be expected to have a greater focus on TB case finding and increasing Xpert testing among PLHIV in COP21 than in prior years. DSPs will be expected to ensure that 100% of PLHIV who present to care with signs and symptoms of TB or advanced HIV disease in inpatient and outpatient settings receive rapid molecular testing and urine LAM. PEPFAR SA implementing partners will support the NDoH to roll-out TB urine-LAM testing with aim of ensuring that it will be available at all PEPFAR supported sites. PEPFAR SA will roll out Targeted Universal Testing for TB in all high TB burden districts (TB tests offered to all PLHIV, everyone who reported having close contact with a TB patient and everyone who reported having TB in the past two years—all groups considered to be at high risk of TB). To address linkage to TB treatment and reduce pre-treatment LTFU, DSPs will use the case management approach will ensure HIV-infected TB patients are linked to appropriate treatment according to GoSA guidelines.

DSP's will additionally be expected to ensure appropriate implementation of infection prevention and control (IPC) practices and support rapid quality-improvement cycle to ensure that programmatic and facility implementation barriers are resolved rapidly for improved performance. PEPFAR SA will continue to monitor risk assessments conducted and track improvement of IPC scores in supported facilities. The IPC checklist used by DSPs to conduct risk assessment also focuses on ensuring that clients with TB symptoms are fast tracked and have a separate waiting area. PEPFAR SA will work with National, Provincial, District, and site-level officials to improve both the monitoring and reporting of key IPC metrics. PEPFAR SA will also utilize feedback from community-led monitoring and our own site visits to target facilities that need to improve implementation of core infection control activities. Priorities for all PEPFAR SA-supported sites include: universal TB screening; all windows being kept open; large multi-language TB infection control posters to be displayed in visible places in the waiting area; patients to be screened for TB symptoms upon arrival; people coughing or with TB symptoms to be seen first to reduce the risk of transmission; people who are coughing to be separated from those who are not while waiting; and people who cough a lot or who may have TB to be given tissues or TB masks (after masks are no longer required by COVID-19). TB champions and roving teams will further strengthen implementation of these activities during COP21. PEPFAR SA has set a goal of 100% of clinics scoring "Green" on TB infection control as per the Ritshidze indicators. DSPs conduct TB quality improvement (QI) activities across all PEPFAR SA supported districts. In COP21, PEPFAR SA will strengthen the collaboration of TB QI activities with the DoH and other partners.

At the above-site level, PEPFAR SA investments include pharmacovigilance, an evaluation of TPT adherence in the context of the roll-out of 3HP, an evaluation to understand missed opportunities for ART initiations among PHLIV with presumptive TB, and advanced clinical care to support the roll-out of TB-LAM (accessible as a POC test at all primary facilities in both inpatient and outpatient settings) and Multi-drug Resistant (MDR) TB treatment.

Population Specific Interventions

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

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

2.3 Investment Profile

The national HIV response in SA is funded primarily by the GoSA through domestic public revenue, with additional funding from external development partners (donors) such as PEPFAR SA and the GFATM, as well as the private sector. Donor funding focuses on complementing government resources and piloting innovative interventions. The country has faced a constrained fiscal environment in recent years (i.e. considerable deficits and a growing debt-to-GDP ratio). Despite these constraints, the GoSA's financial commitment to HIV programs grew annually through the local financial year 2020/21., Funding for HIV grew more than the overall health budget over the last nine years, with the GoSA nearly tripling its domestic budget for HIV treatment to over USD1.5 billion in 2020.

Unfortunately, the SARS-CoV-2 pandemic has had devastating impacts on the economy and public finances. The National Treasury expects that real output may only return to pre-pandemic levels in 2024. The Treasury has hinted at national spending cuts totaling ZAR300 billion (roughly USD20 billion); it is still unclear how much of this will come from the health budget, specifically. Regardless, increases in HIV funding over the next three to five years—at pre-pandemic levels, if at all—are unlikely.

In 2020/21, the total GoSA budget on HIV and HIV/TB was ZAR25 billion (roughly USD 1.7 billion). This may be reduced for 2021/22. However, SA's proportional contribution will remain substantial. In terms of the relative domestic and donor contributions, the most recent available study, the 2016/17 National AIDS Spending Assessment (NASA), showed the GoSA's HIV investment comprising more than 71% of all investments. Data collection for a new NASA is underway now, with results expected in March/April 2021. In the interim, Table 2.3.1 reflects recently reported figures for the GoSA, PEPFAR SA, the GFATM, and other donors.

Within the GoSA's response, the NDoH is the largest spender on HIV services, primarily via the HIV/TB Conditional Grant mechanism (ZAR22.0 billion in 2019/20, ~USD1.5 billion), followed by the Department of Social Development (ZAR1.3 billion for 2019/20, ~USD89 million). According to the National Strategic Plan for HIV, TB, and STIs for 2017–2022, insurance costs for private ART patients was estimated to total ZAR2.3 billion (~USD159 million) in 2019/20.

Due to South Africa's high HIV burden and the large and growing number of patients on treatment, HIV program costs are expected to continue to increase over time, primarily driven by expanding provision of ARVs and ART service delivery. However, the continued rollout of TLD is expected to partially offset these increases. Given SA's constrained economy, the GoSA has leveled funding for many services, and future rising HIV and TB resource needs are projected to consume an increasing share of the health budget. PEPFAR SA will work closely with the GoSA and development partners to ensure sustainability and continuity of service provision despite domestic funding cuts (further described in Section 2.4).

Table 2.3.1 Investment Profile (Funding Landscape) for HIV Programs

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	\$	%	%	%	%	2018-2021
Antiretroviral Drugs	\$23,229,923	0%	62%	38%	0%	
Laboratory Supplies and Reagents	\$130,196	0%	100%	0%	0%	
CD4	\$0					
Viral Load	\$0					
Other Laboratory Supplies and Reagents	\$130,196	0%	100%	0%	0%	
Laboratory (Not Disaggregated)	\$0					
Medicines	\$11,448,272	0%	78%	22%	0%	
Essential Medicines	\$458,401	0%	100%	0%	0%	
Tuberculosis Medicines	\$10,875,701	0%	77%	23%	0%	
Other Medicines	\$114,170	0%	100%	0%	0%	
Consumables	\$15,577,722	0%	50%	50%	0%	
Condoms and Lubricants	\$5,616,473	0%	100%	0%	0%	
Rapid Test Kits	\$3,801,375	0%	50%	50%	0%	
VMMC Kits and Supplies	\$5,927,980	0%	0%	100%	0%	
Other Consumables	\$231,894	0%	100%	0%	0%	
Health Equipment	\$745,599	0%	100%	0%	0%	
Health Equipment	\$745,599	0%	100%	0%	0%	
Service and Maintenance	\$0					
PSM Costs	\$3,766,605	0%	59%	41%	0%	
Total Commodities Only	\$54,898,317	0%	62%	38%	0%	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.

Table 2.3.2 Investment Profile (Funding Landscape) for HIV Commodities

NB: The domestic government figures were not obtained due to cancellation of the Resource Alignment tracking activities.

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	\$	%	%	%	%	2018-2021
Antiretroviral Drugs	\$23,229,923	0%	62%	38%	0%	
Laboratory Supplies and Reagents	\$130,196	0%	100%	0%	0%	
CD4	\$0					
Viral Load	\$0					
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Laboratory (Not Disaggregated)	\$0					
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Essential Medicines	\$458,401	0%	100%	0%	0%	
Tuberculosis Medicines	\$10,875,701	0%	77%	23%	0%	
Other Medicines	\$114,170	0%	100%	0%	0%	
Consumables	\$15,577,722	0%	50%	50%	0%	
Condoms and Lubricants	\$5,616,473	0%	100%	0%	0%	
Rapid Test Kits	\$3,801,375	0%	50%	50%	0%	
VMMC Kits and Supplies	\$5,927,980	0%	0%	100%	0%	
Other Consumables	\$231,894	0%	100%	0%	0%	
Health Equipment	\$745,599	0%	100%	0%	0%	
Health Equipment	\$745,599	0%	100%	0%	0%	
Service and Maintenance	\$0					
PSM Costs	\$3,766,605	0%	59%	41%	0%	
Total Commodities Only	\$54,898,317	0%	62%	38%	0%	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.

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

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
(USG) Funding Source	Total USG Non-PEPFAR SA Resources (USD)	Non-PEPFAR SA Resources Co-Funding PEPFAR IMs ^b (USD)	# Co-Funded IMs ^b (USD)	PEPFAR SA COP Co-Funding Contribution (USD)	Objectives
USAID Maternal and Child Health	N/A	N/A	N/A	N/A	N/A
USAID TB	14,500,000	N/A	N/A	N/A	TB technical assistance to GoSA
USAID Malaria	N/A	N/A	N/A	N/A	N/A
Family Planning	N/A	N/A	N/A	N/A	N/A
National Institutes of Health	135,000,000 ^a	N/A	N/A	N/A	To advance health objectives
Centers for Disease Control and Prevention (CDC) - Global Health Security	135,000	N/A	N/A	N/A	Provide Global Health Security technical assistance and support to the South African Government through the Field Epidemiology Training Program
Peace Corps	2,322,800	N/A	N/A	N/A	Peace Corps USG non-PEPFAR SA resources are allocated to its Literacy Enrichment Project which focuses on strengthening literacy for school aged children in South Africa
Department of Defense Ebola	N/A	N/A	N/A	N/A	N/A
Millennium Challenge Corporation	N/A	N/A	N/A	N/A	N/A
Other (specify)	N/A	N/A	N/A	N/A	N/A
Total	\$151,967,800				
^a					
^b IM: Implementing Mechanism					

2.4 National Sustainability Profile Update

The most recent round of PEPFAR SA's National Sustainability Profile was completed in November 2019 using the Sustainability Index and Dashboard (SID) 4.0. The engagement

process was led by the South African National AIDS Council (SANAC), GoSA, UNAIDS, and PEPFAR SA, and invited multisectoral partners from government and non-governmental organizations (NGOs), the private sector, Civil Society, health bilateral and multilateral partners, and international NGOs working in South Africa's HIV program. The group completed the review of the index's 17 critical sustainability elements.

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

Since completing the SID in 2019, there has been progress made towards reductions in the vulnerabilities within these elements. For example, in the area of human resources for health, the substantial improvements made to leverage the strategic value of the Ward Based Primary Health Care Outreach Team program (Community Health Workers), including setting performance targets, is expected to lead to important gains in ART patient linkage and retention. These investments contribute to improving sustainability of the national HIV program by optimizing the value of these important community resources. Specifically, the area of health data is also a priority and PEPFAR SA anticipates substantial progress in health data systems is underway to improve the quality, availability and use of data to inform effective program investments.

As noted in Section 2.3 (Investment Profile), the GoSA funds the vast majority of the HIV response in the country, with PEPFAR SA the next largest contributor with about 26% of the overall investment. In COP21, PEPFAR SA will continue to invest in the five program elements with the weakest sustainability scores, consistent with the NDoH/PEPFAR SA HIV Treatment Surge Plan.

The Global Fund for AIDS, TB and Malaria (GFATM) has also made specific commitments in each of these priority areas in the current funding covering the period April 2019–March 2022. In terms of service delivery, the GFATM funds important programming for Key Populations and vulnerable populations, in particular core and layered, comprehensive prevention programs for AGYW and Key Populations. In the area of Human Resources for Health (HRH), the GFATM will support community workers and investments to increase capacity of community-based organizations to contribute sustainably to prevention and treatment objectives. The GFATM has also made commitments to TPT and ARV buffer stocks. Other donors contribute to specific geographic or program areas, including the Bill & Melinda Gates Foundation investment in important formative research that informs PEPFAR SA investments.

PEPFAR SA continues to work closely through the bilateral work streams to ensure that COP investments both leverage and complement the investments of the GoSA and other donors. In particular, PEPFAR SA continues to work closely with the GFATM management committee and the Fund Portfolio Manager to strengthen the alignment of COP21 with the activities financed in the GFATM funding (April 2022–March 2025). The ongoing USG participation on the Country

Coordinating Mechanism (CCM) and GFATM Oversight Committee has resulted in increased efficiencies and proactive reprogramming to support additional effective interventions.

PEPFAR SA will continue to support activities and areas of investment that have impact on epidemic control in SA. Sustainability of investments and their impact is a significant consideration for all program investments made, including collaboration with the Department of Treasury to ensure alignment.

2.5 Alignment of PEPFAR SA investments geographically to disease burden

In COP21, PEPFAR SA continues to prioritize the 27 districts that account for nearly 80% of the national HIV burden, which are the same 27 focus-for-impact districts in the NSP. To further focus the PEPFAR SA investment, COP21 resources are targeted in the five largest metropolitan districts (Johannesburg, eThekweni, Ekurhuleni, Tshwane, Cape Town), which account for approximately 34% of the national HIV burden. In COP18, the alignment analysis revealed the need to make additional investments in the 1,437 highest burden facilities that serve 90% of the PLHIV on treatment in the 27 priority districts in South Africa. In COP19, PEPFAR SA provided targeted DSD support to these facilities with enhanced support at the largest volume facilities through the Siyenza program. In COP20 and COP21 PEPFAR SA continues to focus investments on the highest burden sites where these investments will have the most significant impact on HIV/TB epidemic control.

PEPFAR SA remains committed to reach the UNAIDS 90-90-90 and 95-95-95 goals as set out in the World Health Organization (WHO) guidelines and global best practices, and with the PEPFAR Strategy for Accelerating HIV/AIDS Epidemic Control (2017–2020). Targeting in the 27 districts for COP21 remains aligned with this long-term goal of epidemic control in South Africa. PEPFAR SA's targets for COP21 aim to reach or exceed 81% ART coverage in all 27 districts, and to reach or exceed 81% coverage in every 5-year age-sex bands within each district inclusive of private sector coverage.

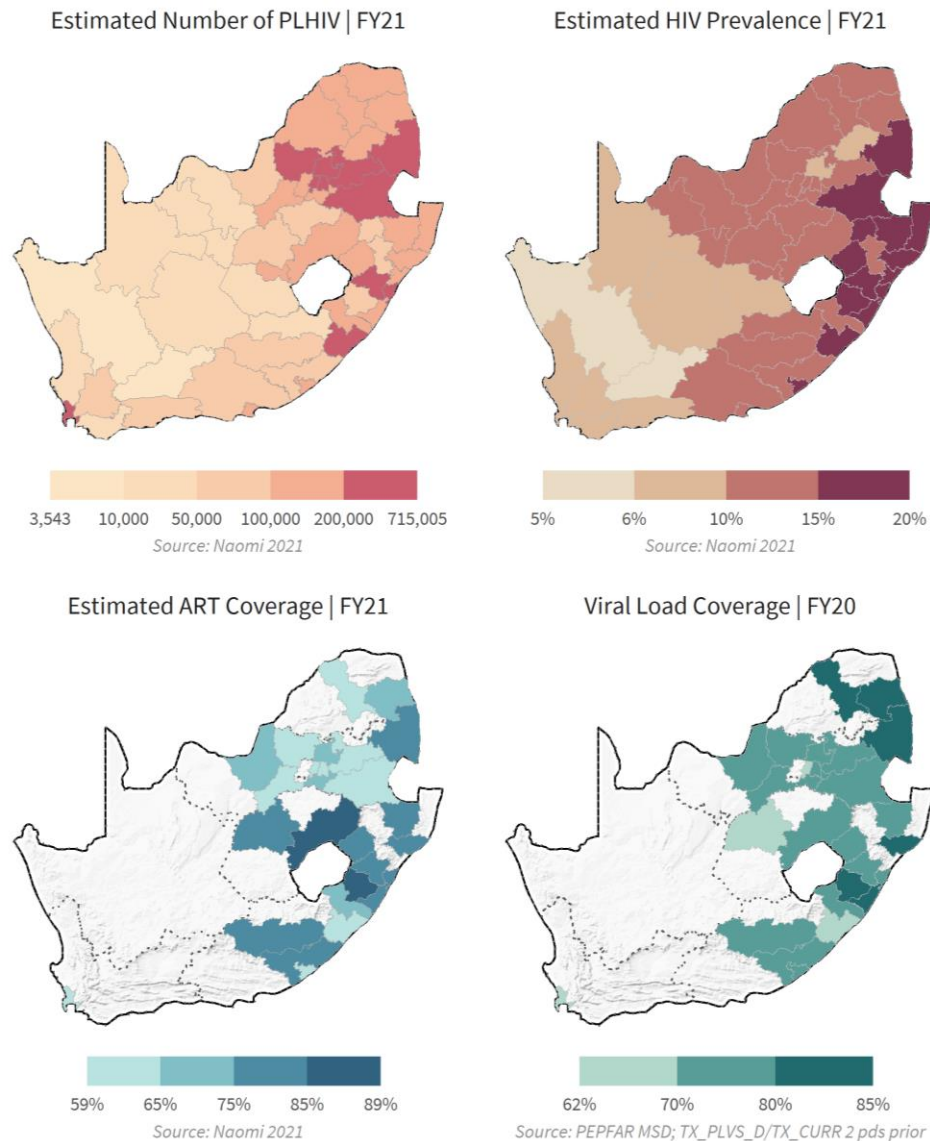
PEPFAR SA will provide targeted support to facilities to reach the target of 81% ART coverage, with support linked to facility HIV burden and growth needed. In COP21, PEPFAR SA plans to continue intense facility support to high-volume facilities. Once facilities achieve performance standards in ART coverage, PEPFAR SA will adjust direct service delivery support strategically to maintain 81% ART coverage and improve focus on sites remaining that have not yet reached 81% ART Coverage.

As in COP20, PEPFAR SA will not be setting individual facility level targets in COP21, instead opting for a partner performance management approach to ensure districts achieve their rolled-up targets to reach 81% ART coverage, allowing for a more agile response to the unique needs of facilities to reach ART coverage and maintenance thereof.

DREAMS programming in COP21 will continue to focus on AGYW and their communities in 24 districts. This includes the four historic DREAMS districts, and 20 more expansion districts which were added to the program in COP20. In addition to the 11 districts with historical prevention programming, epidemiological data signaled a need for PEPFAR SA DREAMS to

expand into the following new districts in COP20: Lejweleputswa, Thabo Mofutsanyane, Sedibeng, Ugu, Uthukela, Zululand, Mopani, Capricorn, Ngaka Modiri Molema, Dr Kenneth Kaunda, Buffalo City, OR Tambo, and Alfred Nzo.

Figure 2.5.1 PEPFAR South Africa: People Living with HIH (PLHIV) Treatment Coverage, and Viral Load Monitoring Coverage



2.6 Stakeholder Engagement

PEPFAR SA engages with the PLHIV sector and Civil Society Forum (CSF), through the South African National AIDS Council (SANAC) secretariat. The CSF is a broad-spectrum platform of 18 organized sectors of society, including women, men, lesbian, gay, bisexual, transgender, queer and intersex people (LGBTI+), youth, NGOs, labor, people with disabilities, PLHIV, and other representatives. PEPFAR SA also closely collaborates with multiple stakeholders including the GoSA, other donors, and multilateral organizations, such as GFATM, UNAIDS, World Health Organization (WHO), the Clinton Health Access Initiative (CHAI), the Bill &

Melinda Gates Foundation (BMGF), the International AIDS Society (IAS), and Médecins Sans Frontières, among others.

PEPFAR SA engages with these stakeholders through quarterly and even more frequent meetings, especially with those organizations, such as the GFATM, across which areas of funding and focus are similar, to ensure alignment and synergy of activities.

Additionally, PEPFAR SA representatives actively participate in the technical working groups of SANAC, the GTAFM Country Coordinating Mechanism and form part of the HIV/TB project or program teams at the various levels of GoSA.

Annually, Civil Society provides strategic inputs towards the PEPFAR SA COP development processes. During COP19 and COP20, the PEPFAR SA team facilitated several meetings with the PLHIV sector to strengthen a community-led monitoring program (Ritshidze), that is part of the multiple initiatives to strengthen community involvement towards addressing the HIV/AIDS epidemic. For COP21, the Civil Society Forum (CSF) was initially engaged in the coordination of multisectoral inputs. Initial meetings with PEPFAR SA, the SANAC secretariat, and the CSF leadership were held mid-January and the beginning of February (February 2, 2021) to discuss the coordination of Civil Society's inputs into COP21. As part of the COP21 Engagement process, PEPFAR SA organized targeted consultations and leveraged coordination meetings to engage with multilateral and bilateral donors and key international NGOs, SA Government Departments and foundations. These included meetings of the SANAC Civil Society Co-Chairs; Bill and Melinda Gates Foundation; Clinton Health Access Initiative; AIDS Health Foundation; MSF; GIZ; AIS; SA Government Departments; the World Health Organization; Global Fund Portfolio Manager; United Nations International Children's Emergency Fund (UNICEF) and UNAIDS.

Community-led Monitoring

The PEPFAR SA COP21 will continue to support the COP20 NDoH-endorsed community-led monitoring program known as Ritshidze (Saving our Lives). Community-led monitoring will contribute to South Africa's HIV/AIDS and TB responses by empowering PLHIV to monitor facilities, provide community led solutions, and hold authorities accountable for providing high-quality HIV and TB care and support.

During COP19 and COP20, the Ritshidze program scaled up to monitor 400 PEPFAR SA-supported Siyenza sites in the 27 districts within 8 provinces in South Africa. The team was scaled up in October 2020 with 100 Ritshidze District Organisers and Community Monitors trained and onboarded. The Ritshidze tools were finalized and the Ritshidze dashboard was launched and operationalized in September 2020.

Using tablets, Community Monitors conduct surveys on a quarterly basis to capture data. Using data collected, fieldworkers will analyze the findings in the Facility report available on the dashboard, assessing the key challenges and generating evidence-based solutions for addressing them, in the "State of the Clinic" report. The findings of the monitoring efforts

reflected in the “State of the Clinic” report form the basis of regular engagement with facility staff, clinic committees, and implementing partners in order to raise challenges, identify solutions for facility staff and implementing partners to undertake, and then monitor the implementation of these solutions. Where challenges cannot be addressed at a facility level, fieldworkers will escalate the issues to provincial or district level, as appropriate, through direct and regular participation and engagement in Operation Phuthuma. All the data collected are available on a public data dashboard⁸ searchable by province, district, site, or agency, as well as by thematic area.

The Ritshidze program has shared multiple tools and best practices with other UNAIDS countries seeking to implement a community-led monitoring program. In addition, SANAC is adapting these tools to monitor PEPFAR funded Key Population sites.

2.7 Stigma and Discrimination

In COP21, PEPFAR SA will expand support for programming which seeks to reduce stigma and discrimination in line with South Africa’s National Human Rights Plan: A comprehensive response to human rights-related barriers to HIV, TB services and gender inequality in South Africa <https://sanac.org.za/wp-content/uploads/2020/03/HR-STRATEGY-FULL-electronic.pdf>. Particular focus will be placed on reduction of stigma and discrimination as a part of DREAMS and Key Populations programming.

In the DREAMS portfolio, the primary focus is on the reduction of stigma and discrimination experienced by adolescent girls and young women who are seeking HIV testing and prevention services such as PrEP. In addition to continuing to support capacity building in adolescent and youth friendly services (AYFS) for client-centered sensitive care, DREAMS also implement parenting and caregiver programs which aim to create a supportive environment for AGYW and serve as a platform for PrEP, HTS, and sexual and reproductive health awareness generation. Additionally, re-invigorated community awareness generation activities around post-violence care services will also aim to reduce stigma around survivors who choose to access these services.

