Global Fund COVID-19 Response Mechanism (C19RM)
Funding Request Form

Date Created: 6 April 2021
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Summary Information

Country (or multicountry)	SOUTH AFRICA		
Principal Recipient(s), grant name(s) and Implementation Period(s)	**Principal Recipients:** 1. National Department of Health (NDoH) 2. Networking HIV and AIDS Community of Southern Africa (NACOSA) 3. Beyond Zero (BZ) 4. AIDS Foundation of South Africa (AFSA) **Grant name**: C19RM 2021, South Africa **Implementation period**: 01 August 2021 – 31 December 2023		
Planned start and end dates of the C19RM activities by grant	01 August 2021 – 31 December 2023		
Currency	**US dollar (US$)**		
C19RM Base Allocation amount	**Submission type**	**Amount (US$/EUR)**	**Submission date**
	C19RM Fast-track Funding Request[1]	N/A	N/A
	C19RM Full Funding Request	US$80 514 995.00	30 June 2021
	Total:	**US$80 514 995.00**	**30 June 2021**
C19RM Above Base Allocation amount[2]	**Submission type**	**Amount (US$/EUR)**	**Submission date**
	C19RM Full Funding Request	US$80 514 994.00	30 June 2021
	Total:	**US$80 514 995.00**	**30 June 2021**

[1] PPE, diagnostics and therapeutics and costs relating to the effective deployment of such health products.
[2] This is only relevant for the full submission.

Section 2. C19RM Full Funding Request

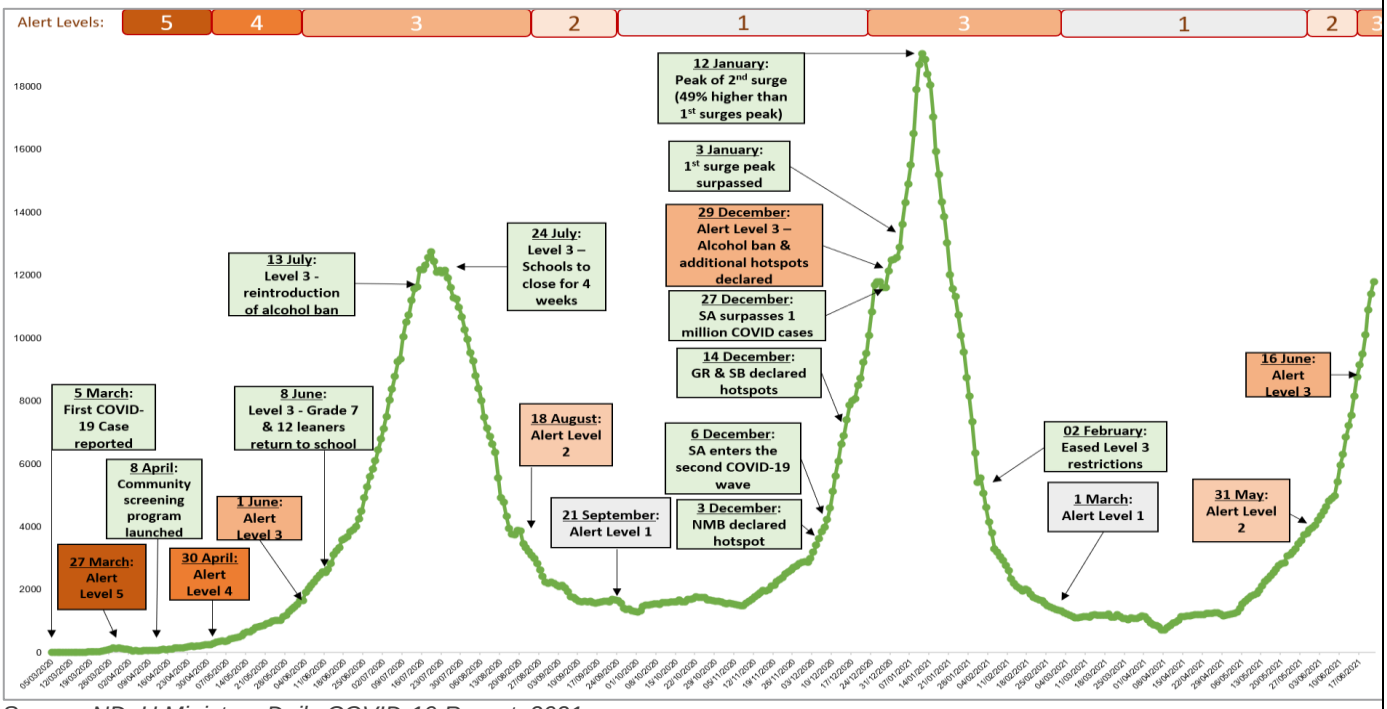
2.1 Context

2.1.1 Briefly describe the critical elements of the **country context** that informed the development of this funding request by summarizing the a) current COVID-19 epidemiological context and its evolution, b) impact of COVID-19 on the overall health system, and specifically on HIV, TB and malaria, c) role of civil society in the country's overall COVID-19 response; and d) challenges encountered in the COVID-19 response to date.