The KP program integrates anti-stigma and discrimination communication in all aspects of direct service programming through social asset building and mental health services. KP peer educators come from the communities in which they work and host community dialogues to increase visibility of KP members and answer questions in a safe environment. Social workers at our sites provide comprehensive psychosocial services and verified linkages to social support to all our KP. Our FSW and PWID programs work closely with the South African Police Service to improve relationships between police and criminalized KP groups. This collaboration is done at a local level through informal dialogues, continuous engagement and discussions with local police precincts in areas where outreach occurs and invitations to sensitization workshops. The PEPFAR SA KP program will continue to collaborate with GFATM partners to contribute

⁸ Ritshidze data dashboard. Available at: <http://data.ritshidze.org.za/>

towards developing a national human rights violations monitoring and response system. Housed at SANAC, this system will utilize local KP networks to collect data on potential human rights violations and provide a platform for response through referrals to appropriate medical and legal services

In COP19, PEPFAR SA supported the development of a robust KP sensitization toolkit which has been rolled out to all DSPs, Civil Society, and Department of Health staff and is freely available online (<https://portal.foundation.co.za/Course/Details/1093>) This toolkit has been adopted by the NDoH to be incorporated as a part of standard in-service training for all facility staff. The training toolkit features moving personal stories from KP service beneficiaries and provides an overview of clinical and social needs of specific KP members. In COP20, approximately 150 trainers from the DSPs, Civil Society, and Department of Health representatives were trained on the toolkit and provided with training materials. Additionally, PEPFAR SA is supporting an overhaul of the National Department of Health's Key Populations Program (Formerly the High Transmission Area Program). The new program will be focused on the WHO KP groups and will greatly expand visibility and access to services for KPs in communities where PEPFAR SA is unable to support a verticalized KP drop-in center.

3.0 Geographic and Population Prioritization

PEPFAR SA first pivoted to focus on the 27 (of 52) districts with the highest burden of HIV in COP15. These districts consistently contain nearly 80% of PLHIV. Since COP17, an increased emphasis has been placed on the four metropolitan districts with the highest unmet need (Johannesburg, eThekweni, Ekurhuleni, Tshwane) and in COP19 Cape Town was also included as a priority metro. For COP21, targets were set to ensure >81% coverage by the end of FY22 across all districts and all age/sex bands within each district. PEPFAR SA completed additional modeling (the Naomi model) to estimate PLHIV and ART coverage within each of these sub-populations. These revised PLHIV estimates were agreed on with both NDoH and the Office of Global AIDS Coordination (OGAC). PEPFAR SA's program will be focused on closing treatment gaps in each of these populations and thus targets were set to reflect the most aggressive increases in the number of patients on treatment in the sub-populations/districts with the highest unmet need.

In COP19 and COP20, all PEPFAR SA-supported districts were heavily impacted by the SARS-CoV-2 pandemic. In COP21, PEPFAR SA will intensify and tailor back to care efforts to return patients to care, and focus on closing the treatment gap. Core care and treatment interventions described above (Section 2.2) have been designed to specifically to address these priorities.

The MINA campaign and roll out of the Coach Mpilo case management strategy have been designed to significantly increase demand for and retention on ART among men. In alignment with the NDOH's national strategy on reaching men, PEPFAR SA will additionally provide support to strengthen linkages between Voluntary Male Medical Circumcision (VMMC) and treatment programs, with a focus on incorporating knowledge of HIV status and adherence to ART as part of a broader self-care approach. The VMMC program continues to review the most reliable VMMC coverage level estimates to assist with strategic COP target allocation. The

Human Sciences Research Council (HSRC) estimates/projections in FY19 and the more recent Imperial College of London estimates in FY20 (results of which are still to be formally released) consistently show that the estimated VMMC coverage remains low, with not a single district reporting the desired 80% VMMC coverage in any of the target age groups. Therefore, the program continues to set targets for all 27 PEPFAR SA-supported districts, taking into account prior performance and districts with a comparative advantage to perform better going forward. All the proposed targets have been set within the 15–34 year old age group, with a strong preference for the 15–19 and 20–24-year-old age groups (~70%) as per the COP21 guidance.

Priority populations for prevention were identified based on HIV risk profiles, with the greatest focus being on AGYW and OVC. DREAMS programming in COP20 expanded from four original implementation districts to an additional 20 districts with extremely high incidence and high burden of PLHIV. In COP 21, PEPFAR SA DREAMS will maintain COP 20 approved geographic expansion plans and focus on achieving 100 percent saturation in the 4 original districts of City of Johannesburg, Ekurhuleni, eThekweni and uMgungundlovu. Focus will be on achieving at least 45 percent saturation in the 20 new DREAMS districts in collaboration with Global Fund in the seven shared districts. In COP21, the SA OVC Program will contribute to the PEPFAR SA pediatric surge through continued scaling up and enrollment of C/ALHIV and support for the continuity of treatment for children under 18 years of age.

KPs are characterized by high HIV prevalence with social marginalization and stigmatization contributing to high infections; KPs include female sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prisons. Focus districts for KP are selected based on KP populations size estimations, in careful coordination with GFATM to ensure national coverage of KP programs with no program overlap. By reaching saturation of treatment and prevention interventions among key and priority populations in the highest burden districts, SA will disrupt HIV transmission and reduce HIV incidence.

ec Amathole District Municipality	X				
ec Buffalo City Metropolitan Municipality	X		X	X	
ec Nelson Mandela Bay Municipality	X		X	X	
ec Oliver Tambo District Municipality	X	X			
ec Sarah Baartman (Cacadu) District Municipality	X	X			
gp City of Johannesburg Metropolitan Municipality	X	X	X	X	

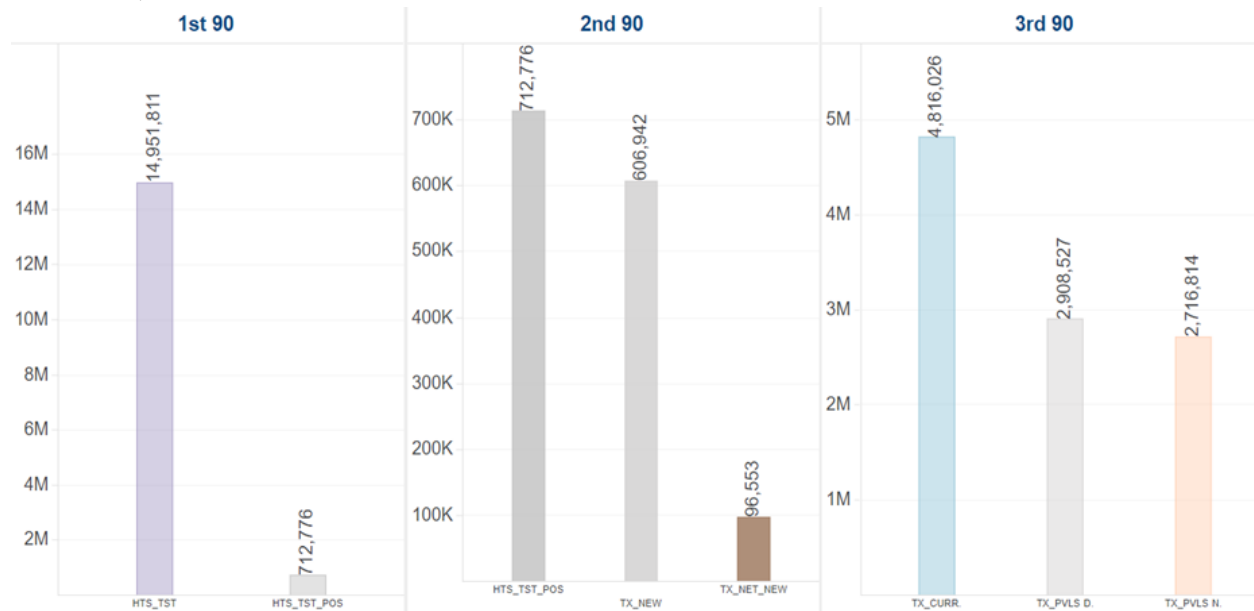
gp City of Tshwane Metropolitan Municipality	X	X	X		X
gp Ekurhuleni Metropolitan Municipality	X	X	X		
gp Sedibeng District Municipality	X				
kz eThekweni	X	X	X		
kz Harry Gwala District Municipality	X				
kz uMgungundlovu District Municipality	X	X	X		
kz King Cetshway	X				
kz Zululand District Municipality	X				
lp Capricorn District Municipality	X				
lp Vhembe District Municipality	X	X			
mp Ehlanzeni District Municipality	X	X	X		X
mp Gert Sibande District Municipality	X	X			
mp Nkangala District Municipality	X	X			
nw Bojanala Platinum District Municipality	X				
nw Dr Kenneth Kaunda District Municipality	X	X			
nw Ngaka Modiri Molema District	X	X			
wc Cape Winelands District Municipality	X				
wc City of Cape Town Metropolitan Municipality	X	X	X	X	
wc Eden District Municipality	X				
wc Overberg District Municipality	X				
wc West Coast District Municipality	X				

Table 3.1 Current Status of Antiretroviral Therapy Saturation

Table 3.1 Current Status of ART saturation				
Prioritization Area	Total PLHIV/ % of all PLHIV for COP20 [1]	# Current on ART (Nov FY2020) [2,3]	# of Districts FY2021(COP20)	# of Districts FY2022 (COP21)
Attained			-	-
Scale-up Saturation	2,714,864 (35%)	1,343,785	4	4
Scale-up Aggressive	3,486,197 (44%)	2,454,612	23	23
Sustained			-	-
Central Support	1,680,852 (21%)	1,009,592	25	25
[1] Eaton, J & Johnson, L. Unpublished Document – NAOMI 2021 District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)				
[2] NDoH Program data (DHIS), November 2020.				
[3] DATIM FY20Q4 APR Results.				

4.0 Client-Centered Program Activities for Epidemic Control

Figure 4.0.1 PEPFAR performance metrics toward achievements of the 95–95–95 cascade, FY20



4.1 Finding the missing and getting them on treatment

In COP21, PEPFAR SA will continue to support case finding through targeted geographic interventions for specific populations using a focused and strategic mix of modalities. Facility-based testing will continue to be the main case-finding strategy through full implementation of enhanced Provider Initiated Counseling and Testing (PICT) at the acute, chronic, and maternal-and-child-health patient care streams. PICT optimization including utilizing HIVSS will be the focus to ensure the routinization of offering HIV testing. This will be done within other healthcare provision and testing provided at a clinic, to minimize the impact on stigma and increase HIV testing for those who are eligible to be tested. Screening tools will be used to identify those likely at risk of undiagnosed HIV infection to offer routine HIV testing. Routine analysis of patient headcount vs. PICT will be used to identify gaps in testing service provision as well as help determine when facility testing opportunities have been saturated.

PEPFAR SA will additionally support assisted HIVSS efforts for patient populations with a special focus on men and key populations including: (1) Patients in the queues waiting to consult clinicians, (2) distribution channels such as the workplaces and transport hubs, (3) partners of pregnant and breastfeeding women, and (4) through KP program sites. In COP21, the targets for self-screening as a targeted testing modality will focus on reaching the partners of index clients, community testing, as well as assisted self-screening at facilities.

Facility-based index testing will be fully implemented, targeting all new HIV positive clients, clients who have unsuppressed viral loads, STI patients, and TB patients. The unsuppressed

viral load patient focus is crucial because these clients are at risk of transmitting to sexual partners and vertical transmission of HIV and may also potentially be transmitting resistant strains of the virus. Therefore, contacts of index cases with acute infections or who have a high viral load will be prioritized for tracing. Other priority populations for index testing include pregnant and breastfeeding women, as well as adolescent girls.

Screening and monitoring incidence of intimate partner violence (IPV) is a high priority for this testing modality. All implementing partners will fully comply with the government SOP in screening all clients for a risk of violence before contacting partners. No contacts who have ever been violent or are at risk of being violent will ever be contacted in order to protect the individual and other partners the contact may have that are unknown. To ensure fidelity in the scale-up of index testing, including alignment with WHO Five C's of HIV Testing Services (HTS), the DoH supports ongoing trainings and refresher trainings for its staff on the correct implementation and monitoring of index testing. Similarly, PEPFAR SA-funded DSPs will implement ongoing trainings and mentorship for their staff. Additionally, with the help of adverse event monitoring tools which are documented for each DSP and shared with Civil Society, the fidelity of index testing will be scrutinized at every facility performing this work. Index testing will always be voluntary as per the government SOP and human rights requirements. Monthly analyses comparing site level acceptance rates and partner elicited acceptance rates against the average will be conducted to identify cases where coercion may be happening. Facilities with acceptance rates of 80% or above will be rapidly investigated to identify if coercion is occurring. After contacting the provided contacts, healthcare providers will follow-up with the individual after a reasonable period to assess whether there were any adverse events—including but not limited to violence, dissolution of the relationship, economic harms, unauthorized disclosure of the client's HIV status, loss of housing, or other harms raised by the client. In cases of violence, clients will be referred to the nearest GBV support services. If no IPV services are available either at the facility or by referral, index testing will not be (re-) implemented. All referrals will be actively tracked to ensure individuals who wish to access them do and referral sites have adequate capacity to provide services to the individual. All adverse events are monitored through a proactive adverse event monitoring system capable of identifying and providing services to individuals harmed by index testing. All adverse events identified will be documented and reported to the DSPs, agencies, and PEPFAR SA who will report these out to Civil Society and the DoH. PEPFAR SA will ensure that all referral options listed for adverse events will be of the highest quality, with proven track records. Index testing implementation reporting is part of the weekly nerve center meetings where clinical cascade performance is discussed at the sub-district level.

Community testing in COP21 will primarily be focused on following-up and testing index test partners and enhanced case-finding among men, with a focus on community hotspots that men frequent. These will include, but are not limited to, workplaces and travel hubs. PEPFAR SA testing partners in the community will be trained to also use self-screening as a way to reach men who are not utilizing testing services at facilities. PEPFAR SA will support mobile outreach services, as an extension of the existing healthcare system in order to encourage access and uptake of basic services such as HIV testing, family planning, STI screening, and ART initiation with management closer to the community as a strategy to reach, initiate, and retain men. Low

yield (2.0%–3.7%) is to be expected from community mobile testing that is conducted to reduce stigma for index contacts who are traced and offered testing in communities, as well as from DREAMS and OVC entry points as these are essentially prevention programs. Additionally, in COP21, DSPs will ensure coordination of smaller Community Based Organizations (CBO) to ensure the quality of counselling as well as ensuring those who test positive are escorted from testers to clinicians who initiate ART treatment. PEPFAR SA will scale up community self-screening to focus on patients not engaging in more traditional testing modalities.

Additionally, recency testing for newly diagnosed individuals will be doubled in COP21. Based on the results of recency testing, community hotspots will be identified and targeted for enhanced testing and other prevention activities.

HIV case-finding for Key Populations (KP) will be streamlined in COP21. Risk screening tools will be scaled up and a blended social network strategy/index testing approach will be used to find “hidden” KP individuals who do not know their status. All counselors engaged in index testing/partner notification counseling and contact solicitation will receive training inclusive of KP sensitization with regard to index testing - including those in general population clinics where most KPs in the country continue to access services. As detailed in the DoH’s SOP for HIV index testing, contact registers only contain the identity number of the index client and no information on the mode of transmission so as to protect the confidential information of both the index client and contacts when doing tracking and tracing. Additionally, recency testing will be used in conjunction with partner notification services to further find hard-to-reach KP individuals, and to identify emerging hot-spots. The focus will be on establishing high HIV transmission hotspots, and on locating untested permanent sexual partners, biological children, and regular injecting partners of KP individuals. Finally, self-screening test kits will be distributed via index clients and peers and assisted self-screening will be used in settings such as prisons and other enclosed and crowded spaces. The KP program will increase utilization of HIV self-screening tests in PrEP programs and will track these to allow disaggregating from those intended for case-finding. Key Populations teams primarily use assisted self-screening which allows for immediate confirmation of HIV status, and linkage to either PrEP or ART.

4.1.1 Population-Specific Interventions

In addition to these broad national- and site-level strategies, PEPFAR SA continues to focus efforts on ensuring that population-specific gaps are addressed through population-specific strategic interventions. To address the case finding and retention gaps among men, PEPFAR SA will support the GoSA through a diverse, but complementary set of interventions, including facility and community index testing, workplace testing, targeted community-based case finding (in identified hot spots), social network strategies, and increased self-screening. Extended hours, youth and male-friendly spaces that improve the experience of men will be strengthened. Linkage to treatment will be enhanced through further scale-up of community ART initiation and private sector innovations such as pharmacist-led ART initiations, where possible. A specific focus including the treatment pathway being part of fast-track ART initiation and on demand creation for RPCs and internal and external pick-up points, and adherence clubs will further support increased retention among men.

Similarly, to close the treatment gap for youth and AGYW, PEPFAR SA will continue working with facility, community, faith-based, and traditional structures to expand adolescent and youth-friendly services in facilities and communities, after-school hours, school health services, self-screening, youth connectors, youth care clubs, and mHealth (including social media). PEPFAR SA will continue to work with the Department of Basic Education (DBE) and provincial and local authorities to accelerate roll-out of the comprehensive sexuality education (CSE) program, and the provision of school-based health services including HTS and the availability of condoms in schools, in line with the National Adolescent and Youth Health Policy. PEPFAR SA will use support of community-led monitoring partners to further identify facilities that are providing services in a manner that is not friendly to young people, in order to quickly target interventions to remediate the situation.

Case finding and clinical management remain the principal gaps in the clinical cascade for children. PEPFAR SA will utilize index testing, risk screening tools, school health services, PICT, nutrition and growth monitoring, immunizations, and additional mentoring and support for pediatric case management (i.e., phlebotomy, dosing, viral load monitoring) to strengthen the pediatric HIV program. Index testing remains a high yield modality for identifying children and adolescents living with HIV (C/ALHIV) and will be scaled up to ensure that 100% of biological children of people living with HIV are offered testing.

PEPFAR SA will support the DoH to reach HIV-positive mothers with RPCs that particularly respond to the needs of the mother-infant pair. PEPFAR SA partners will support the NDoH implementation of the RPCs for C/ALHIV in their supported districts.

Specific pediatric linkage officers will be placed in sites with high volumes of pediatric clients to ensure linkage to OVC programs and to ensure treatment of CLHIV identified within OVC programs. PEPFAR SA will advocate for Dolutegravir 5 and 10mg dispersible tablets to be approved by SAHPRA and eligible C/ALHIV to be transitioned to the new WHO approved regimens. This will be accompanied by strengthening the use of the NHLS results for action spreadsheet as well as eLabs to ensure that all C/ALHIV with unsuppressed viral loads are actioned in a timely manner. Efforts will be intensified to monitor that all C/ALHIV are on optimal doses of antiretroviral treatment as per their weight.

In line with the success of the Siyenza and Operation Phuthuma campaigns, PEPFAR SA will expand its intensive partner management and support in COP21. Using developed SOPs and tools, many PEPFAR SA staff will continue spending a predominant part of their time providing direct support to facility personnel, sub-district, and district HIV leadership, and more direct oversight to DSPs. In districts that are designated DSD districts, PEPFAR SA will continue its facility- and community-level human resource investments to enable increased HIV testing, same-day initiation, extended service hours, patient navigation, active linkage, case management, adherence and retention tracking and tracing, and differentiated care.

4.1.2 Linking People to Treatment

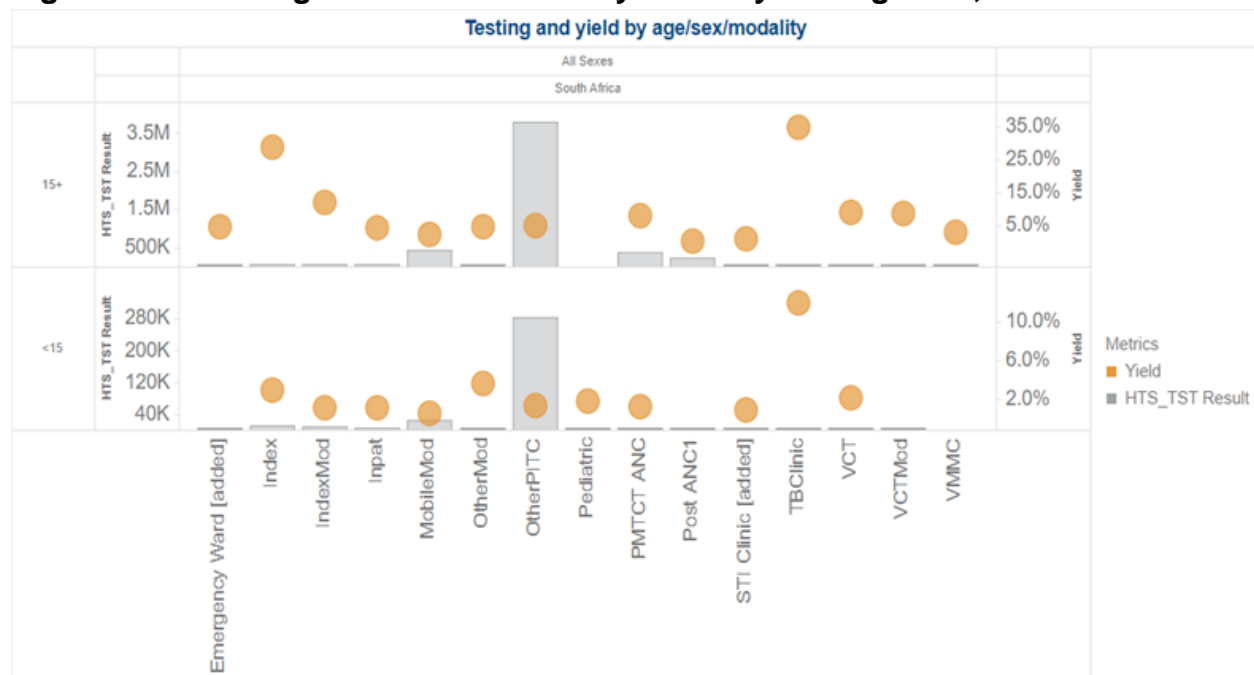
Strategies to improve linkage in COP21 include same-day ART initiation, community ART, and further scale-up of linkage officer/case manager support staff. Over the course of COP20,

partners (both through direct placement of staff and mentorship of NDoH staff) have sustained the gains made in same-day ART initiation across priority sites. Many districts continue meeting the 95% linkage proxy threshold and all districts will be expected to maintain this target in COP21.

In all these efforts, PEPFAR SA is committed to continuing support for public health facilities and expanding efforts in communities to improve case identification, linkage to ART (by intensifying both ART initiations and ART refills within the community for hard-to-reach areas), reduction in treatment interruptions, ART adherence, and other treatment support.

Key Populations programs will continue to provide mobile outreach to KP groups at hot-spots or events at times that are convenient for the target population. Point of care services will allow for same-day ART initiation. ART refills will be delivered to hotspots, and social workers and counsellors will reinforce uptake through enhanced adherence counselling, motivational interviewing techniques and U=U messages. Multi-month dispensing will be provided to KP individuals after risk assessment.

Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY20



4.2 ART continuity and ensuring viral suppression

Retention on ART is a significant challenge for the SA national HIV program. Historically the SA national program has focused on finding patients who dropped out of care and relinking them to ART. During the second half of COP20 and during COP21, PEPFAR SA will focus on preventing treatment interruptions by providing patient centered approaches which include better understanding of individual characteristics and reasons for missing treatment; improving patient’s experiences during clinic visits (by reducing queues, decanting stable patients, expanding hours of operation, providing population-specific services such as Men’s Corner or

youth-friendly services after school hours); providing enhanced support SMS reminders; addressing common mental health issues (such as anxiety, depression, and alcohol abuse); and through “case managers”/“peer-buddies” to patients initiating therapy.

Critical to ensuring ART continuity and viral suppression, PEPFAR SA will work directly with the GoSA to scale with fidelity the 2020 Adherence Guideline Standard Operating Procedures (SOPs) that were revised to address key challenges across the HIV care continuum.

PEPFAR SA will support the GoSA to ensure that no-one’s HIV status is ever disclosed by any clinical or non-clinical staff or implementing partner — either through intentional verbal disclosure, or unintentionally through queuing systems, multiple people being attended to in the same room, or unattended files.

In COP21, PEPFAR SA will provide a package of psychosocial support at all PEPFAR SA supported sites that includes provision of individualized counseling to patients. Where possible, peer-led case managers and support groups will further act as a bridge between clinicians and patients. Any person living with HIV can access these services at any time, with an enhanced focus provided for patients who are new on treatment, recently experienced a treatment interruption, or currently experiencing unsuppressed VL. PEPFAR SA will focus on better understanding the individual characteristics and reasons for disengaging from care and ensure that those people returning to care are offered support (including through psychosocial support and voluntary support groups) to improve long term retention and viral suppression.

Additional strategies to improve retention in COP21 include ensuring that all protocols are routinely followed if a PLHIV misses an appointment (including SMS, phone call, home visit) at all PEPFAR SA supported sites. PEPFAR SA will continue to closely monitor missed appointments through the Siyenza program and will increasingly incorporate Ritshidze data to further strengthen approaches to improve the quality of treatment at these sites. PEPFAR SA will continue to provide human resource investments for direct service delivery and will ensure PEPFAR SA-funded staff have the equipment (phones/ airtime/ data/ computers) needed to effectively follow-up with PLHIV who miss appointments.

In FY20, the retention gap was highest among both males and females aged 20–24 years. Additionally, data show that alcohol and substance abuse, high levels of gender-based violence, and mental health challenges increase the risk of interrupting HIV treatment and contribute significantly to this retention gap. In response to this challenge, there are specific activities planned for COP21 for each of these affected population groups enlisted below.

The MINA (For Men. For Health. “me” in the context of “my community”) Campaign will continue to reach young men to ensure messages on adherence to treatment, retention in care and U=U (Undetectable = Untransmittable) messages are embedded, disseminated, and well understood. To increase retention among young men and women, PEPFAR SA will continue to provide population-friendly services namely male-friendly services, support groups (I-ACT) and postnatal care clubs, community ART (both initiation and maintenance), active promotion and enrolment in RPCs, and will continue to increase the number of external pick-up points available. To foster the continuity of ART amongst PLHIV, we aimed to expand 3-month

dispensing of ART in all PEPFAR SA supported districts in COP20 and initiate implementation of 6-month dispensing in COP20 with expansion in COP21. Through continuous collaboration with the NDoH, PEPFAR SA aims to service hard to reach populations with MMD of ART through mobile clinics. The implementation of the bicycle ART delivery model which was a success in COP19 and COP20 will continue in COP21 for targeted home deliveries of medicines for patients at high-risk where possible.

Although VL suppression rates are high among those currently on ARVs, the roll-out of TLD and DTG-based regimens during COP20 and COP21 are expected to further improve VL suppression and thus have a significant impact on community-level VL suppression rates. PEPFAR SA will continue to support the NDoH to roll out and monitor the transition to TLD in South Africa. With the eLab platform, patients who are virally unsuppressed will be identified early and recalled for enhanced adherence counselling with the support of case managers. The PEPFAR SA program will also focus on improving HIV viral load testing coverage through enhanced patient and provider reminder systems, and integration of home phlebotomy into home delivery of medication models.

Furthermore, during FY21 site-level efforts will work to emphasize the role and functions of the case manager in enhancing and ensuring better outcomes in the linkage and ART continuity among clients in all population types and age groups.

In COP21, PEPFAR SA will provide support to the NDoH at national, provincial, and district levels to routinize mental health (MH) screening at the primary care level with management at that level of common issues such as anxiety, depression, and alcohol abuse. The referral network for more complex MH cases will be strengthened.

The Key Populations program will prioritize continuity of treatment among all KP groups (i.e., Sex Workers (SW), men who have sex with men (MSM), transgender (TG) people, People who Inject Drugs (PWID), and people in prisons in COP21. Viral load coverage has been very low, ranging from 12% among PWID to 86% among TG. Low viral load coverage has been primarily due to structural factors such as high mobility of the groups, homelessness, and general lack of data, and cell phone access. PEPFAR SA and implementing partners are working with the National Health Laboratory Services to ensure optimal turn-around time. In addition, PEPFAR SA will be rolling eLABs out to all Key Populations sites and ensuring that all clinical staff have procedures in place for following up on due viral loads. Viral load suppression has also been suboptimal apart from MSM who reached 93% and prisons at 91%; suppression among SWs was 59%, 46% among TG, and 45% among PWID.

U=U messages will be developed and tailored to the needs of each specific KP group and these will be disseminated through channels that are easily accessed by these communities. For MSM, for example, social media will be scaled up while peer support among SWs and PWID will be strengthened.

In addition, all KP implementing partners have been trained on eLABS to reduce turn-around-times, and point-of-care viral load testing will be conducted. Early interruption of treatment (<3 months) will be monitored, and clients will be followed up, and provided with enhanced

adherence counselling using motivational interviewing techniques. Social workers/case managers will continue to provide follow-ups and psycho-social support to clients on treatment. Same-day initiations will be strengthened with the support of motivational interviewing and peer role models, MMD, and drop-offs of medication at hot-spots or places of choice by the client. SMS motivation that has been developed by the SW team will be expanded to other KP groups: this comprises a daily message that encourages and reminds the client to “take their pill” every day.

Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY20

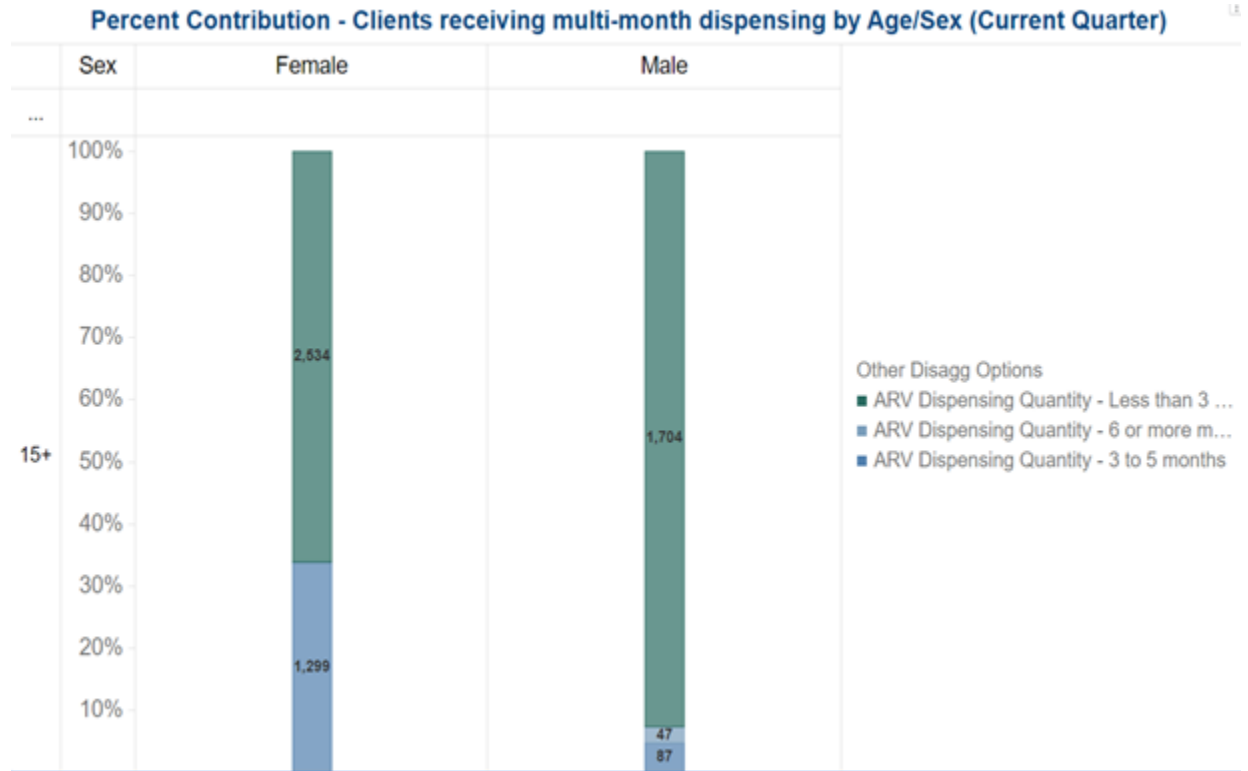
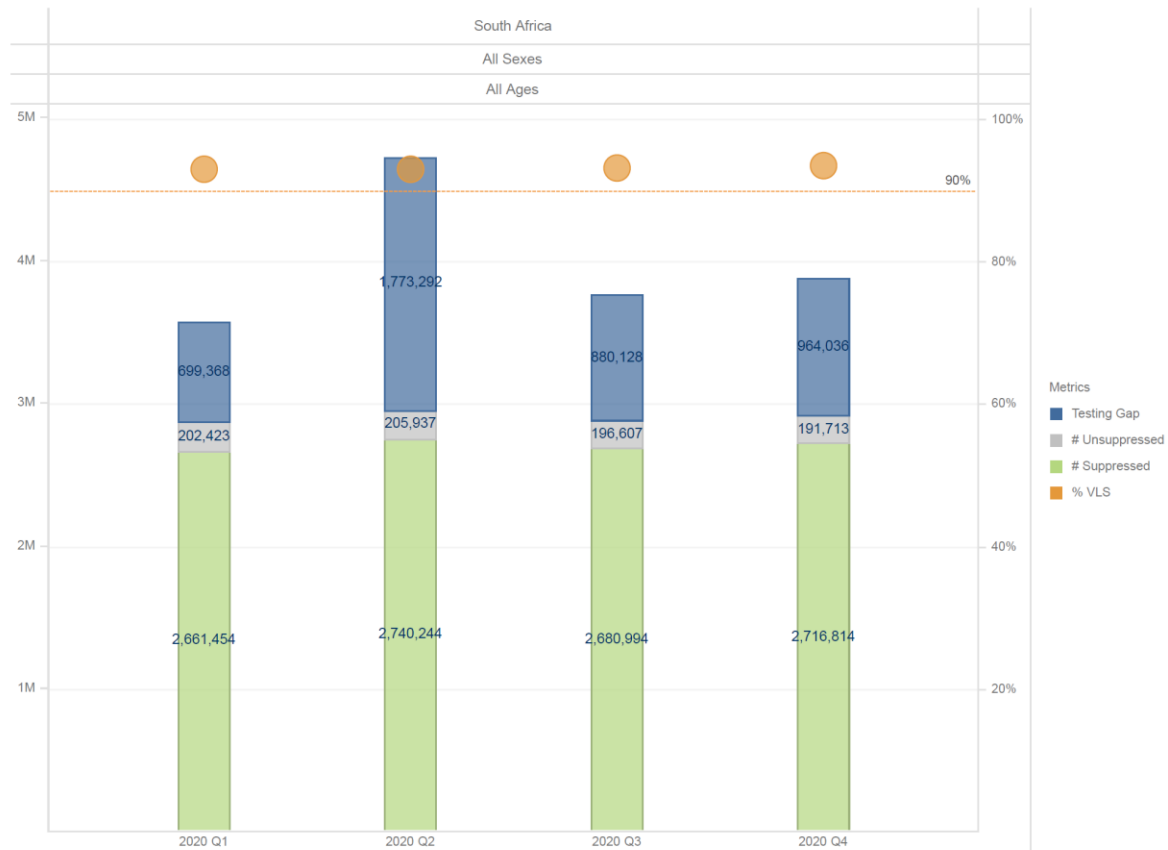


Figure 4.2.2 Viral Load Outcomes, FY20



4.3 Prevention, specifically detailing programs for priority programming:

4.3.1 DREAMS, Adolescents and Young People

PEPFAR SA recognizes the crucial importance of slowing the high HIV incidence of adolescent girls and young women to achieving epidemic control. Progress made with targeting AGYW with evidence-based, age-specific, multi-session, and layered prevention interventions using both comprehensive community platforms and school based curricular and co-curricular interventions supporting AGYW will continue in COP21. In COP20, DREAMS received a significant funding increase to \$90m, representing a 3-fold increase in funding over previous years, and this enabled the expansion of the program from the original 4 to an additional 20 districts with extremely high incidence and high burden of PLHIV. PEPFAR SA completed DREAMS expansion consultation meetings and implementing partner introductions in all eight focus provinces and the 24 districts during the first and second quarters of FY21. These introductions and consultations also included joint planning discussions with relevant stakeholders from health, education, social development, and AIDS council structures (including Civil Society).

In line with the priorities for DREAMS listed in South Africa’s COP21 PEPFAR Planning Letter, PEPFAR SA will implement the following:

AGYW PrEP Implementation: In COP21, the OU will continue to leverage innovative strategies to support PrEP implementation, focus on strengthening the integration of PrEP services into HIV combination prevention approaches, and utilize all DREAMS interventions as a platform to strengthen demand creation, adherence and retention support for PrEP among AGYW. Additionally, the program will explore the feasibility, acceptability, and potential approaches to implementation for new PrEP technologies such as the Dapivirine Ring and long-lasting injectables. The PEPFAR SA DREAMS program will also target AGYW (15–24 years) in sero-discordant relationships and pregnant and breastfeeding women to be linked to PrEP services.

DREAMS Beneficiaries Mentoring Support: In accordance with COP21 guidance, the PEPFAR SA DREAMS programs will ensure that implementing partners are compliant with guidance on “DREAMS mentoring”. The OU will guide DREAMS implementing partners to include intensive support to DREAMS beneficiaries through improved mentoring services that aim to reduce vulnerabilities, improve health outcomes, and increase resilience in AGYW.

Economic Strengthening: South Africa reported increased unemployment numbers in 2020 with 35.9% of females aged 15–24 years not in employment, education, or training. In COP21, PEPFAR SA DREAMS will continue to identify and leverage immediate and innovative opportunities for economic strengthening among AGYW 20–24 years. These opportunities will include providing financial literacy training to all DREAMS beneficiaries and intensifying creation of pathways to employment for older AGYW through self-employment, wage employment, and linkages to further education and training. In complement to the pathway to further education for older AGYW, our basic economic strengthening package in DREAMS also includes a pathway to support return to school for younger AGYW who have not yet completed matric.

Improved GBV Response: In COP21, the PEPFAR SA team will leverage the gains made in FY20 to ensure that the DREAMS post-violence care services continue to be of the highest quality, strengthen the implementation of clinical/routine enquiry and first-line support across the DREAMS platform, with responsive bi-directional linkages between DREAMS services. In addition, the program will focus on linkages between post-violence care services and PrEP, building from AGYW transitions from PEP. PEPFAR SA will also continue to ensure all DREAMS providers/staff (e.g., facilitators, mentors, PrEP/HTS providers, etc.) interacting with beneficiaries are trained on the LIVES, (Listen, Inquire, Validate, Enhance Safety and Support) approach, and are well-positioned to provide referrals to quality specialized services. To strengthen program monitoring, DREAMS implementing partners will also report on custom indicators to better communicate outcomes. Community awareness generation activities will be key to supporting not only an increase in accessibility of services (including PEP access within the post-rape window period), but also to supporting a reduction in stigma and discrimination (i.e., “shifting the burden of shame”) for those survivors who do access services.

Tracking and Reporting on Layering: PEPFAR SA has transitioned to a web-based cohort tracking system to track and report on layering, thereby addressing challenges in demonstrating layering between different packages and services beyond the AGYW_PREV indicator. This tracking will also include focused attention on addressing challenges in reporting on completion

of the primary and secondary DREAMS packages and demonstrate the successful direct linkage to services. In COP21, PEPFAR SA is aiming for improved primary package completion and layering with the secondary package for DREAMS beneficiaries.

DREAMS Sub-National Unit (SNU) Saturation Plans:

As noted in the COP21 PLL, the SA DREAMS program experienced significant disruptions due to COVID-19 and the need for greater implementation acceleration. PEPFAR SA DREAMS will maintain COP 20 approved geographic expansion plans and focus on achieving 100% saturation in the four original districts of City of Johannesburg, Ekurhuleni, eThekweni, and uMgungundlovu. Focus will be on achieving at least 45% saturation in the 20 new DREAMS districts in collaboration with GFATM in the seven shared districts.

DREAMS Coordinator and Deputy Coordinator: PEPFAR SA through PCO is on track to finalize onboarding of Deputy Coordinator and in the recruitment process for the USDH DREAMS Coordinator (USDH) in COP20.

4.3.2 Orphans and Vulnerable Children (OVC)

The PEPFAR SA OVC program continues to prioritize strategies that both reduce the risk of acquiring HIV for children and adolescents in the epidemic through family-based approaches, as well as prevent sexual violence and HIV acquisition in very young adolescent girls and boys through evidence-based approaches. In FY20, OVC IPs quickly adapted existing strategies to the COVID-19 context and successfully provided critical care and protection through remote case management services to children and families affected by HIV during COVID-19 related restrictions, especially C/ALHIV and child survivors of sexual violence requiring intensive support. Despite these challenging circumstances, OVC IPs exceeded their FY20 targets and are on track to meet their FY21 targets. Through intensified targeting efforts, the OVC program has continued to increase the enrollment of C/ALHIV and improved the proportion of children age <19 years on treatment from high volume clinics and high-volume SNUs into the OVC program from 7% in FY17 to 63% in FY20. In addition to prioritizing C/ALHIV, the OVC comprehensive case management program provides wrap around services for priority sub-populations including children of PLHIV, HIV exposed infants, children of key populations, survivors of sexual violence, teen mothers, and double orphans due to HIV/AIDS. These wrap around services provide critical family-based support across the cascade to ensure treatment continuity and viral suppression for children and adults through empowering beneficiaries with HIV treatment literacy and family strengthening.

Building on COP20 implementation, the PEPFAR South Africa strategic priorities for COP21 are aligned with the three OVC program models: OVC Preventive, OVC Comprehensive, and the OVC/DREAMS Family Strengthening. In COP21, USAID targets were adjusted across all 25 districts to accommodate the reduced budget of 23% for the OVC program, while reducing the number of targets in selected districts through responsibly graduating or transitioning beneficiaries through closely monitored graduation and transition plans. OVC IPs will continue to prioritize C/ALHIV enrollment through strengthened relationships with DSPs to ensure at least 90% of PEPFAR-supported CLHIV in high volume sites are offered enrollment. All OVC

Comprehensive households will be assessed for graduation readiness and will be prepared for graduation to meet the 20% graduation target.

In COP21, 574,495 beneficiaries will be reached across the three OVC program models. The OVC Preventive target is 27% of the overall OVC_SERV target and 102,161 young adolescents will be reached. COP21 OVC Comprehensive targets are 58% of the overall OVC_SERV target in order to provide comprehensive, family-centered case management services and 331,884 beneficiaries will be reached with comprehensive wrap around services. DREAMS/OVC targets were assigned following discussions with the interagency AGYW portfolio allocating 140,380 DREAMS girls age 10-17, which comprises 24% of the overall OVC_SERV target.

4.3.2.1 Primary prevention of HIV and sexual violence among 9–14 year olds:

In COP21, OVC IPs will continue to scale up interventions for primary prevention of sexual violence and HIV for girls and boys ages 9–14 using ChommY, Vhutshilo 1, IMPower/IM Safer curricula approved by S/GAC in 2020. ChommY and [Vhutshilo 1](#) are multi-session curricula that were developed in South Africa and approved by S/GAC in 2020. ChommY is the Department of Social Development (DoSD) mandated curricula implemented by DoSD through the G2G agreement, and other implementing partners. While some overlap may exist between OVC Preventive and OVC Comprehensive, the majority of young adolescents targeted for OVC Preventive will be targeted through schools, and some OVC may be enrolled in both programs depending on their HIV risk factors.

4.3.2.2 OVC/DREAMS Family Strengthening

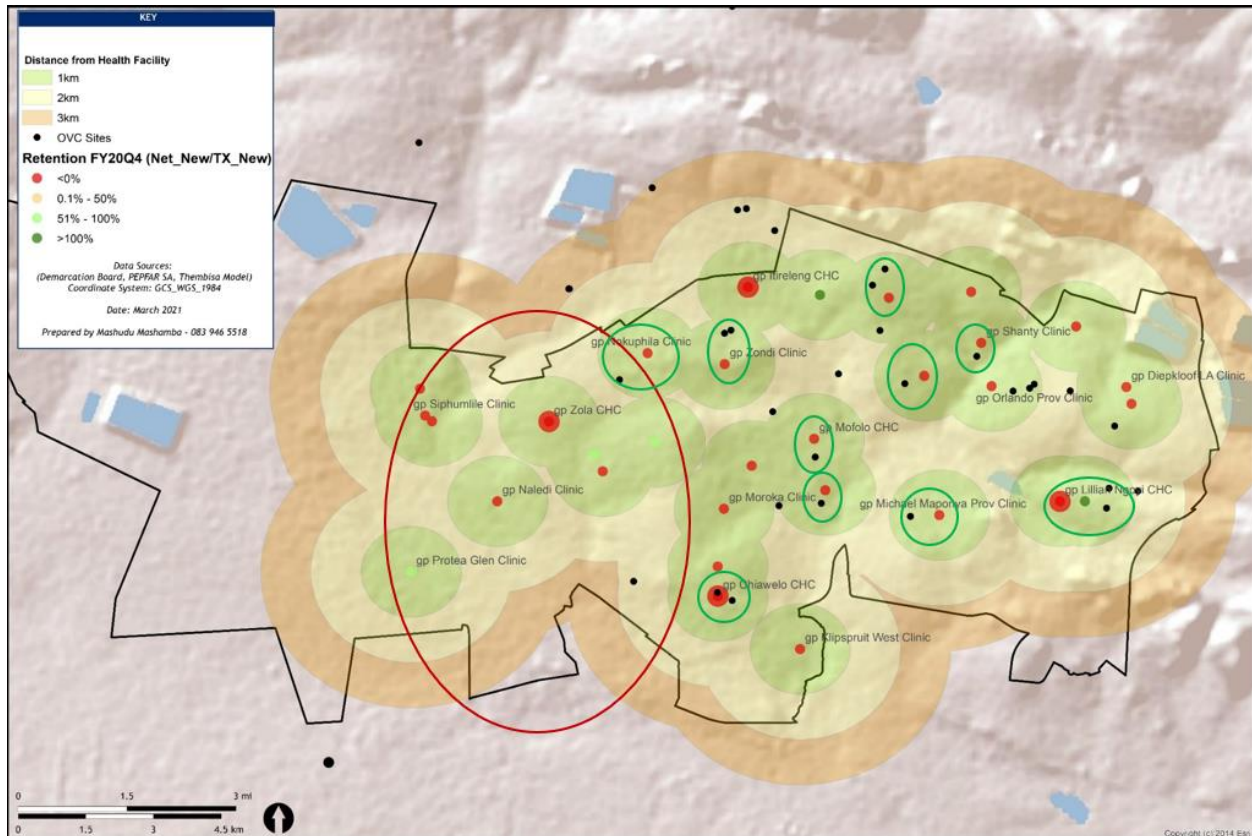
OVC IPs will also continue to provide family strengthening services to DREAMS girls aged 10–17 years using the Let's Talk and Parenting for Lifelong Health (Sinovuyo Teen) parenting curricula. DREAMS and OVC IPs will strengthen procedures to identify and enroll AGYW in need of family-based case management and child protection support to be enrolled in the OVC program; and enroll AGYW aged 10–17 years in the OVC program that need more intensive HIV prevention support. In COP21, the OVC program will reach 140,380 DREAMS girls aged 10–17 years.