Coronavirus disease 2019 (COVID-19) is a public health emergency of international concern that has triggered a huge burden on the world. The novel coronavirus that causes COVID-19 i.e., SARS-CoV-2, was first discovered in the Wuhan province in China in December 2019. COVID-19 was declared a Global Pandemic on 11 March 2021 by the Director-General of the World Health Organization (WHO). To date, SARS-CoV-2 has infected over 144 million people and killed over three million people worldwide. South Africa (SA) reported its first COVID-19 case on 5th March 2020 and as reflected in ***Figure 1*** below by 25th June 2021, the cumulative number of COVID-19 cases reported was 1,895,905, with 89,2% (1,675,827) recoveries. Regrettably by 25th June 2021 the country had also recorded a cumulative total of 59,621 COVID-19 deaths - a national case fatality rate (CFR) of 3.1% (NDOH, 2021). To date, the highest number of COVID-19 deaths was recorded during the second surge of COVID-19 transmission, which occurred between November 2020 and February 2021. Analysis of morbidity and mortality data shows that older age is the single factor most strongly associated with the severity of COVID-19 disease and risk of hospitalisation and death. The risk of death (adjusted hazard ratios) for healthy people aged 60 years and older is at least ten times that of a healthy 40-year-old. Similarly, HIV and TB were associated with an increase in COVID-19 mortality risk (Boulle et. al., March 2021).

With a 7-day moving average (7dMA) of 5,959 cases, SA officially entered its third wave on 10th June 2021 - the new wave threshold is defined as 30% of the peak 7dMA of the previous wave (19,033 cases) after having exited a wave. As of 25th June 2021, SA had 145 904 active cases, with 18,762 new cases reported over the last 24 hours; and 30,8% increase in new cases, 21,9% increase in hospitalisations, and 26,4% increase in deaths compared to 7-days prior.

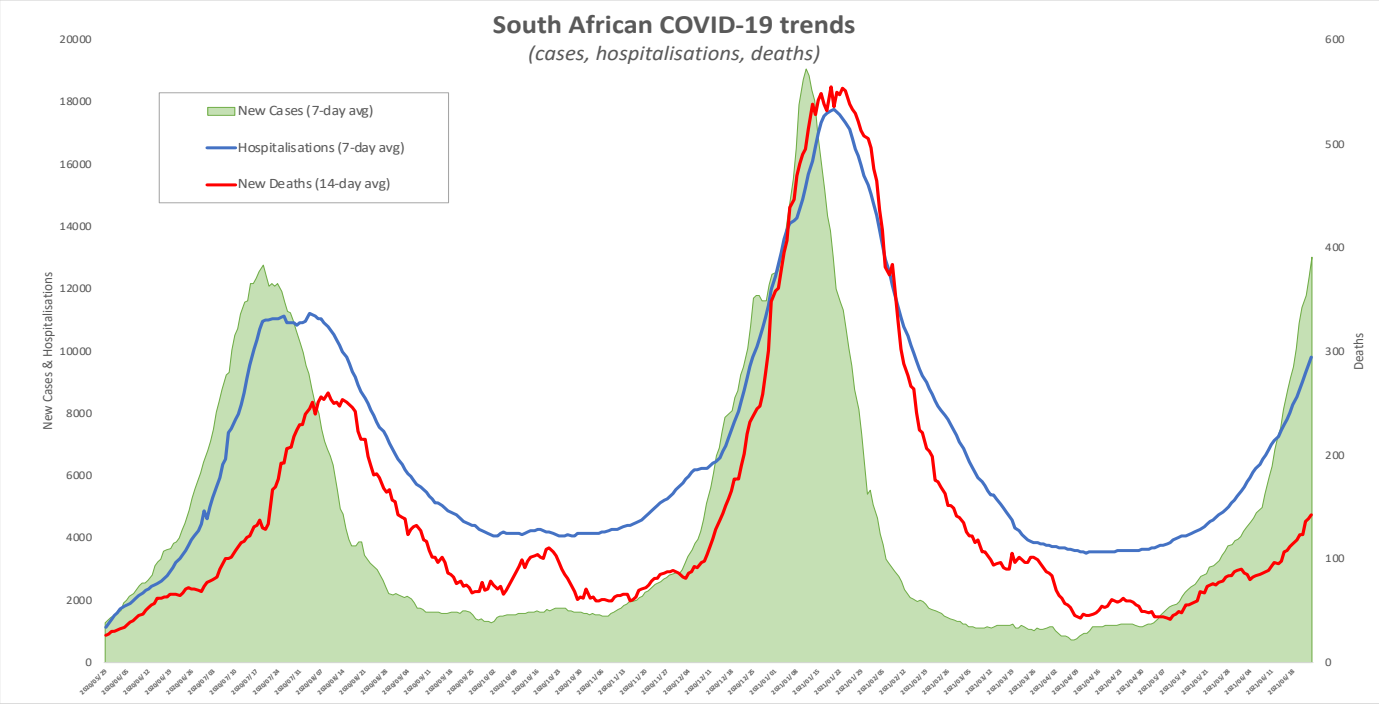
Figure 1: Stages of South Africa's COVID-19 Response as of 25th June 2021.