4.3.2.3 OVC Comprehensive Program and reaching C/ALHIV

In COP21, OVC IPs will continue to deliver intensive case management to priority sub-populations including C/ALHIV, children of PLHIV, HIV exposed infants (HEI), children of female sex workers (CFSWs), teen mothers, and survivors of sexual violence, meeting beneficiaries at their time of need, whether in the clinic, community or in their homes. In COP21, the SA OVC Program will contribute to the PEPFAR SA pediatric surge through continued scaling up and enrollment of C/ALHIV and support for the continuity of treatment for children under 18 years of age, and will actively participate in the multidisciplinary team to ensure that 100% of biological children of PLHIV with unknown status are offered HIV testing. For unsuppressed C/ALHIV, the SA OVC Program will provide a more intensive care and support package, including case conferencing and support for transitioning children to optimized ART, in order to improve OVC contribution to the 3rd 95. Building on the formalized MOUs with DSPs established in COP20, the OVC IPs will actively engage DSPs in key activities to improve the functionality of the multidisciplinary team through tracking bi-directional referrals, scaling up case conferencing,

identifying solutions for shared confidentiality challenges, and joint case identification. These efforts will also include cross-training amongst DSPs and OVC case workers to provide necessary support to help C/ALHIV and their families reach their health goals, such as viral suppression.

Figure 4.3.1 Mapping of OVC sites and Health Facilities in Region D of City of Johannesburg



In COP21, the OVC program will intensify collaboration and bidirectional referrals with DSPs and KP partners to refine a family-centered differentiated approach tailored to children of FSWs, to improve access to and uptake of EID, index testing, linkage to ART, and retention in care to achieve viral suppression, as well as other critical health, psychosocial and economic strengthening interventions. The PEPFAR SA OVC program will also strengthen GBV screening for referral and linkage to comprehensive post-violence care service.

4.3.5 Key Populations

PEPFAR SA has shown success and improvements in its Key Population prevention, care and treatment investments targeted to female sex workers, men who have sex with men, transgender women, people who inject drugs, and incarcerated individuals, despite the impact of the COVID-19 lock downs in COP19 and COP20. All Key Population programs are aligned with strong country strategic plans and informed by population-size estimations and bio-behavioral data. In 2016/17, SANAC launched strategic plans for sex workers and LGBTQI+ (<https://sanac.org.za/reports>) aligned with the NSP 2017–2022. The National Sex Worker Plan

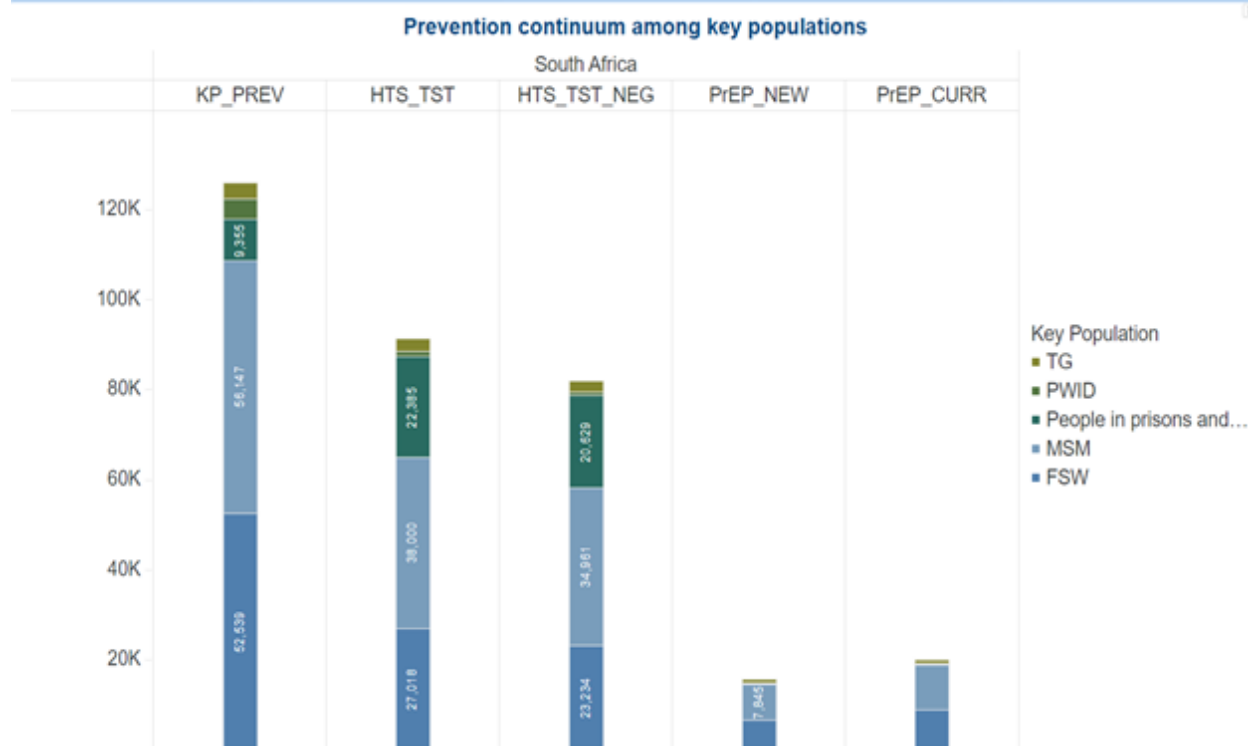
was updated and LGBTQI+ plan reviewed in 2020 (<https://sanac.org.za/reports/>). These plans demonstrate strong consensus on the strategic direction and confirm GoSA's support. In addition, PEPFAR SA supported the development of a strategic plan for the GoSA's High Transmission Area program in 2020, and dissemination of these guidelines continue in COP20.

The core of the COP20 program focuses on peer-led outreach and mobilization, targeted strategic communication and demand creation, and dedicated Key Population mobile and drop-in centers. These centers provide prevention services, HIV testing and treatment; STI screening and treatment; TB screening and referral; PrEP; PEP; and other primary health services, including sexual and reproductive health and psychosocial support. Additional targeted services, including hormone replacement therapy for transgender people and opioid substitution therapy for people who inject drugs, are also provided. PEPFAR-SA will continue to support the development of National Department of Health's key population program, and will advocate for sensitive and clinically competent treatment for KP in the public health facilities. In COP21, PEPFAR SA will focus on translating KPIF and COVID-19 innovations into routine programming. PrEP uptake will be scaled up through a focus on KPIF and COVID-19 innovations including building on virtual outreach, scaling up targeted demand creation activities strengthening continuity of PrEP through loyalty programs and motivational interviewing, rapidly expanding PrEP programming in prisons. Viral load coverage and suppression will be strengthened across all KP groups through the use of eLABS, point-of-care testing, and client-centered enhanced adherence counselling. Partners will monitor early interruption in treatment (<3 months) and follow up to ensure clients remain in care. Same-day ART initiation will be strengthened through motivational interviewing and accompanied by multi-month drug dispensing and drug delivery to hotspots or other areas that are convenient to the client.

HIV case finding will be streamlined and targeted in COP21. We will implement index testing, with recency testing in selected districts, and a blended social network strategy-index testing approach across all districts to find KP individuals who do not know their status. Risk screening tools and self-testing (assisted and secondary distribution) will be scaled up.

This core package of services is complemented by interventions focused on stigma reduction, community mobilization, and use of strategic information for program management. We will continue to roll out the Sensitization toolkit to public health facilities, and to strengthen condom and lubricant promotion and distribution by the GoSA ensuring consistent availability at all PEPFAR supported sites, with specific focus on KP groups.

Figure 4.3.2 Prevention Continuum by Key Population Group



4.3.6 Voluntary Male Medical Circumcision (VMMC)

The VMMC program has historically performed very well, conducting approximately 500,000 circumcisions per year for the past five years. However, in FY20, after another strong start the VMMC program was fully suspended when the National State of Emergency and a full country lock-down were announced by President Cyril Ramaphosa, in March 2020, as a result of the SARS-CoV-2 pandemic. The VMMC program remained suspended for a period of five months, these months coinciding with the winter-season which happens to be the high-performance season for the VMMC program. As a result, in FY20, the program performed only **159,739** VMMCs or **31%** of the annual target. This less-than-desirable performance was apparent across the PEPFAR SA supported districts with the exception of the Eastern Cape Province districts, showing good performance as a result of another successful VMMC campaign during the Traditional Male Initiation season in late 2019, just before the onset of COVID-19.

The VMMC program suspension was lifted in August 2020 and, since then, the program has seen a strong rebound. At the time of this update, the VMMC program is operational in all provinces and districts again, albeit at different stages of scale-up. We are seeing a steady increase in the sites that are offering VMMC services and the demand for VMMC is on the rise again. Once again, we were fortunate to be able to implement another very successful campaign in Eastern Cape Province in late 2020, which has contributed a lot to the FY21 performance to date. Based on preliminary data, we estimate that the VMMC program has performed approximately 60,000 VMMCs in the first quarter, or approximately 20% of the annual target for FY20 thus far. A second wave of COVID-19, over the holiday period, has

reminded us that there is no predicting what else COVID-19 will bring us. However, while some provinces and districts still advocate for caution and restraint, there appears to be no more appetite for another program suspension, and the program scale-up continues to move ahead.

Meanwhile, since the re-start in August 2020, the VMMC program has also fully implemented the complete cessation of circumcisions of boys aged 10–14 years old and achieved the new OGAC age pivot requirements as per the COP20 technical considerations.

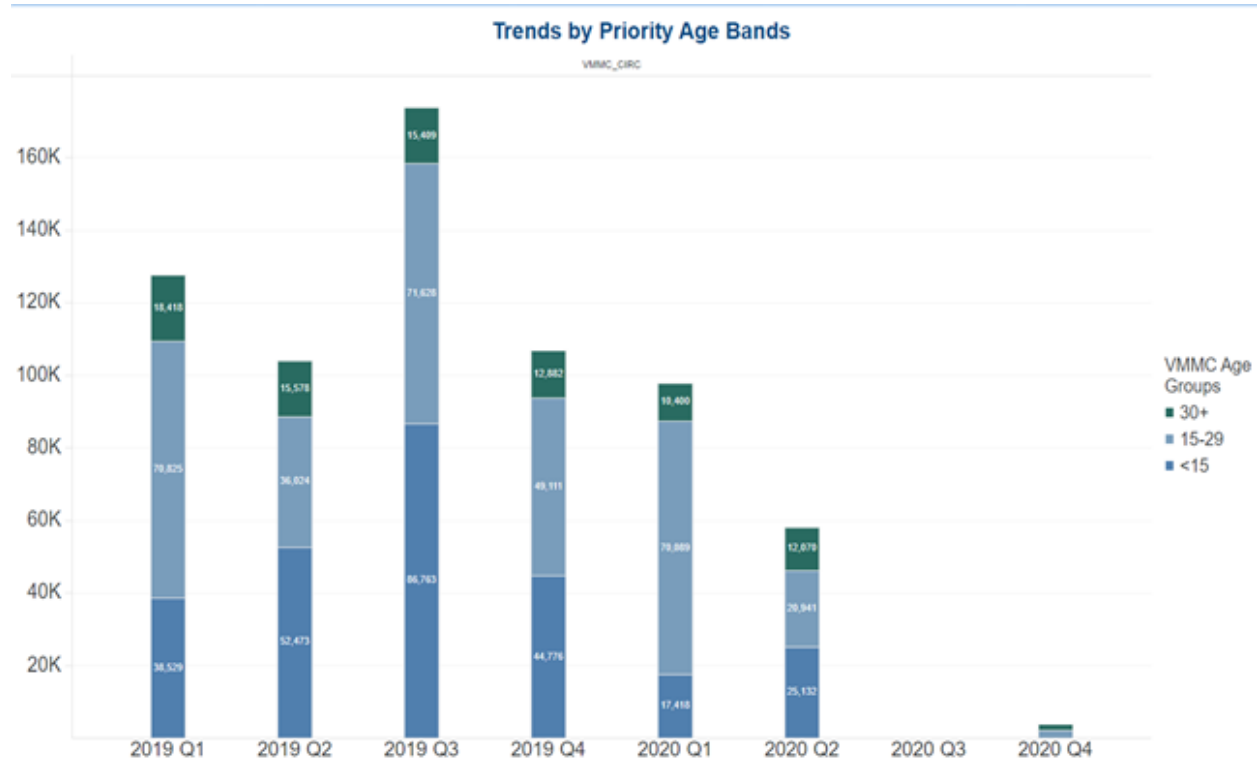
In addition, during September/October 2020, we successfully completed partner transitions from USAID- to CDC-supported implementing partners in 12 of the 27 districts. This was done through a collaborative process between USAID and CDC, the two agencies' implementing partners, and the respective provinces and districts as to limit the disruption of the process and to protect client services and program performance.

For FY22, we anticipate that the VMMC program will operate at full capacity again. Programs and service delivery will be implemented with a strong focus on client safety, not only the safety of the VMMC procedure, but also the compliance with the strict infection prevention and control (IPC) protocols and other COVID-19 prevention measures that we are now used to implementing. PEPFAR SA also continue to work towards even more refined strategies to specifically target men between the ages of 15–24 years, the key target group for VMMC services.

Based on flat-lined VMMC program funding, we have set a target of 315,000 VMMCs for FY22, similar to the current year's target. We do not anticipate any cost reductions or additional cost-efficiencies since we already reduced the per circumcision cost by approximately 40% over the past two years. Also, we anticipate that we may require an increased level of effort on IPC and safety measures, as well as extra resources for demand generation activities to specifically attract the men aged 15–24 years.

South Africa has for a long time lacked reliable VMMC coverage data to assist with target allocations. In FY19, the Human Sciences Research Council (HSRC) was contracted to triangulate its household survey (2017) findings with a number of other available data sources (surveys, models, and programmatic data) to calculate reliable VMMC coverage estimates by district. Furthermore, in FY20, the Imperial College of London conducted its own estimates and projections exercise considering all available data (results of which are still to be formally released). While just estimates, the results consistently show that, the estimated coverage remains low, with not a single district reporting the desired VMMC coverage, in any of the age groups, of $\geq 80\%$. Therefore, we will continue to set targets for all 27 PEPFAR SA supported districts based on prior performance with more targets being assigned to better performing districts with a comparative advantage to perform better going forward. All the proposed targets have been set within the 15–34-year old age group, with a strong preference for the 15–19 and 20–24-year-old age groups (~70%) as per the COP21 guidance.

Figure 4.3.3 Voluntary Medical Male Circumcision Quarterly Trends by Age



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

There are three main priorities for PEPFAR SA in COP 2021.

1. Accelerate and complete COP 2020 focus on linkage, retention, and regaining patients lost to follow-up to reach the 95-95-95 goals. There is a need for significant pediatric performance improvements across the clinical cascade and pediatric ARV optimization. This priority was addressed in section 4.1.1, 4.3.3 and 4.3.4 of this SDS.
2. Optimize testing across the program to close gaps in case finding and increase yield. Target testing to focus on populations and areas at high risk for HIV infection and improve index testing scale-up and performance. This priority was addressed in section 2.2, 4.1.1, 4.35 and 4.5of this SDS.
3. Accelerate VMMC and increase DREAMS completion, focusing on GBV and economic strengthening for older AGYW in DREAMS. This priority was addressed in section 4.3.1 of this SDS.

4.5 Additional Program Priorities

There have been several recent policy changes that have affected HIV-related programming in South Africa. The Protection of Personal Information (POPI) Act was approved by South Africa’s

Parliament in 2013; however, certain provisions only came into effect in July 2020. The intent of the Act is to safeguard personal information. It models the format of the European Union's Global Data Protections Regulations. However, in practice, local enforcement of the POPI Act--in particular the recent provisions--has resulted in significant challenges for PEPFAR SA and local institutions, including implementing partners. This impediment is specifically highlighted in the Minimum Program Requirements (MPR)--item 2 under prevention and OVCs. However, its impact is broad-reaching, as it affects all aspects of patient-level information and how that information can be shared and used for HIV programming. POPI Act enforcement has resulted in a discontinuation of access to routinely collected, individual-level data, which impedes referral tracking and program monitoring.

Other policy changes may have positive impacts on HIV programming, as they offer legal leverage for advocating for new or improved implementation. Regulation 43260 was issued in April 2020 as an emergency measure to address challenges posed by the COVID-19 pandemic. The regulation exempts schedule 2, 3, and 4 substances from South Africa's 6-month prescription maximum, as specified in the Medicines and Related Substances Act, and sets a new allowable maximum validity of 12 months. The aim was to reduce in-person visits to health facilities for drug pick-ups only. The regulation was temporary, though it was renewed on 20 November 2020 and again in March 2021. It will expire again six months after its issuance; however, the natural experiment that it represents offers an opportunity to demonstrate to the GoSA that 12-month scripting is a viable alternative even after the COVID-19 pandemic. The need for 12-month scripting is noted in the MPRs--especially for Repeat Prescription Collection Strategies (RPCs). PEPFAR SA also supported GoSA in the development of pediatric DMOC guidelines that are now in the final phases of approval and should be operational in COP21. Further, PEPFAR SA will work with the GoSA to revise national policies to support community-based ART initiation in line with the 2021 updated WHO guidance.

Finally, after many years of deliberation, in 2020 the GoSA approved the country's first national strategic plan for addressing gender-based violence (GBV) and an amendment to the Domestic Violence Act of 1998. Taken together, these advances establish an operational framework and targets for addressing the national GBV crisis. The need for action to address the persistent violence faced by adolescent girls and young women and other at-risk populations is specifically noted in the MPRs on OVCs.

PEPFAR SA will continue to ensure the scale-up of index testing is in accordance with the PEPFAR Guidance on Implementing Safe and Ethical Index Testing and the DoH SOPs for HIV Index Testing. PEPFAR SA will continue to monitor the quality improvement plans of all the facilities that did not reach the minimum standards during the index testing assessments. The following activities will be undertaken to strengthen the program:

- Intensify supportive supervision and mentoring for all implementers to strengthen sexual partner elicitation skills and documentation of the outcomes per partner;
- Translation of scripts into local language to ensure there are no communication barriers between implementers and the clients;

- Integrate rights-related index testing services to the existing patient's rights/Batho Pele IEC materials;
- Develop and integrate strategies to facilitate anonymous reporting of violation of rights to the existing system;
- Conduct refresher LIVES trainings for implementers to strengthen support for victims of IPV;
- Conduct refresher contact elicitation counselling training workshops; and
- Monitor adverse events by ensuring that DSPs provide actioned tailored outcomes per event;
- Conduct KP sensitization training with all counselors involved with contact solicitation.

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

- Number of clients offered index testing services disaggregated by sex;
- Number of clients accepting index testing services disaggregated by sex;
- Number of contacts solicited disaggregated by sex and adult/child;
- Number of contacts screened positive for IPV disaggregated by sex;
- Number of contacts tested through index testing disaggregated by sex;

Number of adverse events identified through the adverse event monitoring system.

PEPFAR South Africa will maintain the same geographical coverage in the country into COP21 despite the reduced budget. Service delivery packages of care will be tailored the specific requirements of the health districts supports as determined by progress towards attainment of the 95–95–95 targets.

In line with reducing budgets, program efficiencies and effectiveness became paramount for sustaining the gains made towards epidemic control. PEPFAR South Africa is accelerating local program ownership through initiating new government to government (G2G) agreements at sub-national levels. These G2Gs are aimed at improving data access and use, strengthening re-engagement of clients back to care, and strengthening primary health in the country.

PEPFAR South Africa has strengthened partner management through formation of robust partner management teams that include site activity, strategic information experts, government liaisons and cross program liaisons (prevention and HSS) for effective partner management.

4.6 Commodities

While the GoSA will maintain its significant investment in the procurement of HIV-related commodities in 2021/22, the estimated budget at this time is under discussion in light of the country's aggressive response to the COVID-19 pandemic, including the procurement and scale-up of vaccines through pharmaceutical companies as well as the COVAX global initiative.

As planned in its current year three funding, the GFATM will invest USD15 million in ARVs for treatment and USD830,000 for PrEP (annual estimates based on new grant funding estimates), as well as USD900,000 for HIV Self-Screening (HSS) kits. With HIV commodity needs primarily covered through host country and GFATM financing, PEPFAR SA will invest USD7,838,000 toward the procurement of VMMC commodities and HIV tests (including HIV Self-Screening tests).

South Africa will continue the transition from TEE to TLD, building on gains made in 2020 in spite of global supply chain and logistics challenges from COVID-19, targeting an estimated 4 million adult patients by the end of December 2021. Late last year, the NDoH renewed their multi-month dispensing, 12-month scripting policy thereby enabling the continued legalization of this patient-focused modality that will help foster ARV retention. This is also a key policy shift within South Africa and a critical step toward formalizing 3-, 4- and eventually, 6-month dispensing for chronic medicines such as ARVs. The NDOH plans to expand current 2- and 3-MD ART in a targeted manner throughout 2021, which will allow the NDOH to closely monitor treatment outcomes and 3-MMD will be expanded for those not decanted to the Central Chronic Medicines Dispensing (CCMDD) program. The CCMDD program will continue to expand eligibility criteria to include TB patients, while optimising 3-MMD in COP20. No funding gaps for commodities have been projected for the period covered under COP20. The NDOH's 6-MD pilot working group began in earnest in February 2021 and now includes three target districts, which is one additional district relative to the plan from last year.

The impact of the coronavirus pandemic in South Africa has provided the NDOH a platform to learn about the importance of centralised planning, ordering recommendations to provinces, pipeline guidance to suppliers, and prompt notification and subsequent resolution of supply-chain related challenges. Going forward, the NDOH will build on these lessons learned to continue developing a more resilient health system vis-a-vis supply chain and logistics capacity building. This strategy includes a strengthened workforce management support system; ARV/TB contract management services; and a greater focus on governance infrastructure between central and provincial DOH.

There has been an accelerated need to ensure a balance of pharmaceutical and supply chain skills, thus professionalising the supply chain and centralising activities to specialised teams. COVID-19 response planning, including vaccine planning, will inform the National Health Insurance (NHI) planning going forward. The NDoH is working closely with its suppliers regarding any anticipated supply issues from the manufacturers. The South African Health Products Authority (SAHPRA) and NDoH continue to work closely together to understand how this may impact registration updates for critical products going forward. The NDoH will continue to research new products to optimise treatment of patients. The process followed for registration of new products will be according to SAHPRA protocols, including 3HP, pediatric 4-in-1 formulation, as well as pediatric dolutegravir 5- and 10-mg oral tablets

4.7 Collaboration, Integration and Monitoring

Throughout the past several years, substantial gaps have emerged in performance related to initiation and maintenance of PLHIV onto ART. These gaps were further widened by the SARS-

CoV-2 pandemic in COP19 and COP20 due to the strict nationwide lockdown periods (which resulted in significant drops in facility headcount), health facility closures, healthcare worker COVID-19 infections and deaths, and healthcare workers in quarantine in South Africa. Working with the NDoH, PEPFAR SA has collaborated on specific approaches to address these critical program gaps. The COVID-19 adjusted activities implemented in COP20 will continue into COP21, including 1) reinforcing Siyenza, the intense, site-level support that PEPFAR SA and NDoH launched in February 2019, 2) strengthening the commitment of the NDOH's "Operation Phuthuma" that leads HIV/TB programming for NDoH to reach the 95–95–95 targets, 3) building off of NDoH's SOP for all HIV/AIDS, STI and TB (HAST) Managers, 4) increasing commitments to HRH and VL result reporting, 5) documenting and addressing facility-based challenges through in-person and remote support. Careful monitoring of the fidelity of the implementation of these interventions will help South Africa reach the 95–95–95 targets. Notable activities for collaboration, integration and monitoring include:

- PEPFAR SA and the NDoH will continue to prioritize Operation Phuthuma and the intensive focus on high-volume sites. PEPFAR SA supported Operation Phuthuma sites in Phase 1 (February – July 2019) in 343 sites while Phase 2 (August 2019 – February 2021) it expanded to 417 sites. Between February 2019 and February 2020, PEPFAR SA staff conducted 3,873 in-person site visits. From March 2020 to the end of September 2020 (FY20 Q3-4), PEPFAR SA staff conducted 1,312 remote site support calls to provide technical support and problem-solving in coordination with Provincial and district level-DOH facility and IP staff with a focus on improve HIV case finding, ART initiation, and treatment continuation.
- PEPFAR SA and IPs continue to support Operation Phuthuma at all levels of government. Through Operation Phuthuma and Siyenza, PEPFAR SA and NDoH established a new way of doing business that includes routine monitoring of key indicators, weekly reporting and data-driven decision-making, and achievement driven IPs that work with DoH to address site-level bottlenecks immediately. District and Provincial forums (E.g. Nerve Centers or Management Review Meetings) regularly review performance, identify and address bottlenecks and monitor implementation of action items continuously to improve the quality of health services. While many of these forums were paused during COP19 and early COP20 due to the SARS-CoV-2 pandemic nationwide lockdown, many have resumed through online platforms and in-person where possible. These forums are providing a space for DoH to "own" their programs and drive performance in alignment with the NDoH circulars that were sent in COP19. PEPFAR SA's COP21 activities will continue to bolster these forums for optimal collaboration and coordination to effectively expedite the resolution of site-level challenges.
- To ensure IPs share accountability for their performance, IPs are reporting monthly data to PEPFAR SA. In COP21, PEPFAR SA will continue its focus on scaling up PLHIV newly initiated on treatment, while intensive efforts are placed on treatment continuation. PEPFAR SA has directed attention to improving IP capacities to continue PLHIV on treatment and to re-engage those who have defaulted treatment. IPs who are underperforming will be placed under Corrective Action Plans (CAPs) which are monitored closely by agency leads.