Source: NDoH Ministers Daily COVID-19 Report, 2021

As the COVID-19 pandemic evolved, it demanded reprioritization of financial and human resources to save lives. The government has since redirected resources towards COVID-19 containment and prevention interventions, to bolster the public health response. The National Department of Health (NDoH) guided by the *National Plan for COVID-19 Health Response* ***(Annex 1),*** has established operational management and coordination structures to plan, develop, coordinate, and implement practical COVID-19 public health response strategies, and this has generated useful evidence, learnings, and momentum to augment the national COVID-19 response including improved resurgence planning and monitoring; see *Plan of action to mitigate a COVID-19 resurgence in SA (****Annex 2)***. In addition, the NDoH has received financial and in-kind support from developmental partners' including WHO, Global Fund (GF), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), private sector (e.g., Solidarity Fund) and others, to boost SA's emergency response. During the pre-vaccine era, the use of non-pharmaceutical interventions (NPIs) contributed to a steady and greatly reduced COVID-19 transmission in SA. In the advent of new vaccines and guided by the *South African COVID-19 Vaccine Strategic Plan* ***(Annex 3),*** SA began its three-phased vaccine roll-out in February 2021 in accordance with the national prioritisation framework. By 25th June 2021, over 2,6 million health workers and people aged 60 years or more had been vaccinated. Effective 15th July 2021, vaccine registration will open for people aged between 50 and 59 years and all public servants. SA urgently needs systems support to accelerate vaccine delivery services, reach herd immunity, and avert further loss of lives.

Figure 2: National New Cases, Hospitalizations & Deaths as of 25th June 2021



Source: NDoH Ministers Daily COVID-19 Report, 2021

In the last decade, SA made commendable strides in the management of HIV and TB however, these gains are currently threatened by the COVID-19 pandemic. The country's risk-adjusted COVID-19 response strategy, including different levels of lockdown reduced access to routine health services. Consequently, ART initiation and treatment adherence, TB diagnosis, treatment initiation, and successful treatment completion were negatively impacted as shown in section 2.3 below. COVID-19 puts huge strain on the overall health system, specifically national hospital and laboratory infrastructure and capacity. Careful planning, aggressive resurgence monitoring, optimal risk communication and community engagement (RCCE) are essential to ensuring routine services are not considerably affected and the health system does not collapse during potential COVID-19 surges.

SA acknowledges the vital role of civil society in the national COVID-19 response as demonstrated by the civil society participation in the multisectoral Ministerial Advisory Committee (MAC), establishment of the Community Constituency COVID-19 Front (CCC^3F) to facilitate civil society sectors and networks participation, involvement of civil society in COVID-19 screening, contract tracing, testing, RCCE and other

related and important initiatives. To strengthen contact tracing, screening, and testing as well as address vaccine hesitancy and improve vaccine uptake, more needs to be done to intensify civil society involvement at local or community levels, mitigate the impact of COVID-19 on communities, specifically the high risk, vulnerable and marginalised populations with inadequate access to essential HIV and TB services attributable to structural, social, and economic factors.

The current COVID-19 driven economic crisis has aggravated labor disputes leading to health worker strikes and amplified DoH staff shortage. Furthermore, economic vulnerability has worsened social economic drivers to health outcomes and health seeking behaviour e.g., increased gender-based violence (GBV) and lack of money for transport to care. The government introduced COVID-19 specific social grants to assist the unemployed and minors. Similarly, COVID-19 has disrupted children's safety, nutrition, health, daily hygiene, and sanitation, as well as hampered their education. The government introduced the "*COVID-19 social relief of distress grant"* to assist those in dire need e.g., the unemployed and minors, and specifically, the Department of Basic Education (DBE) gave learners access to resources, educational content and lessons through radio, TV and the 2Enable online platform throughout the various COVID-19 lockdown levels. The National Treasury has made financial resources available to bolster SA's response to the COVID-19 pandemic and the success of interventions deployed so far has been realized through government resource provision and mobilisation from donors, however the need for additional resources remains as clearly explained in section 2.5.1 below. For example, with three large tertiary level hospitals i.e., Charlotte Maxeke, Helen Joseph, and Rahima Moosa in Gauteng (GP) being out of commission due to fire damage and water shortage, there is a severe shortage of intensive and high care public sector beds in GP wherein 11 777 (62,8%) of the new cases were recorded on 25th June 2021. With the developing third wave, extra resources are required to reinforce government's COVID-19 response including vaccine delivery services to roll-out of the *South African COVID-19 Vaccine Strategic Plan* ***(Annex 3)*****,** health systems recovery and transformation.

2.1.2 Summarize which stakeholders have been engaged in the development and decision-making for this Funding Request, including the national HIV, TB and malaria programs, central medical stores (or equivalent), laboratory systems, **civil society and key and vulnerable populations** (including both CCM members and non-CCM community representatives), and communities most severely affected by COVID-19.

To mount a comprehensive COVID-19 response, multisectoral COVID-19 management and coordination structures were established and these include the multisectoral MAC, the CCC^{3}F, all established to facilitate civil society sectors and networks participation in the COVID-19 response, using lessons learned from SA's recognised multisectoral HIV, TB and STI response. To inform the development of C19RM 2021 funding request, the CCM approved a two-pronged stakeholder engagement process including key informant interviews (KIIs) and facilitated discussions based on the WHO *Intra Action Review (IAR) Framework.* The approach was applied to facilitate the elicitation of lessons learned from implementation of C19RM 2020 and identification of priority interventions for C19RM 2021 application. The stakeholder engagement processes kicked off with first identifying relevant stakeholders, which culminated in an official CCM endorsed list of key stakeholders i.e., *Stakeholder Consultation Plan* ***(Annex 4)*** attached, with the consultation database.