- PEPFAR SA and NDoH are committed to improving the use of unique identifiers across sites and programs in clinical settings. PEPFAR SA and NDoH will continue to monitor full implementation of HPRS as the unique identifier system to track patients across facilities and trace defaulting ART patients. Both PEPFAR SA and NDoH will work to strengthen the implementation and routine use of HPRS within South Africa.
- PEPFAR SA and NDoH will continue to hold high level weekly coordination meetings to evaluate program performance, the identify gaps, and the need for additional support to the provinces, districts, and facilities. PEPFAR SA technical staff, in coordination with the NDoH, will support the development of any technical material, as needed.
- PEPFAR SA will continue to consolidate and analyze monthly data from the facilities using its Siyenza interagency dashboard that allows for joint decision-making to support program management.
- PEPFAR SA is consolidating the gaps identified in the facilities that will require escalation to the NDoH, provincial or district level. The data will continue to be shared monthly to obtain NDoH guidance and action, as needed, to support improvements in specific districts and facilities.
- PEPFAR SA will consolidate and analyze timely facility data to identify interventions that successfully lead to improved program performance, that will be presented as a package in the form of “best practices” that will then be scaled up in the remaining Operation Phuthuma facilities to accelerate performance improvement. Understanding resilience and best practices during the SARS-CoV-2 pandemic is important as these strategies will strengthen health systems and better prepare facilities for this and future pandemics.
- PEPFAR SA’s program has been strengthened by increased collaboration with GFATM and Civil Society. This collaboration has improved program planning, resulting in a more robust and comprehensive HIV response. This collaboration will further increase in COP21, as PEPFAR SA will continue to benefit from community-led monitoring through the PLHIV sector’s Ritshidze, which will continue to monitor HIV services at PEPFAR-supported sites within the 27 priority districts. PEPFAR SA and Civil Society will increase accountability by jointly monitoring facility-level adherence to guidelines, observing staff performance, and serving as an additional data source to increase facility-level improvement.
- To optimize the PEPFAR SA investments in addressing these gaps, PEPFAR SA will continue to collaborate with GoSA, GFATM, and other key partners to ensure that resources are leveraged and that investments are planned to be complementary both technically and geographically. PEPFAR SA is working with the SANAC and GFATM Principal Recipients to harmonize interventions, indicators, and geographies aimed at preventing HIV and GBV among AGYW and Key Populations. These harmonization efforts are a result of strengthened collaborative relationships between PEPFAR SA staff and the GFATM Fund Portfolio Team, the Country Coordinating Mechanism Secretariat (based at SANAC), and the Principal Recipients. PEPFAR SA, SANAC, and GFATM Principal Recipients are exploring opportunities to consolidate monitoring and evaluation and routine reporting tools (a health information system assessment is on-going to guide these decisions).

4.8 Targets by population

The targets for the following four tables should be generated using data from the COP21 approval memos:

Table 4.8.1 Antiretroviral Therapy Targets by Prioritization for Epidemic Control

Table 4.8.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART	Additional patients required for 80% ART coverage	Target current on ART	Newly initiated (APR FY22)	ART Coverage (APR 22)
		1		2	TX_NEW	
	N/A	N/A	N/A	TX_CURR	N/A	N/A
Scale-Up Saturation	2,389,241	1,343,785	567,608	1,824,147	266,881	76%
Scale-Up Aggressive	3,914,895	2,454,612	677,304	3,180,410	421,358	81%
Sustained	N/A	N/A	N/A	N/A	N/A	N/A
Central Support	1,593,141	1,017,629	256,884	2,333	858	0.15%
Commodities (if not included in previous categories)	N/A	N/A	N/A	N/A	N/A	N/A
Total	7,897,276	4,816,026	1,501,795	5,006,890	689,097	63%

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

Table 4.8.2 Voluntary Male Medical Circumcision Coverage and Targets by Age Bracket in Scale-up Districts

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
District	Target Populations	Population Size Estimate	Current Coverage*	VMMC_CIRC Target	VMMC_CIRC Target
		(FY2021)	(FY2021 expected)	(in FY2021)	(in FY2022)
ec Alfred Nzo District Municipality	15-34 year olds	115,808	30.5%	13,077	13,077
ec Amathole District Municipality	15-34 year olds	121,047	9.3%	17,079	17,080
ec Buffalo City Metropolitan Municipality	15-34 year olds	112,568	12.8%	30,133	30,000
ec Chris Hani District Municipality	15-34 year olds	106,654	4.5%	10,291	10,289
ec Oliver Tambo District Municipality	15-34 year olds	264,171	12.1%	8,743	8,743
fs Lejweleputswa District Municipality	15-34 year olds	106,745	54.6%	2,441	2,460
fs Thabo Mofutsanyane District Municipality	15-34 year olds	125,263	44.5%	3,923	3,922
gp City of Johannesburg Metropolitan Municipality	15-34 year olds	1,040,548	60.8%	15,360	15,357
gp City of Tshwane Metropolitan Municipality	15-34 year olds	673,020	56.7%	16,118	16,117
gp Ekurhuleni Metropolitan Municipality	15-34 year olds	735,590	46.1%	5,896	5,895
gp Sedibeng District Municipality	15-34 year olds	172,374	60.4%	3,740	3,738
kz eThekweni Metropolitan Municipality	15-34 year olds	713,613	49.2%	56,434	56,455

kz Harry Gwala District Municipality	15-34 year olds	83,090	49.7%	5,603	5,603
kz King Cetshwayo District Municipality	15-34 year olds	160,628	51.5%	9,571	9,571
kz Ugu District Municipality	15-34 year olds	147,498	34.7%	9,598	9,597
kz uMgungundlovu District Municipality	15-34 year olds	197,819	47.5%	8,658	8,658
kz Uthukela District Municipality	15-34 year olds	118,445	44.0%	6,164	6,136
kz Zululand District Municipality	15-34 year olds	141,515	44.5%	7,166	7,293
lp Capricorn District Municipality	15-34 year olds	192,751	52.7%	3,923	3,923
lp Mopani District Municipality	15-34 year olds	177,928	26.7%	5,386	5,386
mp Ehlanzeni District Municipality	15-34 year olds	302,270	50.6%	7,304	7,270
mp Gert Sibande District Municipality	15-34 year olds	230,503	56.9%	8,449	8,623
mp Nkangala District Municipality	15-34 year olds	306,385	35.5%	20,707	20,620
nw Bojanala Platinum District Municipality	15-34 year olds	355,760	42.1%	10,237	10,284
nw Dr Kenneth Kaunda District Municipality	15-34 year olds	135,620	37.5%	3,168	3,166
nw Ngaka Modiri Molema District Municipality	15-34 year olds	155,849	25.5%	13,248	13,249
wc City of Cape Town Metropolitan Municipality	15-34 year olds	756,804	23.2%	11,153	11,186
TOTAL	15-34 year olds	7,750,266	39.4%	313,570	313,699

*Coverage Estimates reported from HSRC VMMC coverage estimates report by district in South Africa.

SOURCE: VMMC coverage modelling estimates, DHIS and DATIM

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Target Populations	Districts	Population Size Estimate* (SNU's)	Disease Burden*	FY22 Target
AGYW [10-24 yrs] (PP_PREV)	ec Alfred Nzo District Municipality	89,803	9%	16,940
	ec Amathole District Municipality	67,539	9%	
	ec Buffalo City Metropolitan Municipality	59,908	9%	11,560
	ec Chris Hani District Municipality	61,039	9%	
	fs Lejweleputswa District Municipality	55,001	9%	9,590
	fs Thabo Mofutsanyane District Municipality	70,870	9%	12,640
	gp City of Johannesburg Metropolitan Municipality	426,553	9%	109,305
	gp City of Tshwane Metropolitan Municipality	279,029	9%	24,487
	gp Ekurhuleni Metropolitan Municipality	297,242	9%	23,074
	gp Sedibeng District Municipality	69,754	9%	13,700
	kz eThekweni Metropolitan Municipality	317,923	9%	30,635
	kz King Cetshwayo District Municipality	96,534	9%	16,740
	kz Ugu District Municipality	76,887	9%	13,070
	kz uMgungundlovu District Municipality	103,856	9%	11,214
	kz Uthukela District Municipality	72,598	9%	7,690
	lp Capricorn District Municipality	117,839	9%	22,050

	lp Mopani District Municipality	110,994	9%	19,710
	mp Ehlanzeni District Municipality	180,694	9%	30,743
	mp Gert Sibande District Municipality	119,417	9%	18,820
	mp Nkangala District Municipality	145,022	9%	24,550
	nw Bojanala Platinum District Municipality	147,301	9%	11,937
	nw Dr Kenneth Kaunda District Municipality	70,266	9%	5,893
	nw Ngaka Modiri Molema District Municipality	86,138	9%	7,540
	wc City of Cape Town Metropolitan Municipality	370,358	9%	64,629
AGYW [10-24 yrs] (PP_PREV) - subtotal*		3,492,565		506,517
Female Sex Workers (KP_PREV)	ec Chris Hani District Municipality			
	ec Oliver Tambo District Municipality	3,062	53%	2,040
	gp City of Johannesburg Metropolitan Municipality	9,564	72%	5,540
	gp City of Tshwane Metropolitan Municipality	9,963	53%	3,911
	gp Ekurhuleni Metropolitan Municipality	7,525	53%	4,036
	kz eThekweni Metropolitan Municipality	9,264	55%	6,712
	kz iLembe District Municipality			
	kz uMgungundlovu District Municipality	2,883	53%	1,684
	kz Uthukela District Municipality			
	lp Vhembe District Municipality	3,765	53%	2,076
	mp Ehlanzeni District Municipality	5,042	53%	2,628
	mp Gert Sibande District Municipality	3,300	53%	1,576

	mp Nkangala District Municipality	4,063	53%	2,016
	nw Dr Kenneth Kaunda District Municipality	2,595	53%	1,088
	nw Ngaka Modiri Molema District Municipality	3,303	53%	1,260
	wc City of Cape Town Metropolitan Municipality	9,395	40%	4,680
FSW (KP_PREV) - subtotal*		73,724		39,247
MSM (KP_PREV)	ec Buffalo City Metropolitan Municipality	4,604	30%	1,460
	ec Nelson Mandela Bay Municipality	7,435	30%	2,287
	gp City of Johannesburg Metropolitan Municipality	40,199	43%	15,207
	gp City of Tshwane Metropolitan Municipality	21,221	30%	9,907
	gp Ekurhuleni Metropolitan Municipality	27,493	30%	11,033
	kz eThekweni Metropolitan Municipality	25,633	30%	11,093
	kz uMgungundlovu District Municipality	5,414	30%	1,927
	mp Ehlanzeni District Municipality	7,772	30%	2,960
wc City of Cape Town Metropolitan Municipality	28,734	27%	12,107	
MSM (KP_PREV) - subtotal*		168,505		67,981
TGW (KP_PREV)**	ec Buffalo City Metropolitan Municipality	830	46%	373
	ec Nelson Mandela Bay Municipality	1,260	46%	567
	gp City of Johannesburg Metropolitan Municipality	3,892	63%	1,753
	wc City of Cape Town Metropolitan Municipality	2,413	46%	1,087

TGW (KP_PREV) - subtotal*		8,394		3,780
People Who Inject Drugs (KP_PREV)***	gp City of Tshwane Metropolitan Municipality	4,514	58%	2,026
	mp Ehlanzeni District Municipality	1,395	17%	626
People Who Inject Drugs (KP_PREV) - subtotal*		5,909		2,652
Inmates (KP_PREV)	ec Amathole District Municipality	1,104	12%	660
	ec Buffalo City Metropolitan Municipality	3,712	12%	2,208
	ec Nelson Mandela Bay Municipality	2,855	12%	1,700
	ec Oliver Tambo District Municipality	4,197	12%	1,516
	ec Sarah Baartman District Municipality	1,651	12%	980
	fs Fezile Dabi District Municipality			0
	fs Lejweleputswa District Municipality			0
	fs Thabo Mofutsanyane District Municipality			0
	fs Xhariep District Municipality			0
	gp City of Johannesburg Metropolitan Municipality	10,658	12%	6,340
	gp City of Tshwane Metropolitan Municipality	10,390	12%	6,180
	gp Ekurhuleni Metropolitan Municipality	8,074	12%	4,804
	gp Sedibeng District Municipality	700	12%	420
	kz Amajuba District Municipality			0
	kz eThekweni Metropolitan Municipality	2,500	12%	1,488

kz Harry Gwala District Municipality	1,562	12%	928
kz King Cetshwayo District Municipality	2,612	12%	1,552
kz Ugu District Municipality			0
kz uMgungundlovu District Municipality	1,151	12%	684
kz Umzinyathi District Municipality			0
kz Uthukela District Municipality			0
kz Zululand District Municipality	2,864	12%	1,704
lp Capricorn District Municipality	1,308	12%	780
lp Vhembe District Municipality	4,697	12%	2,796
lp Waterberg District Municipality			0
mp Ehlanzeni District Municipality	1,314	12%	780
mp Gert Sibande District Municipality	1,535	12%	912
mp Nkangala District Municipality	1,738	12%	1,060
nc Frances Baard District Municipality			0
nc Zwelentlanga Fatman Mgcawu District Municipality			0
nw Bojanala Platinum District Municipality	1,710	12%	1,020
nw Dr Kenneth Kaunda District Municipality	3,214	12%	1,912
wc Cape Winelands District Municipality	3,478	12%	2,068
wc City of Cape Town Metropolitan Municipality	6,526	12%	3,880
wc Garden Route District Municipality	1,698	12%	1,012
wc Overberg District Municipality	1,206	12%	720
wc West Coast District Municipality	3,427	12%	2,040

Inmates (KP_PREV) - subtotal*		85,881	12%	50,144
TOTAL*		3,834,978		670,321

**Key Populations data has been taken from the UCSF, Key Populations Cascade Project 2016.*

Source: Naomi estimates, Datapack

Table 4.8.4 Targets for Orphans and Vulnerable Children and Linkages to HIV Services

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
District	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY22Target) OVC_SERV Comprehensive	Target # of OVC (FY22Target) OVC_SERV Preventative	Target # of active OVC (FY22Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY22 Target) OVC*
ec Alfred Nzo District Municipality	53,226	4,000	1,000	6,504	3,679
ec Amathole District Municipality	83,519	4,047	953	0	3,346
ec Buffalo City Metropolitan Municipality	37,922	11,203	4,801	4,466	9,452
ec Chris Hani District Municipality	77,033	4,000	1,000	0	3,301
ec Oliver Tambo District Municipality	252,601	8,009	2,002	0	6,606
fs Lejweleputswa District Municipality	N/A	1,401	600	3,831	1,229
fs Thabo Mofutsanyane District Municipality	69,372	6,945	3,691	5,045	6,144
gp City of Johannesburg Metropolitan Municipality	154,382	61,600	26,400	52,896	55,252
gp City of Tshwane Metropolitan Municipality	90,469	15,500	4,500	0	12,070
gp Ekurhuleni Metropolitan Municipality	133,873	12,000	3,000	0	10,255
gp Sedibeng District Municipality	47,649	13,600	2,400	4,929	11,887
kz Amajuba District Municipality		-	376	0	

kz eThekweni Metropolitan Municipality	221,572	32,000	8,000	0	27,850
kz Harry Gwala District Municipality	55,785	8,503	1,500	0	7,119
kz King Cetshwayo District Municipality	99,107	5,950	1,050	6,395	5,351
kz Ugu District Municipality	78,122	3,500	1,500	4,741	3,026
kz uMgungundlovu District Municipality	88,618	7,021	3,003	0	5,667
kz Uthukela District Municipality	75,420	6,402	1,601	0	5,304
kz Zululand District Municipality	104,278	6,808	1,201	0	5,691
lp Capricorn District Municipality	95,223	8,241	2,400	9,425	7,487
lp Mopani District Municipality	81,600	9,172	2,803	8,026	8,133
mp Ehlanzeni District Municipality	135,560	28,000	7,000	11,127	23,528
mp Gert Sibande District Municipality	88,571	16,000	4,000	7,018	13,427
mp Nkangala District Municipality	71,577	15,736	3,934	8,704	12,905
nw Bojanala Platinum District Municipality	77,076	7,200	1,800	0	6,113
wc City of Cape Town Metropolitan Municipality	96,687	31,805	7,951	7,272	27,401
wc West Coast District Municipality*		3,237	3,763	0	2,452
TOTAL	2,369,242	331,880	102,229	140,379	284,675

Footnotes: Population size estimates for OVC assumed constant between 2020 and 2021. Data displayed for Priority districts only. Several districts (N=4) have OVC_SERV FY21 targets but were excluded due to location (Centrally Supported) or because beneficiaries targeted are not OVC but rather beneficiaries of HIV primary prevention programming aged 10-14. Excluded Districts: kz Amajuba District Municipality (Primary Prevention Targets) - <18 Target: 138, kz Umkhanyakude District Municipality (Primary Prevention Targets) -<18 Target: 167, lp Vhembe District Municipality (Primary Prevention Targets) - <18 Target: 125, lp Waterberg District Municipality (OVC Targets)-<18 Target:110, 18+ Target:3, wc West Coast District Municipality(Placeholder Targets)-<18 Target:4780, 18+ Target: 6692.

*West Coast District is used to house Community Grants targets temporarily as grants selection is not completed at time of COP planning and will be moved to the selected districts during the first Operational Plan Update (OPU) cycle.

4.9 Cervical Cancer Program Plans

PEPFAR SA does not implement cervical cancer activities.

4.10 Viral Load and Early Infant Diagnosis Optimization

The revised FY20 PMTCT guidelines have included additional VL testing for pregnant women at birth and at 6 months post-delivery to strengthen VL monitoring of pregnant and breast-feeding women. NHLS is monitoring the use of eGK (electronic gate keeping) code usage nationally. These codes are used to allow for repeat VL testing for pregnant and post-partum women and prevent rejection of specimens. These activities are being supported by PEPFAR SA implementing partners in their supported districts and will strengthen the VL monitoring of pregnant and breastfeeding women.

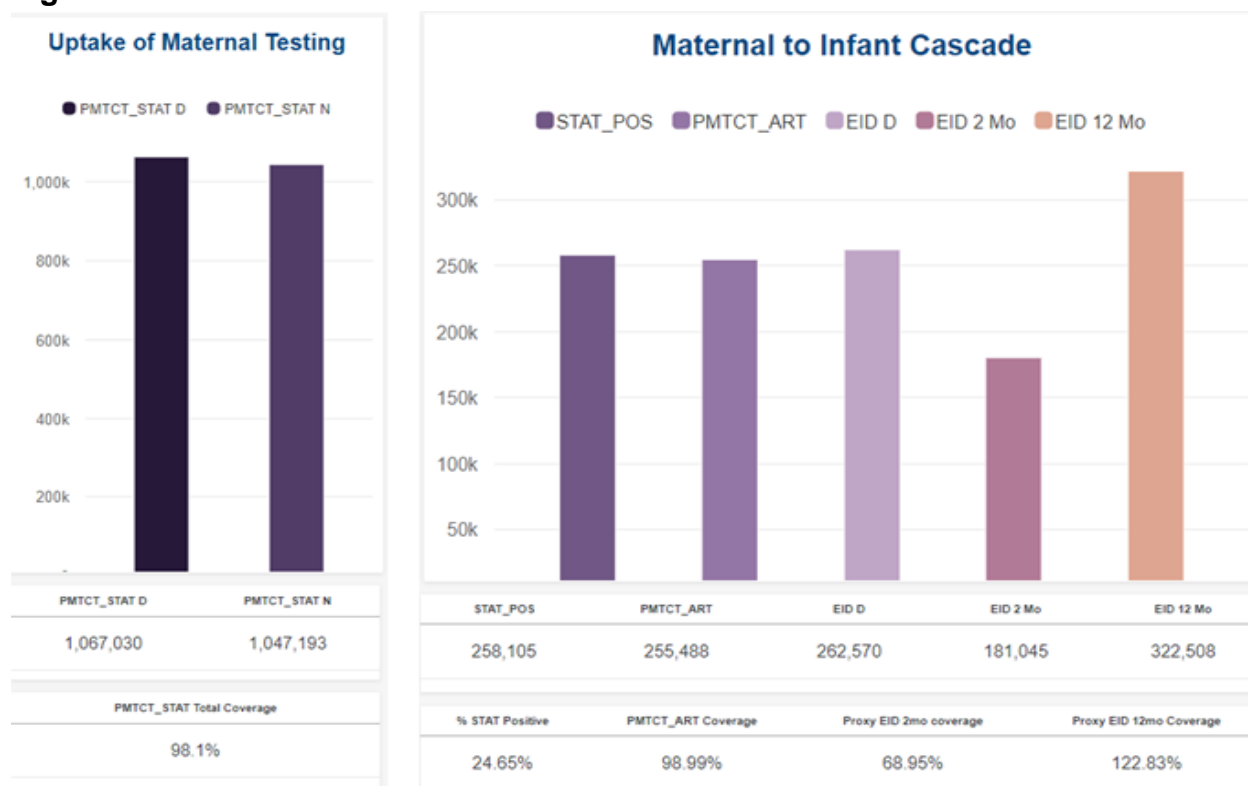
In addition, PEPFAR SA has funded the eLABs system that is being used to improve turnaround times, reduce specimens' rejection rate, and improve results usage to manage patients for VL. This has been rolled out to 1500 facilities in the 27 PEPFAR SA-supported districts. PEPFAR SA has been working with the DoH at the provincial and district levels to improve the utilization of the system to improve VL management.

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

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

Although COVID-19 had a significant impact on clinic attendance, there were some innovations introduced including providing access to community VL testing and immunization catch-up campaigns which help to identify exposed infants who missed their PCR tests. These new activities are being used to improve access to and quality of care.

Figure 4.10.1 Prevention of Maternal to Child Transmission Cascade



5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Systems support activities strengthen components of the health system that are critical to the successful implementation of HIV prevention and treatment health services. This is the focus of COP21 and builds on investments from prior COP years. Systems investments implemented at the above-site level are designed to address the most critical systems-based barriers that inhibit HIV epidemic control in SA. These key systems barriers were identified through a range of strategic processes, including the NSP, the PEPFAR MER system, and intensive site improvement and monitoring (including Siyenza), and are linked to the SID scores. The investments are aligned with the GoSA and other development partners, and in particular the GFATM, to optimize opportunities to leverage and complement and to ensure the best return on these investments. As budget reductions in the above site portfolio (ASP) occur, PEPFAR SA's focus is on ensuring the availability of HIV and TB commodities as well as the continuity of services including laboratory and continued improvement of programs through quality information and functioning information systems. Clearly defined and agreed upon benchmarks of progress are established and documented for each of the funded activities (summarized below). The benchmarks will be monitored actively to ensure that activities are on track and continue to address barriers to the success of the broader portfolio (see also Section 4.5 on partner management).