A total of three weeks was allocated for the stakeholder consultation process and the SANAC CCM secretariat facilitated the process. National and provincial multisectoral stakeholders including government departments, civil society, private sector, development partners, existing PRs and SRs were consulted, and they provided invaluable inputs to this funding request. Over 300 stakeholders were consulted across the GF-supported districts/ provinces and inputs were also solicited from the Provincial Councils on AIDS (PCAs). The latter consultations included civil society sectors and local CBOs participation, representing the voices of the key and vulnerable populations (KVPs) and communities most affected by COVID-19. In addition, a Civil Society Forum (CSF) IAR was also convened to ensure all 18 SANAC civil society sectors were given the opportunity to provide inputs from their constituencies as they represent the voices of community members. Lastly, the NDoH Project Management Office (PMO) and Incident Management

Team (IMT), and subnational DoH COVID-19 management and coordination structures were also consulted to ensure their inputs are considered and inform this C19RM funding request.

2.1.3 Indicate how the **national COVID-19 response coordinating bodies** have been consulted in the development of this request and will be involved in implementation of the proposed C19RM activities.

In an endeavour to optimally manage, coordinate and monitor the national COVID-19 response, a *national governance and coordination structure* was established as depicted in ***Annex 5*** attached. At national level, National COVID-19 Command Council (NCCC) is the ultimate governance and stewardship structure for SA's whole-of-government COVID-19 response. Within the NDoH, the PMO, chaired by the Director-General (DG) and reporting to the Minister of Heath, is the highest decision-making structure followed by the national IMT, the technical structure for the public health emergency response.

KIIs and focused discussions were held with the PMO and IMT Chairs as well as IMT Workstreams' Leads to determine key priorities for this C19RM proposal. At provincial and district level, representatives from the relevant multisectoral COVID-19 response governance and coordination structures participated in IARs and provided inputs accordingly. Upon confirmation of award, the PMO and IMT will work closely with the South African National AIDS Council (SANAC) Technical Support Unit (TSU) team responsible for C19RM coordination to develop comprehensive implementation plans and an overall performance monitoring framework to facilitate regular C19RM reporting by PRs, SRs and any new C19RM 2021 implementers or service providers, as well as hold them accountable.

2.2 Implementation of C19RM 2020 award

2.2.1 Indicate how much of the previously awarded C19RM funding has been spent and committed and explain how it helped achieve set objectives.

Following the approval of the C19RM 2020, SA received a total amount of US $52,162,866 and the grant was implemented through the current GF PRs. At the point of this C19RM 2021 funding request submission to GF, the total C19RM 2020 spent was US $ 40,457,249.00 with commitments, equivalent to 78% of the total SA C19RM 2020 allocation. SA CCM is seeking GF permission to use C19RM 2020 unspent funds to implement outstanding activities until December 2021. All unspent C19RM 2020 funds (including financial obligations) are included in the C19RM 2021 budget, highlighting the source of funding to be C19RM 2020 as per budgeting guidance provided. Table 1 below, illustrates C19RM 2020 expenditure including commitments as of 30 June 2021.

Table 1: C19RM 2020 expenditure as of 30 June 2021

C19RM budget allocation	AFSA	NACOSA	Beyond Zero	NDoH	All PR's
Budget allocation	$ 5,878,422.96	$ 4,040,743.78	$ 4,090,335.06	$ 38,153,364.20	$ 52,162,866
Expenditure by end June Including commitments	$ 3,620,960.96	$ 2,166,456.78	$ 2,794,858.06	$ 31,874,973.20	$ 40,457,249
Balance	$ 2,257,462	$ 1,874,302	$ 1,295,477	$ 6,278,391	$ 11,705,631
% Spend	**62%**	**54%**	**68%**	**84%**	**78%**

The COVID-19 pandemic was an unanticipated occurrence that threatened to derail HIV and TB programs, overwhelm community and health systems, and cause significant morbidity and mortality. To support countries to respond to COVID-19, the C19RM 2020 grant had three main objectives namely, *1) Mitigating COVID-19 impact on HIV, TB, and malaria programs, 2) Reinforcing the national COVID-19 response, and 3) Urgent improvements in health and community systems.* The C19RM 2020 funding enabled current PRs

and SRs to regain the momentum to implement their GF funded programs amidst COVID-19 thereby reducing the negative impact of COVID-19 on routine HIV and TB GF programming.

At community level, SRs adapted and crafted innovative approaches to sustain HIV and TB programs implementation, including the integration of COVID-19 screening and testing into the implementation of regular GF-supported HIV and TB interventions. At each interaction with a client, COVID-19 screening was performed prior to service provision thereby directly contributing to the national COVID-19 screening and testing efforts. Through the C19RM 2020 funding, GF and selected non-GF geographic areas benefitted from the provision of screening, testing and contact tracing services by the additional GF supported staff employed by SRs and PRs.