COP21 focuses on addressing the following areas of system barriers:

1. Human Resources for Health
2. Efficient and Effective Patient Linkage and Retention
3. Interoperable Patient Data Systems and Need for Robust and Consistent Surveillance Data for Program Planning
4. Strategic Allocation of HIV Resources
5. Utilization of Civil Society Resources
6. Drugs and Commodities Planning
7. Utilization of the Private Sector
8. Strengthening Laboratory Infrastructure and Processes

Each of these barriers is presented below with a summary of the planned COP21 investments and expected outcomes of the investment. The COP21 minimum requirements (see Appendix D) related to the investment are also included below.

Central coordination of the health workforce will improve workforce enumeration, planning, coordinated skills building, and opportunities to increase efficient and effective service delivery. Support for up to 20,000 health care workers (HCW) was provided during the surge period of COP18 and COP19. In recognition of the looming challenges posed by the imminent COVID-19 pandemic, specifically to HIV/TB services delivery, PEPFAR SA agreed to continue the majority of the HRH support through COP20. However, a phased transition of this HRH support is planned in COP21. PEPFAR SA is working closely with the the Department of Health at all levels to plan for the reduction in PEPFAR-funded frontline staff and protect program gains made during the Surge. Above-site HRH investments, such as those outlined below, will be additionally supportive in working to improve HRH.

Summary of COP21 Above-Site Investments (HRH)	Expected Outcomes
<ul style="list-style-type: none"> • PEPFAR SA will support the implementation of information systems to collect and synthesize data on national human resources information system (HRIS) and the human resources inventory database (HRID) for PEPFAR SA supported staffing. • PEPFAR SA will second staff to the NDoH to provide essential HR support for condom and Key Populations programming. • PEPFAR SA will provide technical support at the national level towards strengthening HIV & TB related activities at the national and sub national levels. These include guideline development, training of trainers at provincial levels and lower level engagement in the 27 priority districts for ART 	<p>HRH planning/ coordination and systematic capacity building for service delivery will result in an optimized health workforce to achieve epidemic control.</p> <p>Fully comprehensive and functional health workforce registry inclusive of all cadres across the public sector private sector, integrated HRH and programmatic data to monitor site-level staff performance and utilized to optimize human resources planning.</p>

<p>linkage and initiation, pediatrics, VMMC, and HMIS coordination.</p> <ul style="list-style-type: none"> PEPFAR SA will improve implementation and generate use of cost-effective capacity-building program for health care workers to ensure adherence to latest standards and guidance. 	<p>Improved engagement of the HIV cluster in NDoH.</p>
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Key Systems Barrier 2: Efficient and effective patient linkage and retention

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

***Related COP21 Minimum Requirements:** Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups; Adoption and implementation of differentiated service delivery models, including multi-month scripting and delivery models to improve identification and ARV coverage of men and adolescents; Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting.*

<p>Summary of COP21 Above-Site Investments (Patient Linkage and Retention)</p>	<p>Expected Outcome</p>
<ul style="list-style-type: none"> PEPFAR SA will support implementation of high transmission area (HTA) guidelines to provinces and districts to support best practices in delivering care to Key Populations. PEPFAR SA will support the NDoH in revisiting the Ideal Clinic platform to reflect lessons learned from Operation Phuthuma on how to optimize HIV service delivery and other quality improvement initiatives. PEPFAR SA will identify individuals out of care and identify best methods to improve programs for initiation on ART and sustained linkage to care. PEPFAR SA will reinforce the Undetectable = Untransmissible campaign to improve linkage and retention across the program. The U=U campaign will continue to be population appropriate and support the NDoH’s welcome back strategies and involve both facility level communications interventions and mass media. Demand generation will focus on the priority patient groups for PrEP and ART. 	<p>Strengthened guidelines and implementation accountability structures on linkage to care and differentiated service delivery will result in more efficient and effective HIV services.</p> <p>PEPFAR SA will disseminate recommendations to at least 9 provincial departments and to 52 districts about the HTA guidelines and KP care will be improved.</p> <p>In response to the U=U campaign, proxy linkage and retention rates. It is expected that the proportion of patients disengaged from care will be reduced to below 15% in U=U campaign districts.</p>

Key Systems Barrier 3: Interoperable patient data systems

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

Related COP21 Minimum Requirements: *Scale up of unique identifiers for patients across all sites; Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.*

Summary of COP21 Above-Site Investments (Interoperable Patient Data Systems)	Expected Outcome
<ul style="list-style-type: none"> ● Improvement of the surveillance of priority public health events associated with: <ul style="list-style-type: none"> ○ Adverse events associated with different types of HIV treatment, including pregnant women and their perinates; ○ Tracking patients longitudinally from testing to viral suppression; ○ Obtain critical information on HIV incidence and the status of 95–95–95 through the 6th round of the South Africa National HIV Prevalence, Incidence, Behavior and Communication Survey (SABSSM VI), a nationally representative household survey, carried out by the SA Human Sciences Research Council (HSRC), which will be used to inform program interventions and future resource allocation; ○ Strengthening the services delivered to adolescent girls and young women and other at-risk populations. ● PEPFAR SA will continue to support strengthening of existing health information systems at all levels for quality patient-level data. The development of a patient-centered digital health information system is a core element of the South Africa National Digital Health Strategy (2020–2024). This includes support to key NDoH aggregate health information systems, to improve the timeliness and accuracy of reporting. ● Continuous system supports the implementation of the Synchronized National Communication in Health (SynCH) system for CCMDD program monitoring and implementation. 	<p>Better integrated and higher quality surveillance and programmatic data will result in a strong public health response to achieve epidemic control. Improved patient-level data coordination will result in better care and management of health resources.</p> <p>Increased proportion of facilities with DHIS2; DHIS2 skills transfer activities continue; Dissemination and capacity building for 95–95–95 dashboards continue; dissemination of data quality reports continues.</p> <p>Updated estimates of HIV prevalence, incidence, and 95-95-95 progress at national and subnational levels.</p> <p>Improved SynCH utilization rate.</p> <p>Continued functioning of patient-centered digital health information system and timely reporting and transfer of quality patient-level data to maintain continuity of HIV and TB service delivery.</p> <p>Provincial information hubs accessed by all levels of the Health System (i.e. facility, district, province).</p> <p>Routine quarterly data dissemination instituted as part of Phuthuma and</p>

<ul style="list-style-type: none">● Transfer of sustainable solution to capacitated South African NDoH team.	<p>able to account for longitudinal client record.</p> <p>Information Hub Solution transitioned to NDoH ownership.</p>
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Key Systems Barrier 4: Strategic Allocation of HIV Resources

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

Related COP21 Minimum Requirements: Evidence of resource commitments by host governments with year after year increases.

Summary of COP19 Above-Site Investments (Strategic Allocation of HIV Resources)	Expected Outcome
<ul style="list-style-type: none"> • PEPFAR SA will provide financial and managerial capacity building for the HIV/AIDS conditional grant to 27 priority districts. Ensure the appropriate alignment with PEPFAR SA, prioritization, budgeting, and execution of budgets directed to national HIV/AIDS program. Transition down provincial level support for financial and managerial capacity building. • PEPFAR SA will support the GoSA to improve allocative and technical efficiencies through evidence-based cost modeling and financial capacity building to respond to the changing economic landscape. • PEPFAR SA will support epidemiological and economic analysis to support decision-making from Treasury and NDOH on domestic resource allocation in-light of SAG reduced spend on the program 	<p>The GoSA will leverage domestic resources to more strategically invest to maximize HIV-related health outcomes at national, provincial, and district levels.</p> <p>27 districts receiving technical support on budgeting and budget execution to procure necessary equipment, supplies, and other expenditures essential to HIV service delivery. This involves 95% financial execution at district level of HIV conditional grant against budget planning tool.</p> <p>Pay-for-performance mechanisms implemented and improved after one year of execution across all PEPFAR SA priority districts, through the NDoH. Outcomes-based payment for the HIV conditional grant instituted in policy and payment implemented.</p> <p>Positive trend of resource commitments by host government as compared to previous year. Target of avoiding more than 5% in decreases in 2020/21/20 to 2021/2022 budget cycles.</p>

Key Systems Barrier 5: Utilization of Civil Society Resources

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

Summary of COP21 Above-Site Investments (Civil Society)	Expected Outcomes
<ul style="list-style-type: none">● PEPFAR SA will assess the impact of policies and regulations on HIV.● PEPFAR SA will support multi-sectoral platforms at all levels to coordinate, strengthen implementation and monitoring of activities for the AGYW and the KP cascade including disseminate key policies and guidelines	<p>A more engaged, coordinated, and capacitated civil society will hold the public health sector accountable to the needs of their constituents.</p> <p>Relevant key population national plans are evaluated, accompanied by implementation and monitoring and evaluation plans and effectively rolled out to Implementing Partners and DoH.</p> <p>Updated estimates and cascades to inform program planning.</p>

Key Systems Barrier 6: Drugs and Commodities Planning

Improve integration and triangulation of programmatic data and supply data to better inform planning for drugs and commodities.

Related COP21 Minimum Requirements: Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens.

Summary of COP21 Above-Site Investments (Drugs and Commodities Planning)	Expected Outcome
<ul style="list-style-type: none"> ● PEPFAR SA will optimize supply chain predictability through continued support for demand and supply planning, creating end-to-end visibility and routinized commodities availability at national-level and based on district-level aggregate reporting of real-time supply chain and commodities data. ● PEPFAR SA will support the GoSA in evidence-based scale-up of multi-month dispensing of ARVs to include 6MD in a way that accounts for South Africa’s decentralized drug delivery program. ● PEPFAR SA will scale up the "informed push" system, based on body of evidence from pilot to inform national roll-out. This system automates the quantification of stock requisitions for health workers at facilities to save them time and improve accuracy. ● PEPFAR SA will support the GoSA Affordable Medicines Directorate in strategic HIV/TB control operations toward epidemic control, facilitating implementation of NDOH-PEPFAR SA interventions. ● PEPFAR SA will sustain NDoHs capacity to monitor and plan for stock and maintain SyNCH and CCMDD 	<p>Routine integration and triangulation of Supply Chain National Surveillance Centre (NSC) and program data implemented for all PEPFAR SA supported sites. The aim is to have 95% facilities or more reporting into the NSC.</p> <p>27 districts implementing a MMD modality; >95% availability of stock implementing MMD;</p> <p>zero stock-outs associated with implementation of MMD.</p> <p>Reductions in facility visits by patients to 2 per year.</p> <p>500 facilities managing stock through informed push system.</p> <p>NDoH should demonstrate capacity to plan and monitor for stock at ~4,000 health facilities</p>

Key Systems Barrier 7: Utilization of the Private Sector

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

Summary of COP21 Above-Site Investments (Utilization of the Private Sector)	Expected Outcome
<ul style="list-style-type: none">● PEPFAR SA will support full sustainable transition of pick-up point (PuP) models to domestic resources and provide private sector engagement technical assistance to DSPs.● PEPFAR SA will assist in business model design and strategies for repeat prescription collection strategies to promote retention by supporting the NDoH in renewing tenders with providers for pre-packing of commodities (including CCMDD service providers).	<p>A better integrated private-public health system will result in greater accessibility and population coverage of HIV services.</p> <p>Service provider tenders (including CMMDD) supported for smooth transition if needed.</p> <p>All feasible innovative external pick-up point models transitioned to domestic resources.</p>

Key Systems Barrier 8: Strengthened laboratory infrastructure and processes

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

COP21 Associated Minimum Requirement: Lab PEPFAR Minimum Requirement: Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting.

Summary of COP21 Above-Site Investments (Strengthening lab infrastructure and processes)	Expected Outcome
<ul style="list-style-type: none"> ● PEPFAR SA will maintain and monitor eLABs in 1500 PEPFAR SA supported facilities; expand eLABs to all PEPFAR SA supported facilities as approval is granted by the provincial Health Departments; Pilot direct messaging to patients; Hire VL coordinators (3), Clinical trainers(3) and eLABs remote monitors(2); Continuous monitoring of turnaround time from specimens' collection to results returned to the facilities, monitor rejection rates, specimens' volume, instruments downtime for VL/labs; Develop and pilot the module to send VL results to patients' phones. ● PEPFAR SA will continue sending Results For Action (RFA) EID and Crypto LFA positive results and VL>1000 copies/ml to facilities and individuals that are receiving it in FY2020; Expand to more PEPFAR SA-supported facilities. ● PEPFAR SA will also support the NDoH in conducting post market surveillance for HIV rapid test kit quality assurance. ● PEPFAR SA will Support the NHLS External Quality Assurance (EQA) department to implement quality management systems to increase the number of EID, VL, TB and CD4 labs accredited and to maintain accreditation in the ones (21/35) that are already accredited. PEPFAR SA will support the NHLS EQA department to prepare and distribute proficiency testing (PT) panels for all facilities providing HIV-rapid testing (4,600 facilities), as well as viral load, and Early Infant Diagnosis (EID) laboratories. 	<p>Strengthened laboratory infrastructure and processes will ensure great VL monitoring to inform clinical service delivery and improve the rate of viral suppression.</p> <p>Continue to increase awareness of CrAg dashboard and promote registration and use of CrAg RFA reports, Monitor CrAg test discrepancies through inter-laboratory quality assessment.</p> <p>Reduce specimens' rejection rate to below 4% in the facilities accessing eLAB (1500). Expand eLAB to all PEPFAR SA supported facilities, reduced turnaround time (TAT) for VL specimens' processing in the 1500 facilities that have eLABs.</p> <p>Expand RFA to more PEPFAR SA-supported facilities and users at district level;</p> <p>Get 1–3 more labs accredited (decreased budget and COVID impacting lab auditing for accreditation) and maintain accreditation in the ones accredited in FY17–FY20.</p>

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

[REDACTED]

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1.1 Treatment Coverage by Age, Sex and District, by 27 PEPFAR SA District Prioritization (fine age bands) - Children <15 Years [1]

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization (fine age bands) - Children <15 Years [1]														
District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall									
					Female (<15 years)*				Male (<15 years)*				Child ART Coverage (PEPFAR) <15 Years	Adult ART Coverage (PEPFAR) 15+ Years
					<1 year	1-4 years	5-9 years	10-14 years	<1 year	1-4 years	5-9 years	10-14 years		
gp City of Johannesburg Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	54%				53%				54%	53%
	COP 17	Scale-Up Saturation	APR 18	reported	101%	37%	42%	100%	37%	39%	40%	54%		
	COP 18	Scale-Up Saturation	APR19	reported	---	35%	36%	---	30%	33%	33%	48%		
	COP 19	Scale-Up Saturation	APR 20	reported	51%	58%	70%	73%	51%	57%	69%	72%	69%	78%
	COP 20	Scale-Up Saturation	APR 21	expected	136%	82%	82%	82%	100%	82%	82%	82%	82%	78%

	COP 21	Scale-Up Saturation	APR 22	expected	94%	79%	79%	79%	94%	79%	79%	79%	79%	77%
gp City of Tshwane Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	49%				47%				48%	53%
	COP 17	Scale-Up Aggressive	APR 18	reported	97%	35%		35%	96%	35%		32%	35%	53%
	COP 18	Scale-Up Saturation	APR19	reported	88%	42%		46%	69%	37%		42%	43%	56%
	COP 19	Scale-Up Saturation	APR 20	reported	43%	56%	67%	68%	43%	56%	67%	67%	65%	83%
	COP 20	Scale-Up Saturation	APR 21	expected	99%	87%	87%	87%	89%	77%	82%	87%	85%	81%
	COP 21	Scale-Up Saturation	APR 22	expected	77%	79%	79%	79%	77%	79%	79%	79%	79%	77%
gp Ekurhuleni Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	43%				42%				43%	47%
	COP 17	Scale-Up Saturation	APR 18	reported	73%	41%		44%	72%	41%		39%	42%	54%
	COP 18	Scale-Up Saturation	APR19	reported	66%	36%		39%	49%	32%		36%	36%	48%
	COP 19	Scale-Up Saturation	APR 20	reported	42%	60%	68%	67%	42%	60%	67%	67%	65%	77%
	COP 20	Scale-Up Saturation	APR 21	expected	100%	74%	81%	81%	85%	69%	73%	81%	78%	77%
	COP 21	Scale-Up Saturation	APR 22	expected	65%	79%	79%	79%	65%	79%	79%	79%	80%	81%

kz eThekweni Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	reported	72%				60%				66%	56%
	COP 17	Scale-Up Saturation	APR 18	reported	69%	54%		53%	67%	53%		48%	52%	60%
	COP 18	Scale-Up Saturation	APR19	reported	118%	49%		51%	79%	45%		46%	48%	57%
	COP 19	Scale-Up Saturation	APR 20	reported	48%	78%	79%	75%	48%	78%	79%	74%	76%	83%
	COP 20	Scale-Up Saturation	APR 21	expected	119%	87%	87%	87%	98%	83%	83%	81%	85%	82%
	COP 21	Scale-Up Saturation	APR 22	expected	32%	80%	80%	80%	31%	81%	80%	80%	80%	81%
ec Alfred Nzo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	38%				35%				37%	50%
	COP 17	Scale-Up Aggressive	APR 18	reported	137%	40%		40%	137%	40%		35%	40%	60%
	COP 18	Scale-Up Aggressive	APR19	reported	88%	35%		34%	70%	32%		30%	33%	53%
	COP 19	Scale-Up Aggressive	APR 20	reported	32%	88%	91%	73%	32%	87%	90%	71%	79%	80%
	COP 20	Scale-Up Aggressive	APR 21	expected	88%	89%	95%	89%	90%	89%	90%	84%	89%	87%
	COP 21	Scale-Up Aggressive	APR 22	expected	49%	83%	86%	83%	49%	83%	85%	83%	83%	83%
ec Amathole District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	54%				50%				52%	54%
	COP 17	Scale-Up Aggressive	APR 18	reported	1124%	78%		30%	1081%	76%		22%	60%	63%

	COP 18	Scale-Up Aggressive	APR19	reported	1080%	72%		27%	877%	67%		19%	54%	55%
	COP 19	Scale-Up Aggressive	APR 20	reported	45%	88%	88%	86%	44%	78%	88%	78%	83%	84%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	88%	88%	88%	80%	78%	88%	78%	84%	83%
	COP 21	Scale-Up Aggressive	APR 22	expected	68%	83%	82%	83%	66%	84%	83%	83%	82%	81%
ec Buffalo City Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	107%				103%				105%	47%
	COP 17	Scale-Up Aggressive	APR 18	reported	213%	30%		25%	204%	30%		24%	29%	37%
	COP 18	Scale-Up Aggressive	APR19	reported	78%	37%		43%	54%	30%		39%	37%	40%
	COP 19	Scale-Up Aggressive	APR 20	expected	33%	55%	60%	47%	33%	55%	60%	46%	52%	75%
	COP 20	Scale-Up Aggressive	APR 21	expected	85%	81%	84%	84%	36%	70%	84%	80%	82%	79%
	COP 21	Scale-Up Aggressive	APR 22	expected	56%	79%	79%	79%	54%	79%	79%	79%	79%	79%
ec Chris Hani District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	48%				30%				39%	53%
	COP 17	Scale-Up Aggressive	APR 18	reported	39%	17%		51%	38%	16%		38%	31%	57%
	COP 18	Scale-Up Aggressive	FY19 Q1	reported	57%	108%	0%	35%	24%	100%	0%	33%	33%	55%
	COP 19	Scale-Up Aggressive	APR 20	reported	40%	72%	77%	60%	39%	71%	76%	60%	66%	88%

	COP 20	Scale-Up Aggressive	APR 21	expected	100%	88%	88%	88%	50%	85%	88%	75%	84%	85%
	COP 21	Scale-Up Aggressive	APR 22	expected	115%	85%	85%	85%	115%	85%	85%	85%	85%	84%
ec Oliver Tambo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	38%				24%				31%	50%
	COP 17	Scale-Up Aggressive	APR 18	reported	167%	32%		38%	165%	32%		30%	34%	60%
	COP 18	Scale-Up Aggressive	APR19	reported	77%	28%		32%	39%	23%		26%	27%	51%
	COP 19	Scale-Up Aggressive	APR 20	reported	14%	82%	81%	66%	13%	67%	81%	65%	71%	79%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	82%	83%	83%	83%	67%	83%	69%	78%	79%
	COP 21	Scale-Up Aggressive	APR 22	expected	95%	82%	81%	82%	93%	82%	81%	82%	82%	80%
fs Lejweleputswa District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	78%				40%				59%	51%
	COP 17	Scale-Up Aggressive	APR 18	reported	---	55%		67%	---	56%		63%	60%	59%
	COP 18	Scale-Up Aggressive	APR19	reported	104%	45%		60%	72%	46%		59%	53%	53%
	COP 19	Scale-Up Aggressive	APR 20	reported	57%	84%	76%	73%	57%	83%	74%	72%	75%	83%
	COP 20	Scale-Up Aggressive	APR 21	expected	89%	86%	91%	91%	74%	91%	91%	91%	91%	86%
	COP 21	Scale-Up Aggressive	APR 22	expected	55%	81%	80%	80%	55%	80%	80%	80%	80%	80%

fs Thabo Mofutsanyane District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	49%				97%				73%	56%
	COP 17	Scale-Up Aggressive	APR 18	reported	53%	46%		51%	53%	46%		49%	48%	64%
	COP 18	Scale-Up Aggressive	APR19	reported	68%	41%		49%	35%	41%		45%	44%	59%
	COP 19	Scale-Up Aggressive	APR 20	reported	26%	86%	72%	74%	25%	73%	71%	74%	73%	92%
	COP 20	Scale-Up Aggressive	APR 21	expected	27%	89%	85%	95%	27%	73%	89%	95%	90%	92%
	COP 21	Scale-Up Aggressive	APR 22	expected	100%	81%	81%	81%	100%	82%	81%	81%	81%	87%
gp Sedibeng District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	52%				48%				50%	56%
	COP 17	Scale-Up Aggressive	APR 18	reported	62%	50%		50%	60%	48%		48%	49%	63%
	COP 18	Scale-Up Aggressive	APR19	reported	---	38%		49%	---	36%		44%	41%	61%
	COP 19	Scale-Up Aggressive	APR 20	reported	47%	63%	86%	86%	50%	56%	82%	82%	80%	82%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	63%	86%	86%	71%	57%	82%	82%	80%	78%
	COP 21	Scale-Up Aggressive	APR 22	expected	41%	82%	80%	82%	40%	82%	80%	80%	80%	81%
kz Harry Gwala District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	43%				42%				42%	55%
	COP 17	Scale-Up Aggressive	APR 18	reported	100%	48%		46%	96%	48%		41%	46%	65%

	COP 18	Scale-Up Aggressive	APR19	reported	77%	45%		42%	30%	44%		38%	42%	63%
	COP 19	Scale-Up Aggressive	APR 20	reported	74%	99%	99%	94%	73%	99%	99%	92%	95%	96%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	99%	99%	99%	100%	99%	99%	99%		
	COP 21	Scale-Up Aggressive	APR 22	expected	95%	82%	92%	83%	95%	83%	92%	82%	85%	91%
kz King Cetshwayo District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	44%				39%				42%	54%
	COP 17	Scale-Up Aggressive	APR 18	reported	119%	46%		42%	117%	47%		40%	44%	62%
	COP 18	Scale-Up Aggressive	APR19	reported	104%	44%		40%	79%	38%		37%	40%	59%
	COP 19	Scale-Up Aggressive	APR 20	reported	51%	88%	88%	85%	50%	88%	88%	83%	85%	84%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	88%	88%	88%	89%	88%	88%	88%	99%	95%
	COP 21	Scale-Up Aggressive	APR 22	expected	76%	82%	89%	81%	76%	82%	81%	81%	82%	83%
kz Ugu District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	55%				52%				54%	66%
	COP 17	Scale-Up Aggressive	APR 18	reported	84%	54%		55%	84%	55%		58%	56%	74%
	COP 18	Scale-Up Aggressive	APR19	reported	116%	50%		52%	72%	47%		53%	51%	71%
	COP 19	Scale-Up Aggressive	APR 20	reported	55%	97%	93%	84%	54%	94%	92%	82%	87%	96%