The C19RM 2020 grant contributed to the reinforcement of the national COVID-19 response, by procuring additional COVID-19 tests and consumables; protecting frontline and essential health workers through the provision of PPE and IPC training; additional human resources for health, as well as supply chain improvements. Additional support from the C19RM 2020 grant included support for data management, diagnostic, surveillance, and other relevant public health emergency response systems and capacities to effectively monitor, plan, detect and rapidly respond to subsequent COVID-19 resurgence. The C19RM 2020 investments contributed to SA's COVID-19 emergency preparedness and rapid responsiveness, ensuring that health and community systems are resilient, receptive, and enduring to at best sustain the gains made towards HIV and TB epidemic control.

Mostly importantly, the C19RM 2020 grant enabled current SRs and PRs to reach their Year 2 (April 2020 to March 2021) GF program targets and facilitated a seamless transition into Year 3 (April 2021 to March 2022) program implementation. ***Figure 3*** below shows quarter (Q)3 to Q8 consolidated GF PR performance, with the COVID-19 induced depression observed in Q5.

Figure 3: Consolidated GF Programs Performance across PRs, Q3 to Q8

Source: SANAC CCM Q8 Oversight Report, 2021

2.2.2 Summarize any issues regarding implementation arrangements, innovations, or bottlenecks in service delivery. Please also explain how the C19RM Full Funding Request will address any lessons learned from the implementation of the C19RM 2020 award.

C19RM 2020 Bottlenecks

- National COVID-19 lockdown restricted access to GF-supported and other essential services for key and vulnerable populations e.g.
    - School closures disrupted provision of in-school AGYW services e.g., comprehensive sexuality education (CSE)
    - COVID-19 regulations on gatherings restricted AGYW, MSM and TG community-based outreach activities e.g., career jamborees, dialogues, pride events, etc.
    - Accommodating homeless PWID in shelters and camps during lockdowns restricted access to harm reduction interventions.
- COVID-19 related fear and anxiety, and loss of colleagues, friends and family members to COVID-19 gave rise to absenteeism and mental health issues amongst heath care workers and program staff.
- COVID-19 stigma and misinformation slowed uptake of core GF services (i.e., HIV, TB, STIs and GBV) and in some instances compromised safety and security of community-based outreach teams.
- Limited pre-award consultations with PRs resulted in delayed grant disbursement which in turn hindered post-award contracting and disbursement to SRs and other implementers.
- Delays in the procurement and provision of IPC products because of centralised procurement at PR level hampered GF programming.
- Suboptimal contracting of community-based organisations (CBOs) and civil society sectors (CSS) to strengthen C19RM program implementation at local or community level hindered optimal participation in C19RM activities.
- The flow of C19RM 2020 funds from NDoH to NHLS was a challenge because NDoH does not have any Memorandum of Understanding (MOU) or Service Level Agreement (SLA) with the NHLS [i.e., the latter has SLAs with Provincial Departments of Health (PDoH)] and thus tests kits had to be procured through the NDoH TB SRs, which led to delays and inefficiencies.

C19RM 2020 Lessons learned and Innovations.

- Integration of COVID-19 screening into routine HIV and TB, including GF-programming lessens disruption of essential service delivery due to COVID-19.
- Sustained provision of PPE and IPC products reduces service disruptions due to health care worker infections.
- Provision of GF-supported services through existing community platforms e.g., safe spaces, drop-in centres, CBOs, helps maintain access and availability of services for KVPs i.e., AGYW, MSM, SW, TG and PWID during COVID-19.
- To maintain implementation of the in-school program career jamborees, classroom-based career jamborees can be conducted in full observation of the NPIs.
- Community-based (mobile/ outreach) HIV prevention, treatment, care, and support service delivery renders services accessible despite COVID-19 e.g., community-based HTS with linkage to ART facilitates same-day ART initiation for the newly diagnosed patients.
- Implementation of DoH differentiated ART models e.g., multi-month dispensing (MMD), home-based ART dispensing, CCMDD, for stable patients is instrumental in improving adherence and retaining patients on ART i.e., improving total remaining on ART (TROA) after inception of the national lockdown.
- Virtual programming e.g., on-line training, psychosocial and treatment adherence support and dialogues enables continued service provision for the DoH and implementing partners including GF, PEPFAR and other partners.
- Training of community-based workers from CBOs to conduct COVID-19 prevention information dissemination, screening and contact tracing strengthens community response systems.
- Hiring additional facility, district, and provincial level data management personnel to augment DATCOV implementation capacity facilitates real-time availability of COVID-19 data for planning and decision making.
- Implementation of Provincial Department of Health (PDoH) Catch-up Plans to mitigate the impact of COVID-19 on HIV programming requires teamwork, and continuous consultation amongst provinces, districts, and their donor-funded non-government organisations (NGOs) implementing partners, with regular oversight and technical guidance from NDoH Provincial Leads.

C19RM 2020 Recommendations

- Use lessons learned and innovations from C19RM 2020 implementation to inform/ shape successful implementation of C19RM 2021 priorities.
- Facilitate engagement of PRs in the C19RM proposal development and post-award orientation process to accelerate full understanding of the C19RM implementation arrangements thus facilitate rapid contracting and disbursement to implementers.
- Strengthen SANAC CCM coordinating structures for robust C19RM implementation oversight and performance monitoring and to improve PR and implementers' accountability.
- Strengthen health products procurement (HPP) capacity of civil society PRs to manage the increased demand for health products and other regulatory issues i.e., each PR should have a full time Procurement and Supply Management (PSM) specialist to support HPP and related grant activities.
- Decentralize procurement of IPC products/ services and other health commodities to SRs, to improve turnaround times, and in accordance with GF procurement guidelines to ensure quality and value for money
- Facilitate contracting of CBOs to strengthen risk communication, community engagement, contract tracing, screening, testing, vaccine hesitancy and improve vaccine uptake.
- Strengthen C19RM implementation by contracting non-GF funded SRs or service providers, preferably prequalified suppliers (rapid turnaround times), to address any COVID-19 response gaps identified at all levels.
- Use the current implementation arrangements to rapidly extend C19RM support to non-GF supported districts/ subdistricts, particularly those declared as high transmission COVID-19 hotspots or experiencing a surge in COVID-19 infections.
- NDoH must find a way to establish a formal contractual relationship with NHLS, to facilitate the flow of funds e.g., contract NHLS as an implementing unit or SR, to allow for efficient and timely flow of funds.

To this end, SA CCM will promote evidence-based application of innovations, lessons learned, and recommendations acquired from the CR19M 2020 implementation to inform and enhance the implementation of activities proposed in this C19RM 2021 funding request.

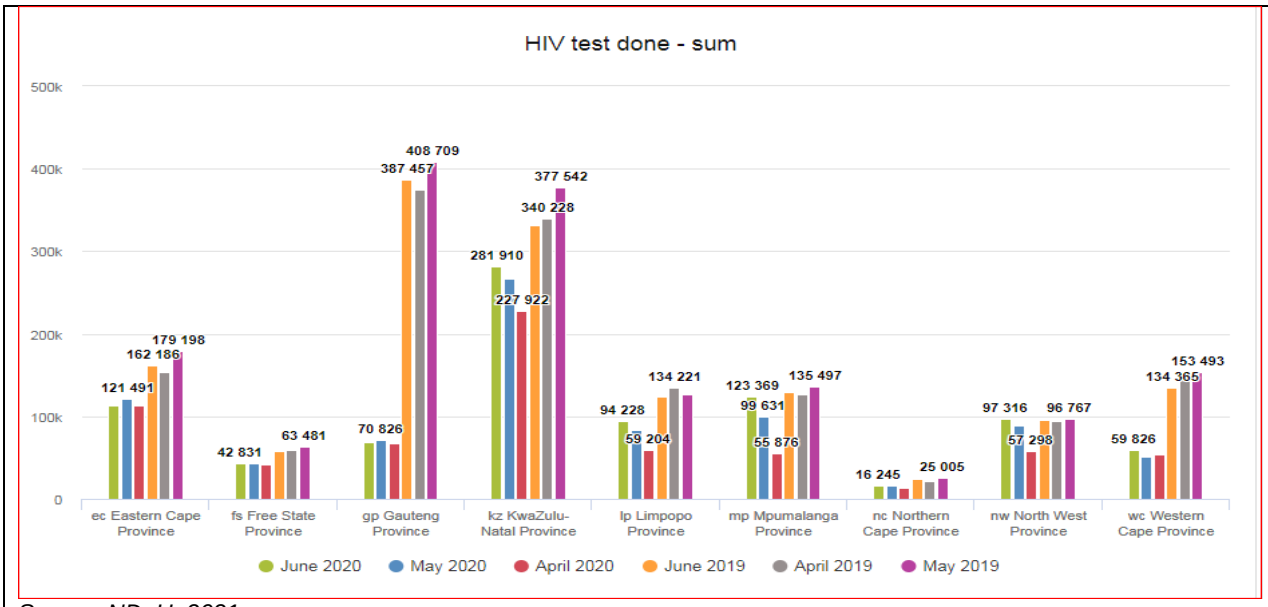
2.3 Funding Request and prioritization

2.3.1 Provide information on disruption of **HIV services** (**particularly for key and vulnerable populations)** and describe how identified gaps, challenges and needs are being/will be addressed by the C19RM Full Funding Request and/or through other funding sources (including Global Fund grant funds). *(Where relevant).*

In response to the COVID-19 pandemic, SA implemented harshly restrictive lockdowns to reduce transmission of SARS-CoV-2 infection and limit the number of patients requiring hospitalisation. The different levels of lockdown, the health services constraints, staff shortage due to high levels of health care worker COVID-19 infections as well as deployment of staff from other essential services to COVID-19, fear, and stigma, caused a significant decline in access to routine health services. Specific to GF-programming, school closures disrupted provision of the in-school AGYW services, slowing progress of program implementers to reach AGYW in GF-supported subdistricts. Similarly, housing homeless PWID in shelters and camps during lockdowns restricted access to harm reduction interventions. COVID-19 regulations on gatherings restricted AGYW, MSM and TG program activities including trainings and community-based activities e.g., career jamborees, dialogues, pride events, advocacy, and social mobilizations, etc. Refer ***figure 3*** in section 2.2.1 above for the consolidated GF PR Q3 to Q8 performance.