	COP 20	Scale-Up Aggressive	APR 21	expected	112%	97%	97%	97%	85%	94%	97%	97%	97%	93%
	COP 21	Scale-Up Aggressive	APR 22	expected	71%	82%	82%	82%	71%	82%	82%	82%	82%	87%
kz uMgungundlovu District Municipality	COP 16	Scale-Up Saturation	APR 17	reported	44%				34%				39%	47%
	COP 17	Scale-Up Saturation	APR 18	reported	98%	35%		36%	98%	35%		41%	38%	56%
	COP 18	Scale-Up Aggressive	APR 19	reported	65%	42%		45%	52%	35%		44%	42%	53%
	COP 19	Scale-Up Aggressive	APR 20	reported	39%	78%	81%	78%	39%	76%	81%	75%	78%	81%
	COP 20	Scale-Up Aggressive	APR 21	expected	126%	84%	84%	84%	110%	84%	84%	84%		
	COP 21	Scale-Up Aggressive	APR 22	expected	72%	83%	82%	83%	71%	83%	82%	82%	82%	80%
kz Uthukela District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	51%				32%				41%	52%
	COP 17	Scale-Up Aggressive	APR 18	reported	103%	47%		41%	100%	47%		35%	43%	62%
	COP 18	Scale-Up Aggressive	APR 19	reported	89%	41%		39%	53%	36%		33%	37%	58%
	COP 19	Scale-Up Aggressive	APR 20	reported	22%	82%	79%	73%	21%	82%	78%	72%	75%	85%
	COP 20	Scale-Up Aggressive	APR 21	expected	75%	88%	88%	88%	75%	88%	88%	77%	85%	80%
	COP 21	Scale-Up Aggressive	APR 22	expected	33%	90%	89%	90%	33%	89%	89%	90%	89%	90%

kz Zululand District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	54%				32%				43%	64%
	COP 17	Scale-Up Aggressive	APR 18	reported	109%	46%		43%	106%	45%		41%	44%	65%
	COP 18	Scale-Up Aggressive	APR19	reported	80%	43%		39%	66%	39%		37%	40%	59%
	COP 19	Scale-Up Aggressive	APR 20	reported	21%	88%	85%	80%	20%	88%	85%	78%	81%	87%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	88%	88%	88%	88%	88%	88%	88%	88%	85%
	COP 21	Scale-Up Aggressive	APR 22	expected	68%	86%	86%	86%	68%	86%	86%	86%	86%	87%
Ip Capricorn District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	52%				50%				51%	56%
	COP 17	Scale-Up Aggressive	APR 18	reported	88%	51%		50%	88%	51%		49%	51%	59%
	COP 18	Scale-Up Aggressive	APR19	reported	---	41%		43%	---	36%		42%	40%	55%
	COP 19	Scale-Up Aggressive	APR 20	reported	47%	82%	81%	79%	46%	81%	81%	79%	80%	78%
	COP 20	Scale-Up Aggressive	APR 21	expected	88%	82%	82%	82%	63%	82%	82%	82%	82%	77%
	COP 21	Scale-Up Aggressive	APR 22	expected	66%	80%	79%	79%	65%	80%	79%	79%	79%	77%
Ip Mopani District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	56%				55%				56%	59%
	COP 17	Scale-Up Aggressive	APR 18	reported	127%	56%		58%	124%	56%		56%	57%	65%

	COP 18	Scale-Up Aggressive	APR19	reported	---	43%		51%	---	38%		50%	45%	57%
	COP 19	Scale-Up Aggressive	APR 20	reported	34%	83%	84%	80%	34%	82%	84%	81%	82%	84%
	COP 20	Scale-Up Aggressive	APR 21	expected	111%	84%	84%	84%	95%	84%	84%	84%	85%	81%
	COP 21	Scale-Up Aggressive	APR 22	expected	63%	83%	83%	83%	62%	83%	83%	83%	82%	83%
mp Ehlanzeni District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	52%				53%				53%	60%
	COP 17	Scale-Up Aggressive	APR 18	reported	129%	46%		54%	127%	46%		54%	51%	66%
	COP 18	Scale-Up Aggressive	APR19	reported	115%	45%		53%	72%	40%		52%	48%	63%
	COP 19	Scale-Up Aggressive	APR 20	reported	50%	91%	95%	88%	49%	90%	94%	86%	89%	86%
	COP 20	Scale-Up Aggressive	APR 21	expected	96%	96%	96%	96%	76%	96%	96%	96%	96%	92%
	COP 21	Scale-Up Aggressive	APR 22	expected	88%	82%	82%	81%	87%	82%	82%	81%	82%	91%
mp Gert Sibande District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	36%				35%				35%	42%
	COP 17	Scale-Up Aggressive	APR 18	reported	66%	34%		41%	66%	34%		41%	38%	50%
	COP 18	Scale-Up Aggressive	APR19	reported	61%	32%		41%	58%	30%		40%	36%	49%
	COP 19	Scale-Up Aggressive	APR 20	reported	42%	77%	81%	77%	42%	76%	80%	76%	77%	78%

	COP 20	Scale-Up Aggressive	APR 21	expected	90%	84%	84%	84%	96%	79%	84%	84%	84%	80%
	COP 21	Scale-Up Aggressive	APR 22	expected	54%	82%	81%	81%	54%	82%	81%	81%	81%	80%
mp Nkangala District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	45%				44%				44%	49%
	COP 17	Scale-Up Aggressive	APR 18	reported	106%	31%		31%	104%	31%		28%	31%	42%
	COP 18	Scale-Up Aggressive	APR19	reported	80%	33%		42%	63%	28%		39%	62%	72%
	COP 19	Scale-Up Aggressive	APR 20	reported	48%	62%	65%	62%	48%	61%	65%	61%	44%	72%
	COP 20	Scale-Up Aggressive	APR 21	expected	105%	85%	85%	92%	93%	85%	85%	85%	87%	82%
	COP 21	Scale-Up Aggressive	APR 22	expected	82%	79%	79%	79%	81%	79%	79%	78%	79%	77%
nw Bojanala Platinum District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	46%				43%				44%	45%
	COP 17	Scale-Up Aggressive	APR 18	reported	76%	39%		49%	74%	39%		46%	44%	51%
	COP 18	Scale-Up Aggressive	APR19	reported	84%	37%		47%	62%	36%		44%	41%	49%
	COP 19	Scale-Up Aggressive	APR 20	reported	24%	61%	65%	66%	23%	59%	64%	64%	63%	75%
	COP 20	Scale-Up Aggressive	APR 21	expected	107%	80%	81%	81%	92%	76%	78%	81%	81%	75%
	COP 21	Scale-Up Aggressive	APR 22	expected	57%	81%	81%	81%	56%	81%	81%	81%	81%	79%

nw Dr Kenneth Kaunda District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	161%				131%				147%	70%
	COP 17	Scale-Up Aggressive	APR 18	reported	53%	33%		42%	52%	33%		36%	36%	51%
	COP 18	Scale-Up Aggressive	APR19	reported	56%	28%		33%	48%	27%		29%	30%	46%
	COP 19	Scale-Up Aggressive	APR 20	reported	13%	62%	61%	65%	13%	61%	62%	68%	79%	79%
	COP 20	Scale-Up Aggressive	APR 21	expected	100%	81%	84%	84%	84%	80%	84%	84%	84%	80%
	COP 21	Scale-Up Aggressive	APR 22	expected	61%	81%	80%	81%	61%	81%	81%	81%	81%	80%
nw Ngaka Modiri Molema District Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	42%				43%				42%	47%
	COP 17	Scale-Up Aggressive	APR 18	reported	56%	42%		42%	55%	43%		42%	43%	52%
	COP 18	Scale-Up Aggressive	APR19	reported	71%	40%		41%	48%	38%		40%	40%	50%
	COP 19	Scale-Up Aggressive	APR 20	reported	93%	73%	71%	77%	82%	72%	70%	74%	74%	83%
	COP 20	Scale-Up Aggressive	APR 21	expected	91%	74%	87%	87%	83%	77%	87%	87%	85%	83%
	COP 21	Scale-Up Aggressive	APR 22	expected	55%	82%	81%	82%	55%	82%	82%	82%	82%	81%
wc City of Cape Town Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	reported	62%				41%				51%	52%
	COP 17	Scale-Up Aggressive	APR 18	reported	116%	40%		64%	113%	39%		50%	48%	60%

	COP 18	Scale-Up Aggressive	APR19	reported	103%	41%		55%	42%	33%		46%	43%	57%
	COP 19	Scale-Up Aggressive	APR 20	reported	38%	65%	67%	58%	37%	65%	64%	58%	62%	80%
	COP 20	Scale-Up Aggressive	APR 21	expected	113%	80%	80%	83%	84%	65%	64%	77%	76%	80%
	COP 21	Scale-Up Aggressive	APR 22	expected	45%	80%	80%	80%	45%	80%	80%	80%	79%	78%
<p>[1] Source for PLHIV estimates by age, sex, and district: Eaton, J & Johnson, L. Personal communication – District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)</p> <p>Source for number of PLHIV on ART by age, sex, and district: PEPFAR reported data (from TIER.Net) for reported data and PEPFAR targets (from datapack) for expected data.</p> <p>ART Coverage calculations shown in this table do not include private sector contribution to PLHIV on ART.</p> <p><i>*Assumes half of <15 with unknown sex are male and half are female.</i></p>														

Table A.1.2 Treatment Coverage by Age, Sex and District, by Centrally Supported District Prioritization (fine age bands) - Children <15 Years [1]

Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (Central Support Districts) [1]						
District	COP	Prioritization	Results Reported	Coverage: Reported/ Expected	Targets by Age and Sex	Overall ART Coverage (PEPFAR SA)
ec Joe Gqabi District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	63%
	COP 18	Central Support	APR 19	reported	N/A: No target required	63%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
ec Nelson Mandela Bay Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	48%
	COP 18	Central Support	APR 19	reported	N/A: No target required	48%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
ec Sarah Baartman District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	48%

	COP 18	Central Support	APR 19	reported	N/A: No target required	51%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
fs Fezile Dabi District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	49%
	COP 18	Central Support	APR 19	reported	N/A: No target required	56%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
fs Mangaung Metropolitan Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	44%
	COP 18	Central Support	APR 19	reported	N/A: No target required	44%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A

fs Xhariep District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	77%
	COP 18	Central Support	APR 19	reported	N/A: No target required	74%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
rgp West Rand District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	47%
	COP 18	Central Support	APR 19	reported	N/A: No target required	61%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
kz Amajuba District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	58%
	COP 18	Central Support	APR 19	reported	N/A: No target required	64%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A

	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
kz iLembe District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	55%
	COP 18	Central Support	APR 19	reported	N/A: No target required	60%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
kz Umkhanyakude District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	66%
	COP 18	Central Support	APR 19	reported	N/A: No target required	77%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
kz Umzinyathi District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	70%
	COP 18	Central Support	APR 19	reported	N/A: No target required	76%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A

	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
Ip Sekhukhune District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	53%
	COP 18	Central Support	APR 19	reported	N/A: No target required	59%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
Ip Vhembe District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	50%
	COP 18	Central Support	APR 19	reported	N/A: No target required	53%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
Ip Waterberg District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	53%
	COP 18	Central Support	APR 19	reported	N/A: No target required	58%

	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
nc Frances Baard District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	55%
	COP 18	Central Support	APR 19	reported	N/A: No target required	60%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
nc John Taolo Gaetsewe District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	38%
	COP 18	Central Support	APR 19	reported	N/A: No target required	62%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
nc Namakwa District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	41%

	COP 18	Central Support	APR 19	reported	N/A: No target required	50%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
nc Pixley ka Seme District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	58%
	COP 18	Central Support	APR 19	reported	N/A: No target required	61%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
nc Zwelentlanga Fatman Mgcawu District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	35%
	COP 18	Central Support	APR 19	reported	N/A: No target required	44%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A

nw Dr Ruth Segomotsi Mompoti District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	58%
	COP 18	Central Support	APR 19	reported	N/A: No target required	62%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
wc Cape Winelands District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	52%
	COP 18	Central Support	APR 19	reported	N/A: No target required	61%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
wc Central Karoo District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	53%
	COP 18	Central Support	APR 19	reported	N/A: No target required	66%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A

	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
wc Eden District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	52%
	COP 18	Central Support	APR 19	reported	N/A: No target required	55%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
wc Overberg District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	55%
	COP 18	Central Support	APR 19	reported	N/A: No target required	57%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A
	COP 20	Central Support	APR 21	expected	N/A: No target required	N/A
	COP 21	Central Support	APR 22	expected	N/A: No target required	N/A
wc West Coast District Municipality	COP 17	Central Support	APR 18	reported	N/A: No target required	43%
	COP 18	Central Support	APR 19	reported	N/A: No target required	47%
	COP 19	Central Support	APR 20	expected	N/A: No target required	N/A

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

[1] Source for PLHIV estimates by age, sex, and district: Eaton, J & Johnson, L. Personal communication – District-level modeling of South Africa Prevalence by Age and Sex. (Datapack)

Source for number of PLHIV on ART by age, sex, and district: PEPFAR SA reported data (from TIER.Net) for reported data and PEPFAR SA targets (from datapack) for expected data.

APPENDIX B – Budget Profile and Resource Projections

Table B.1.1 COP21 Budget by Program Area

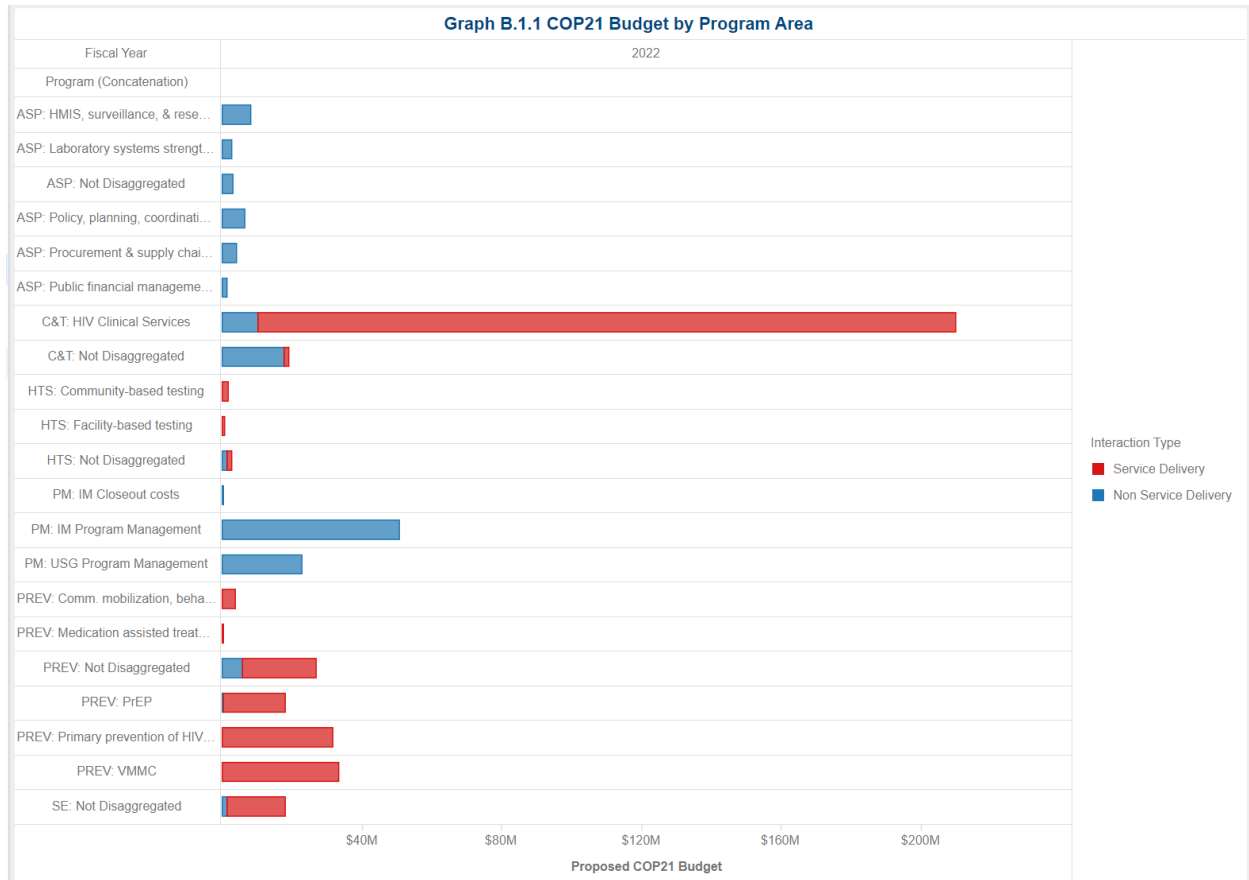


Table B.1.2 COP21 Budget by Program Area

Table B.1.2 COP21 Budget by Program Area

Program	Fiscal Year	2022					
	Metrics	Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$136,146,672	\$329,798,524	\$465,945,196	29.22%	70.78%	100%
C&T	Total	\$27,837,258	\$201,233,749	\$229,071,007	12.15%	87.85%	100%
	HIV Clinical Services	\$10,145,954	\$199,995,553	\$210,141,507	4.83%	95.17%	100%
	Not Disaggregated	\$17,691,304	\$1,238,196	\$18,929,500	93.48%	6.54%	100%
HTS	Total	\$1,260,000	\$3,882,299	\$5,142,299	24.50%	75.50%	100%
	Community-based testing		\$1,617,477	\$1,617,477		100%	100%
	Facility-based testing		\$662,815	\$662,815		100%	100%
	Not Disaggregated	\$1,260,000	\$1,602,007	\$2,862,007	44.03%	55.97%	100%
PREV	Total	\$5,994,136	\$108,080,056	\$114,074,192	5.25%	94.75%	100%
	Comm. mobilization, behavior & norms change		\$3,621,190	\$3,621,190		100%	100%
	Medication assisted treatment		\$431,964	\$431,964		100%	100%
	Not Disaggregated	\$5,709,661	\$21,112,242	\$26,821,903	21.29%	78.71%	100%
	PrEP	\$284,475	\$17,924,063	\$18,208,538	1.56%	98.44%	100%
	Primary prevention of HIV and sexual violence		\$31,671,732	\$31,671,732		100%	100%
	VMMC		\$33,318,865	\$33,318,865		100%	100%
SE	Total	\$1,289,785	\$16,602,420	\$17,892,205	7.21%	92.79%	100%
	Not Disaggregated	\$1,289,785	\$16,602,420	\$17,892,205	7.21%	92.79%	100%
ASP	Total	\$26,291,421		\$26,291,421	100%		100%
	HMS, surveillance, & research	\$8,161,924		\$8,161,924	100%		100%
	Laboratory systems strengthening	\$2,880,000		\$2,880,000	100%		100%
	Not Disaggregated	\$3,127,041		\$3,127,041	100%		100%
	Policy, planning, coordination & management of disease control programs	\$6,457,706		\$6,457,706	100%		100%
	Procurement & supply chain management	\$4,164,000		\$4,164,000	100%		100%
	Public financial management strengthening	\$1,500,750		\$1,500,750	100%		100%
PM	Total	\$73,474,072		\$73,474,072	100%		100%
	IM Closeout costs	\$110,000		\$110,000	100%		100%
	IM Program Management	\$50,638,788		\$50,638,788	100%		100%
	USG Program Management	\$22,725,284		\$22,725,284	100%		100%

Table B.1.3 COP21 Total Planning Level

Table B.1.3 COP21 Total Planning Level			
Fiscal Year	2022		2022
Metrics	Proposed COP21 Budget		
Operating Unit	Applied Pipeline	New	
Total			Total
Total	\$42,040,879	\$423,904,317	\$465,945,196
South Africa	\$42,040,879	\$423,904,317	\$465,945,196

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

Table B.1.4 COP21 Resource Allocation by Program and Beneficiary

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Fiscal Year Program	2022													
	C&T		HTS		PREV		SE		ASP		PM		Total	
Beneficiary	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total
Total	\$229,071,007	100%	\$5,142,299	100%	\$114,074,192	100%	\$17,892,295	100%	\$26,291,421	100%	\$7,347,407	100%	\$465,945,196	100%
Families					\$35,924,997	31%			\$24,100	4%	\$7,728,043	11%	\$448,071,40	10%
Key Pop	\$5,464,524	2%	\$1,821,936	35%	\$7,628,296	7%			\$815,000	2%	\$1,338,984	2%	\$168,967,00	4%
Males					\$33,318,985	29%							\$33,318,985	7%
Non-Targeted Pop	\$222,021,483	97%	\$1,260,000	25%	\$4,803,998	4%			\$23,994,312	91%	\$48,109,645	65%	\$299,999,436	64%
OVC					\$8,328,967	8%	\$17,892,295	100%	\$400,000	2%	\$5,202,920	7%	\$328,238,92	7%
Program & Seedling Women			\$1,130,392	22%					\$418,000	2%			\$1,548,392	0%
Priority Pop	\$1,555,000	1%	\$227,981	18%	\$23,271,511	20%					\$1,109,648	15%	\$368,509,72	8%

B.2 Resource Projections

All COP21 budget planning was completed using the Funding Allocation to Strategy Tool. The overall funding envelope reflects a return to pre-HIV Surge investment levels. Within the portfolio, significant shifts are planned to focus on sustaining momentum toward 90–90–90 and 95–95–95 HIV treatment coverage levels, while maintaining investments in DREAMS and related prevention activities to address continued new infections among adolescent girls and young women. Above site programming was further prioritized, and now accounts for only 4.5% of total PEPFAR SA programming.

Resource projections were made using estimated service package costs for service delivery activities and activity-based budgeting for above-site activities. Treatment budget cost estimates were formulated for two broad packages of programming - (1) continued scale up districts; and (2) retention-focused districts (i.e., those projected to reach or exceed 90–90–90 during FY21 - using a detailed HRH analysis among other inputs available from the Expenditure Reporting and Human Resource Information (HRID) data sets. DREAMS, PrEP, Key Population and OVC programming followed a similar approach carrying forward agreed interagency methodology from previous COPs.

APPENDIX D– Minimum Program Requirements

Table 9. COP 2021 (FY 2022) Minimum Program Requirements

Minimum Program Requirement	Status and issues hindering Implementation
Care and Treatment	
<p>1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.</p>	<p>Status: Test and Start was rolled out in 2016. National ART Guidelines stipulate that patients should initiate ART within 7 days of HIV positive test, including on the day of diagnosis when possible. During FY20, the PEPFAR SA program achieved 100% proxy linkage in Q3 and 90% linkage overall for the year, with linkage consistently ranging from 95-100% at Siyenza sites.</p> <p>Issues: In spite of improvements, overall proxy linkage for FY20 was 90%, which was lower than our target of 95%. Challenges still exist with ensuring those who aren't initially eligible for treatment are rapidly and continuously engaged and in ensuring those identified in the community are linked to treatment. The program must ensure 95% linkage for all clients across all age, sex, and risk groups.</p>
<p>2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥ 4 weeks of age and weigh ≥ 3 kg, and removal of all NVP- and EFV-based ART regimens.</p>	<p>Status: GoSA updated national guidelines to include TLD as a first-line option for all eligible clients in August 2019. Roll-out did not officially begin until Q1 of COP19 with limited uptake. The PEPFAR SA team worked closely with the NDoH to remove barriers, roll-out targets for TLD scale-up and increase the availability of provider and patient information to improve TLD uptake. TLD uptake this year increased with nearly half of first-line ART patients now receiving TLD. Children over 3kg and 4wks are eligible for DTG, but 5mg and 10mg dispersible tablets have not yet been approved and overall uptake among eligible children and adolescents for DTG 50mg tablets remains low. NVP remains an option for infants under 4wks and 3kg and EFV remains available for clients with contraindications to TLD.</p> <p>Issues: South Africa faced significant shortages of TLD for much of calendar year 2020. These stock shortages resulted in temporary holds on TLD transitions and limited the ability to provide 3-month dispensing with TLD in spite of an otherwise favorable policy environment. Ensuring stock stability and reinvigorating TLD transitions are occurring currently during COP20. In COP21, the goal is to make DTG available immediately, as well as improve availability of other pediatric friendly regimens.</p>

<p>3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.</p>	<p>Status: In South Africa, two/three months multi-month dispensing (MMD) is the standard NDoH policy as per the National Adherence Strategy (contingent on stock availability in the district). While the NDoH steering committee has approved a 6MMD prescription for stable patients, the GoSA has delayed implementation to April 2021 citing supply chain challenges caused by the SARS-CoV-2 pandemic. The COVID-19 pandemic has, however, seen the introduction of 12-month scripting to reduce facility congestion. South Africa Health Products Regulatory Authority (SAHPRA) now has registered multiple vendors of 90 count preparations. Decanting guidelines were updated in FY20 to include children aged ≥ 2 years for multi-month dispensing. A matrix of interventions supporting these updates was developed by the pediatric workstream, approved by NDoH on Sep 30, 2020, and is currently being rolled out.</p> <p>Issues: The provinces have been experiencing stock availability challenges to varying degrees. Factors affecting the introduction of 3, 6, or 12- month MMD include: 90 and 180 count pack sizes of TLD which are not on the SA government ARV contract; 180 count packs are not registered in South Africa; changes required in CCMDD tender with the GoSA; and implementation of 6-MMD, which would require accurate supply planning and an upfront investment in additional commodities for buffer stock. In COP21, the country must optimize 3 MMD immediately and swiftly move to 6 MMD as soon as possible.</p>
<p>4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.</p>	<p>Status: South Africa provides IPT for 12 months in adult ART patients (aged ≥ 15 years), and 6 months of IPT for children living with HIV (aged < 15 years and children < 5 years who were exposed to TB (regardless of HIV status) once TB disease has been excluded. SA is, however, expected to introduce 3HP, pending SAHPRA approval. The SOP on enrollment and management of patients on preventive treatment for latent TB Infection, treatment for DS-TB or RR/MDR-TB onto the CCMDD Program has been finalized. Stable patients on ART eligible for TPT are to be enrolled on CCMDD.</p> <p>Issues: Despite TPT availability in all PEPFAR SA-supported districts, initiation and completion is still below target. The overall TPT completion rate remains low at 61% for FY20 Q4. The program continues to work with NDoH to ensure consistent supply of INH and increase TPT coverage. In addition, PEPFAR SA will support the NDoH to roll out 3HP in 4 pilot districts this year upon SAHPRA approval, with broader expansion anticipated in COP21.</p>
<p>5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.</p>	<p>Status: The program saw an initial increase in VL coverage from 76% in FY19Q4 to 81% in FY20Q1. This was, however, followed by a reduction in viral load coverage to 75% by FY20Q4, as facility attendance and laboratory testing decreased in the setting of the SARS-CoV-2 pandemic. eLABS, a technology to improve VL coverage and use, was expanded from 413 facilities at the beginning of COP19 to 1412 facilities currently in COP20.</p> <p>Issues: COVID-19 lockdowns resulted in limited patient mobility to access health services. Despite increasing COVID-19 cases, NHLS remains with sufficient laboratory analyzer capacity for projected VL specimen volumes for FY21, although analyzers and personnel used for VL, EID and TB testing are now also being utilized for COVID-19 testing. Turnaround times may be slightly affected but are anticipated to remain within 4 weeks. Gaps remain in reaching the required VL coverage rates at facility level. Activities to improve coverage are being implemented in COP20 and should continue in COP21 (e.g., eLABS patient support system).</p>

Testing	
<p>1. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under 19 years with an HIV positive biological parent should be offered testing for HIV.</p>	<p>Status: The NDoH has prioritized and is supporting full implementation of index testing for sexual partners and children of PLHIV. The NDoH, with PEPFAR SA support, increased the age of children who are considered contacts for index testing cases from 15–19 years of age. A new NDoH-endorsed index testing tool is being rolled out to ensure further DoH ownership of index testing by all HAST counsellors at all facilities offering index testing. HIV self-screening (HIVSS) is also being scaled up and fully supported with a defined secondary distribution HIV SS cascade recorded by implementing partners to ensure linkage to treatment and recording of yields. Both modalities are now included in the revised National HTS register. The NDoH index testing guidance includes specific procedures to ensure consent, protect confidentiality and prevent harm related to intimate partner violence, informed by broad consultations. Minimum standards tools for Index Testing have been rolled out successfully across the 27 PEPFAR SA-supported districts to ensure continued monitoring of Index Testing Services with a dashboard developed to ensure monitoring of implementation of these tools</p> <p>Issues: Index testing contribution to HTS_TST_POS is at 10%. In COP20 & 21, continued scale up of index testing for all populations, including children (≤19 years) to greater than or equal to 30% TST_POS from index. Some provinces in SA are not supporting HIV SS as a secondary distribution modality (i.e.rKZN) for HIV SS kits (Oraquick). Civil Society has raised several issues relating to index testing through their ongoing Ritshidze platform. Issues such as unusually high acceptance rates, refusal of index testing services without compromise of clinic services, contacting sexual partners regardless of IPV evidence, documentation of IPV screening and referrals and adverse event monitoring have been raised as deserving continued monitoring and attention.</p>
Prevention and OVC	
<p>1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)</p>	<p>Status: Analysis of the PrEP program reveals significant achievement in FY20, with a 108% increase in all PrEP initiations between FY19 and FY20, and a 61% increase in AGYW PrEP initiations from FY19Q4 to FY20Q4. Immediate PEPFAR SA priorities in COP21 include: continuing support for NDoH PrEP scale- up by achieving ambitious PEPFAR SA interagency PrEP_NEW targets, to be implemented as part of a comprehensive package of prevention services. In DREAMS, the priorities will be: 1) continue strengthening of DREAMS layering with PrEP as part of the DREAMS secondary package in order to keep AGYW HIV negative, and 2) focus on PrEP adherence and retention support throughout an individual’s period of risk. Priorities for Key Populations are: 1) expand PrEP rollout in prisons, and 2) increase PrEP initiations through aggressive use of social media, very important people clubs, and e-pharmacy and (3) increase appropriate use of PrEP including event driven PrEP and continued use of PrEP as appropriate through enhanced psychosocial support including social workers at all KP drop in centers</p> <p>Issues: For successful PrEP scale-up, PEPFAR SA will prioritize strengthening demand creation, adherence, and continuation/retention in COP20 and COP21, and will utilize/implement special studies and operations research to better understand the changing risk profiles of AGYW.</p>

<p>2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0–17 years, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9–14 year old girls and boys in regard to primary prevention of sexual violence and HIV</p>	<p>Status: Through effective case management, household visits, and improved use of data and targeting, OVC implementing partners continue to identify the most vulnerable children (including AGYW, children and adolescents living with HIV) and provide 1:1 support that empowers OVC to stay in and progress in school; access health services and grants; reduce violence and abuse; prevent HIV infection; and be adherent and retained in HIV care services.</p> <p>Issues: Structured group-based interventions targeting 9-14-year-old girls and boys will be limited as a result of COVID-19 related restrictions, as well as limited access to children (in schools) in addition to the absence of suitable venues to ensure safe facilitation of the interventions. Challenges with the protection of personal information due to the data privacy law called the South Africa Protection of Personal Information Act 2013 (POPI) Act, which is akin to the data protection requirements found in the European Union Data Protection Directive limit the bi-directional referrals between Care and Treatment and OVC for strengthening viral load suppression and continuity of treatment for 0–17-year-old PLHIV.</p>
<p>Policy & Systems</p>	
<p>1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.</p>	<p>Status: South Africa prohibits, through legislation, informal and formal user fees for HIV, TB, antenatal care, and all primary level care in the public sector. PEPFAR SA continues to work at the national, provincial, and district levels to ensure that this policy is implemented in facilities and that all people have access to HIV services.</p> <p>Issues: No outstanding issues or barriers.</p>
<p>2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>Status: Siyenza in South Africa is being implemented at 422 facilities as of the end of FY20. Due to the SARS-CoV-2 epidemic, PEPFAR SA has temporarily pivoted to virtual weekly video conference meetings in place of in-person site-visits that include staff from PEPFAR SA, DSPs, and DoH. Focal areas for site-level improvement include streamlining RPCs enrollment, RPCsand community HTS and HIV self-screening. The NDoH has continued to support ‘Operation Phuthuma’ in 756 facilities in FY20 and conducts regular provincial meetings virtually, as well as routine Nerve Center meetings in all provinces. Lessons learned are regularly applied to smaller volume facilities in all districts through Operation Phuthuma’s quality improvement activities.</p> <p>Issues: In addition to challenges related to COVID-19, an upgrade to TIER.Net, South Africa’s electronic HIV/TB register, has prevented DSP clinicians and PEPFAR SA technical staff from having access to near-real-time data to identify challenges and address performance gaps quickly. TX_CURR and TX_NET_NEW are impossible to track accurately on a routine basis, and this</p>

	upgrade has affected tracking and tracing of ART clients, reduced TLD roll-out and decanting, and limited above-site monitoring and analyses.
3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	<p>Status: The country has implemented a national strategy to improve ART linkage and retention at all sites. In COP19, PEPFAR SA and NDoH launched the following national campaigns: The MINA campaign that promotes U=U among men; The DabLap campaign to promote differentiated models of care; The Zenzele campaign to promote treatment literacy; a U=U campaign targeting women is also planned in COP20, due for approval in March 2021. The NHLS is also developing U=U messages to be incorporated into viral load counseling practices as part of the eLab platform. These national campaigns amplify PEPFAR SA district support partners' additional support to reduce stigma and encourage treatment.</p> <p>Issues: All PEPFAR SA supported provinces should implement the U=U campaign now in COP20 to promote completion of treatment adherence, VL tests, and youth-friendly treatment literacy.</p>
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	<p>Status: The program continues to exceed the target of 70% of PEPFAR SA funding be awarded to local, indigenous partners. In COP20, PEPFAR SA was at 79%, which is an increase from 78% in COP19. PEPFAR SA adheres to COP guidance recommending that the majority of prime partners are local/indigenous (35 of 58)</p> <p>Issues: No outstanding barriers</p>
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	<p>Status: There is clear commitment by the GoSA to continuously increase budgetary support towards the HIV response. However, the South African economy has suffered due to the COVID-19 epidemic and the SA National Treasury is looking to cut spending by R300 billion (~20b USD) until 2023. Earlier GoSA budget allocations for HIV indicated a continued increase from \$1.7 billion in 2018/19, to \$2.1 billion in 2020/21, accounting for over 70% of the country's HIV expenditure, but it is expected that the GoSA will approve significant budget cuts—including for HIV—as part of their 2021 Mid-Term Expenditure Review due to be finalized in April 2021. The U.S. government committed to only a two-year surge of approximately \$500 million in COP18 and COP19 in addition to their COP base.</p>
	<p>Issues: The GoSA should continue to invest domestic resources to maximize HIV-related health outcomes at the national, provincial, and districts and ultimately to sustain the HIV response; however, it is unlikely that the GoSA will increase budget allocations in the mid-term (3–5 years) compared to prior years.</p>

<p>6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<p>Status: South Africa’s national morbidity and mortality reporting system is supported by a range of data sources and institutions, including the District Health Information System, Birth and Death Registries, census and cause-specific data reporting systems. Current GoSA investments include capacity development to improve the completeness and accuracy of existing data systems and to strengthen reconciliation and triangulation of data from various sources and at all levels</p> <p>Issues: PEPFAR SA should continue supporting expansion of effective national HIV patient-level data reporting systems including implementation of the Health Patient Registration System (HPRS) infrastructure support at the facility level and supporting activities to improve estimates of HIV cause- specific mortality, as well as facilitating access of key health data for program decision making and planning.</p>
<p>7. Scale-up of case surveillance and unique identifiers for patients across all sites.</p>	<p>Status: HPRS is deployed in 3,093 health facilities, which represents 82% of NDOH supported health facilities, which is an increase from 73% last year. As of March 2020, 44.8 million individuals have been registered. This represents 77.5% of the total population of South Africa, which is an increase from 73.3% last year.</p> <p>Issues: Use of HPRS remains inconsistent and challenging. Some of the outstanding issues relate to internet connectivity, gaps in informatics capacity, and system integration barriers that DSPs at facility or district level are unable to resolve.</p>

Site level MPRs related to linkage and retention: During FY 2021 (COP20 implementation), all OUs are expected to fully implement retention-related PEPFAR Minimum Program Requirements at every PEPFAR-supported site that has a known impact on continuity of ART. Site level implementation of these 4 elements must be assessed to inform COP21 planning. In addition, an effective tracking and tracing system must be in place at each site.

Site Level Continuity-Related Performance Standards

<p>Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.</p>	
<p>Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥ 4 weeks of age and weigh ≥ 3 kg, and removal of all NVP- and EFV-based ART regimens.</p>	
<p>Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.</p>	
<p>Adoption and implementation of RPCs that provide choices between facility-based and community-based ART refills and between individual and group ART refill models. All RPCs should consider a family-based approach and offer people the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits. with alignment with other family members' visit schedule, as feasible.</p>	

APPENDIX E- American Rescue Plan Act

Description of Needs and Gaps

South Africa carries the greatest burden of COVID-19 in all of Africa, with over **1,554,975** cases and **53,173** COVID-19 associated deaths (as of April 9th, 2021). Globally, South Africa ranks 20th in cases and 16th in total COVID-associated deaths. In addition, excess mortality since the start of the pandemic is estimated at over 150,000. Although South Africa has just emerged from its second wave, epidemiologists predict a third wave may begin when winter arrives in the southern hemisphere (May-June). This could further be exacerbated by the more infectious COVID-19 variant, the 501.Y.V2 (B.1.351 lineage) that was first identified in South Africa on December 18th, 2021. Unlike wealthier countries, South Africa cannot afford to repeat the hard lockdown imposed in 2020, which caused massive economic and social damage, significant declines in facility attendance, an increase in Gender Based Violence and a reduction in HIV and TB testing, prevention, and treatment.

The SARS COV-2 pandemic has had devastating impacts on the economy and public finances which amplifies socioeconomic barriers facing clients from accessing HIV and TB services.

Over 2.2 million people lost their jobs in just the first quarter of the pandemic in 2020. By May 2020, nearly 40% of households in the country were reporting difficulties meeting their financial obligations. The pandemic has led to economic decline and accelerated recent deterioration of public finances. The economy retracted by 7.8% in 2020, and the budget deficit was expected to grow to 15.7% of GDP. The National Treasury predicts that real output might only return to pre-pandemic levels in 2024. The National Treasury has signaled national spending cuts in its 2021/22 budget (to be released in April 2021) totaling US\$20 billion. Specifically, for health, the National Treasury has tentative plans to reduce provincial human resources for health budgets by 4% while trying to flatline HIV and TB conditional grants, despite increasing demands on the programs.

South Africa must act quickly to vaccinate 67% of its population (or roughly 39.24 million people) in order to stem the spread of its local virus variant throughout the region. Without urgent action, COVID-19 threatens the over \$6.9 billion invested by PEPFAR in South Africa over the past ten years.

Lockdown measures have cut the number of people attending facility headcounts by 25–30% nationally, sometimes higher in COVID-19 hotspots. The virus spread rapidly among DoH staff as well as PEPFAR SA implementing partner workforce during the initial outbreak, especially among data staff and nursing officers. In addition, the economic crisis has escalated labor disputes and health worker strikes, amplified shortages of DoH personnel, and affected the ability of the NDoH to allocate increasing budget allocations for HIV and TB. To date, just over 280,000 health care workers have been vaccinated as part of the first phase, with uncertainty regarding when the implementation of the next phases of vaccination roll-out that will include high-risk populations and later the general population of adults. Specific challenges with use of the vaccines initially procured by the GoSA (effectiveness of Astra-Zeneca against the South African variant and now safety concerns with J&J) have further delayed the roll-out.

Rapid vaccination in South Africa will help prevent the spread of the variant to other countries in the region.

There is significant cross-border migration for work and school in the Southern African region, which has the potential to facilitate the spread of the new coronavirus variant in South Africa. For example, about 40% of mine workers in South Africa originate from Mozambique, Lesotho, and

eSwatini. Many of these lower-income countries have high TB and HIV prevalence. The B.1.351 variant first identified in South Africa has already spread to 68 countries including countries in the region such as Botswana, Zambia, Mozambique, Malawi, Angola, eSwatini, and Namibia as well as Ghana, Kenya, and Comoros. Rapid control efforts are needed to limit further spread.

The Proposed Interventions

The PEPFAR SA program has a wide reach to vulnerable populations through its District Support Partners (DSPs), including many, hard-to-reach rural populations. Prior studies have found a significantly higher risk of COVID-19 infection and severity among those with comorbidities such as HIV, active and past TB, asthma, hypertension, obesity and diabetes. The PEPFAR SA program proposes a strategy for leveraging its extensive national platform to address the challenges specified below with interventions that protect health facility staff and beneficiaries and repair the injuries caused by COVID-19 to the program.

COVID-19-Related Challenge	Proposed Interventions
<p>SA is still recovering from the loss in over 100k patients TX_CURR between FY20Q2 to FY20Q3. While the program is on the road to recovery, FY21Q1 is TX_CURR is more than 30k patients short of FY20Q2 levels.</p> <p>NDoH workforce shortages. Economic challenges and impact on the health sector will exacerbate current HRH shortages, and further threaten the sustainability of PEPFAR SA and NDoH achievements to date.</p> <p>Increased need for HRH strategic management due to COVID-19 has resulted in a strain on the Human Resources Information System (HRIS), especially to support vaccine roll out efforts and to avoid affecting services provided by the HIV and TB program.</p> <p>Low facility head count. Patients' fear and anxiety related to acquiring COVID-19 while attending in-person clinic visits caused significantly lower headcounts at facilities. This generated the need for more out-of-facility services for prevention as well as treatment services.</p> <p>Increasing complexity of cases. Psycho-social factors associated with economic insecurities drove the need for more complex, client-centered case management approaches both in-facility and out-of-facility.</p>	<p>Active case management. PEPFAR SA will increase the number of staff able to support active case management of PLHIV on treatment and retention. PEPFAR SA will increase the role of peer-led case management and coaching interventions proven to return patients to care and retain patients during the lockdown period.</p> <p>Support for HRIS to manage HRH data in support of the COVID vaccine roll out. Strategic utilization of PEPFAR SA supported staff providing support to vaccine roll out efforts will allow for efficient HRH planning to ensure minimal disruptions to HIV and TB services.</p> <p>Increase services out-of-facility. PEPFAR SA will support alternative approaches for prevention, case finding, linkage, and community-based phlebotomy by recruiting more lay counselors, linkage officers, professional nurses, and data capturers to service these models. PEPFAR SA will also support virtual versions of interventions such as the promotion of DREAMS layering interventions through mobile platforms.</p> <p>Increase the rate of decanting. PEPFAR SA will recruit more professional nurses to offer differentiated models to more stable patients and offer multi-month dispensing modalities.</p> <p>CCMDD expansion to include enhancement of SynCH system and processes to cater</p>

<p>Vulnerable populations cannot physically access services. Vulnerable households, Key Populations, and AGYW face intensified socio-economic challenges to access PrEP, the full package of key populations, DREAMS, and OVC services.</p> <p>More staff and supplies are needed to ensure appropriate IPC are maintained. The DoH has limited staffing available to ensure that IPC practices are adhered to at all times.</p> <p>Exponential growth of CCMDD surpassing the March 2021 target in the first half of FY20 due to COVID-19. This growth has resulted in the systems and processes lagging in its ability to cater for all registered clients.</p> <p>Vaccine commodities strain the national supply chain. The need to procure, plan, and manage logistics to vaccinate over 40 million people has strained the national supply chain, thereby affecting the ability of the NDoH to maintain essential commodities for HIV and TB services.</p> <p>COVID-19 testing strained systems that provide laboratory results and resulted in long turnaround times for EID and VL testing. This has resulted in the delay in children accessing ART.</p>	<p>for 3- and 6-MMD. This will result in the decongestion of facilities, whilst retaining patients in care, and ensuring VL suppression is achieved and maintained.</p> <p>Support vaccine delivery. PEPFAR SA will support provincial and district vaccine delivery efforts which include the storage and management of vaccines, administration, and supporting the maintenance of vaccine databases through the recruitment of data capturers and enrolled nurses.</p> <p>Enhance PrEP retention services. PEPFAR SA will expand community-based PrEP services and increase demand among key populations and school-based programs to ensure they retain on PrEP.</p> <p>Improve HIV and TB Supply Security. PEPFAR SA will increase supply chain support to fill gaps left by increasing demand for vaccine logistics.</p> <p>Expansion of the COVID-19 eLab modules to VL and EID testing platforms will allow both COVID-19 testing and timely management of positive paediatric tests. Adding EID to the eLABS system will allow the results to be accessed as soon as the test is done, shortening the TAT for this crucial test for children and access to ART.</p>
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The proposed interventions amount to a total of \$22.5 million that can be obligated immediately once funds arrive in the country. The interventions align to national COVID-19 case management, disaster response, infection prevention and control, as well as vaccine strategies issued by the NDoH. The largest allocation USD16.25 million (72% of the total) will go to the care and treatment program through the DSPs.

In the care and treatment program, the largest portion of the investment, USD11.595 million, will go toward repairing program injury through a set of focused interventions. The DSPs will prioritize the use of the funds as follows based on the activities described above (planned weights for the funds in parenthesis):

- Active case management through the recruitment of more case managers and peer-led coaches.

- Support of alternative out-of-facility approaches for case-finding and linkage through the recruitment of lay counselors, linkage officers, and data capturers.
- Recruitment of professional nurses to support decanting of stable patients
- Administration of vaccine through data capturers and enrolled nurses using 15% of the funds

These activities align to the *PEPFAR Guidance - American Rescue Plan Act COVID-19 Appropriation for PEPFAR Programs* section 1.A – C, and sections 2.A and 2.C. PEPFAR SA proposes USD2.085 million for improving infection prevention and control services at site level (activity 1.A). No more than USD2.57 million will be expended on supporting provincial and district departments of health to deliver and administer vaccines.

The next largest allocation of USD4.25 million (19% of total) will go toward Prevention activities. Prevention activities will focus on the IPC at facilities for VMMC, client support for the retention on PrEP for key populations and AGYW and supporting virtual deployment of services for the layering of DREAMS services. These interventions align to sections 1.A – C related to IPC (with a USD750,000.00 allocation) and 2.C repairing program injury (with an allocation of USD3,50 million).

Lastly, \$2 million (9% of total) will go toward Above Site activities that support the adequacy of the HIV and TB supply chain and program management to support CCMDD and MMD, systems to monitor the human resources for health in a rapidly changing management environment, and updates to the laboratory systems. The interventions align to section 2A related to extraordinary logistics (with a \$1.0 million allocation); Section 2C related to repairing program injury (with a \$650,000.00 allocation); and Section 2C related to laboratory (with a \$350,000.00 allocation).