Between March 2020 and December 2020, access to public health services was limited in varying degrees across provinces and HIV testing and ART initiation were most severely affected as reflected below in ***figure 4*** and ***figure 5,*** respectively.

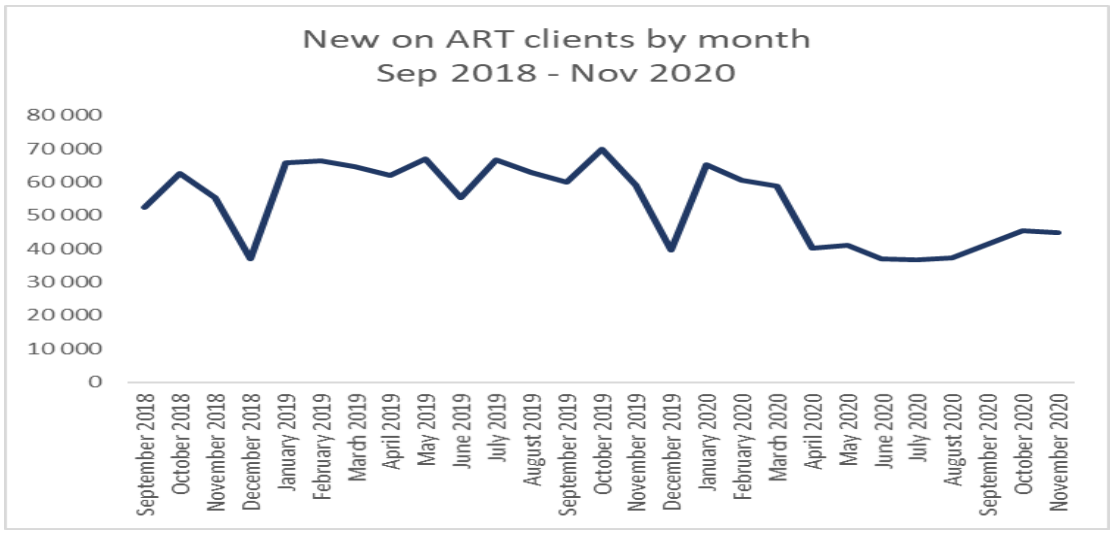
Figure 4: HIV testing by province – April to June 2019 vs April to June 2020



Source: NDoH, 2021

Figure 5 below clearly illustrates the impact of the COVID-19 lockdowns on ART initiation from March 2020 to November 2020

Figure 5: National ART initiation for the period September 2018 to November 2020



Source: NDoH, 2021

In addition to HIV testing and ART initiation, the impact of COVID-19 is visible across all program HIV areas for the period April to June 2020, as reflected in ***table 2*** below.

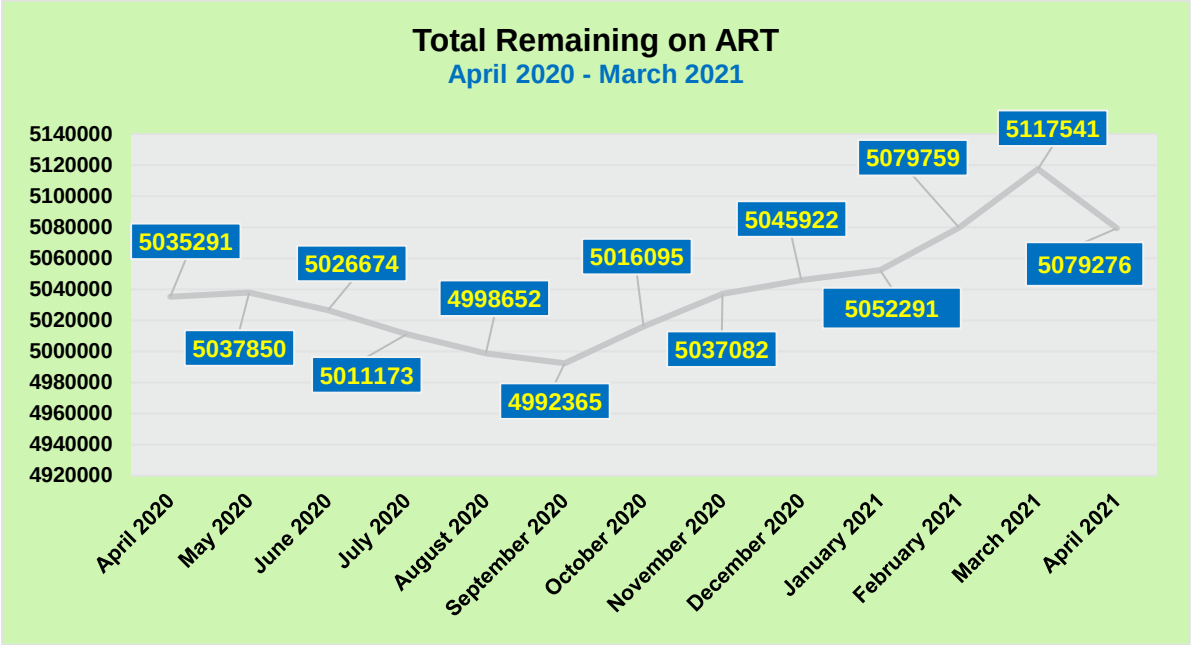
Table 2: Impact of COVID-19 on the National HIV Program – *April to June 2019 vs April to June 2020*

National Indicators	April - June 2019	April - June 2020	Deviation	Growth	Variation
Total HIV tests done	4 467 057	2 428 564	- 2 038 493	Negative	- 46%
Total clients started on ART	184 274	119 305	- 64969	Negative	- 35%
Total Remaining on ART	4 750 086	4 999 390	249 304	Positive	5%
Medical Male Circumcisions performed	219 440	1 899	- 217 541	Negative	- 99%
Male condoms distributed	142 164 157	86 228 821	- 55 935 336	Negative	- 39%
HIV positive new eligible client initiated on TPT	126 962	77 484	- 49 478	Negative	- 39%

Source: NDoH, 2021

Similarly, total remaining on ART (TROA) for the period April 2020 to March 2021 depicted in ***figure 6*** below clearly reveals the decline in TROA from May to September 2020 due to the COVID-19 restrictions. The TROA recovery is visible from October 2020 and peaked in March 2021, and this can be attributed to the risk-adjusted COVID-19 strategy employed in SA, as well as the HIV services adaptation and mitigation strategies implemented to restore and accelerate HIIV service provision. In April 2021, there was a drop in TROA which can be ascribed to SA's mounting third wave at that juncture.

Figure 6: TROA for the period April 2020 to March 2021

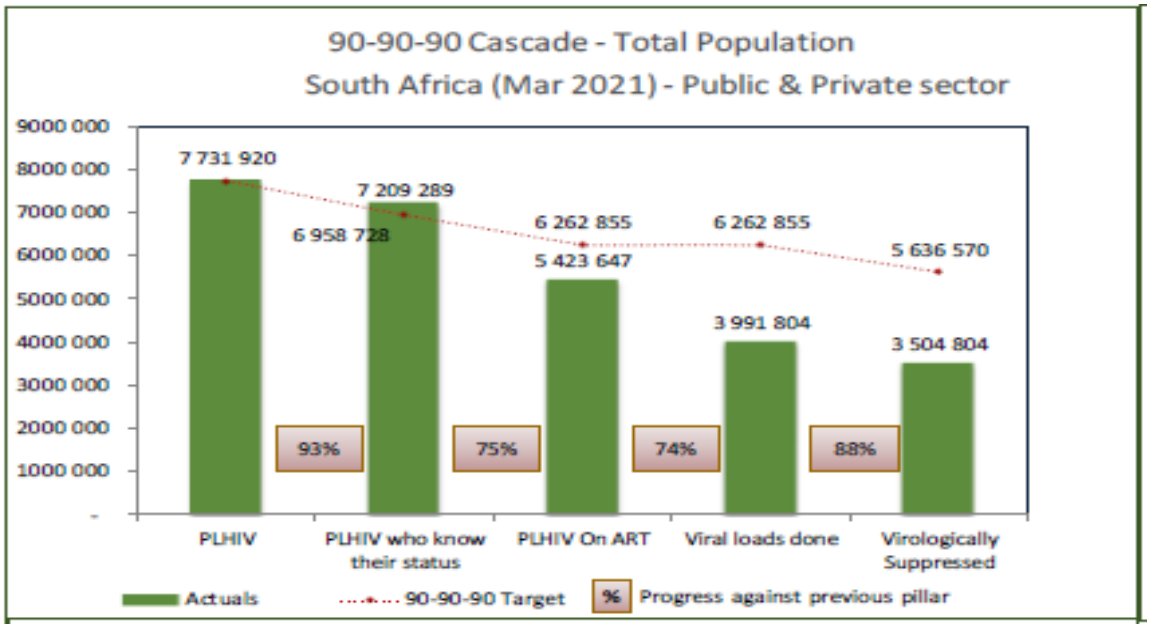


Source: NDoH, 2021

Subsequently, the COVID-19 pandemic retarded the country's progress towards attainment of the 90-90-90 targets by 2020. As illustrated in ***figure 7*** below, SA reported 93-75-88 against the 90-90-90 targets as of March 2021.

To mitigate the impact of COVID-19 on HIV programming, PDoHs developed Catch-up Plans which were amalgamated at NDoH level, accompanied by a Monitoring Plan. The progress of implementing these provincial plans was supervised through monthly virtual meetings coordinated by the NDoH Provincial Leads. Teamwork and continuous consultation with provinces, districts, and their donor-funded NGOs implementing partners was imperative i.e., national, and provincial program managers had to agree on the priority catch-up activities, as well as reporting requirements. Due to funding constraints, existing DoH staff were spread thin and thus had to execute these plans without the luxury of supplemental staff.

Figure 7: SA progress towards achieving the 90-90-90 targets.



Source: NDoH, 2021

With this C19RM full funding request, the DoH and other PRs will implement key activities proposed below, to ensure routine essential HIV services are not considerably affected during future COVID-19 surges. Careful planning by the service providers, aggressive resurgence planning and monitoring, and best possible communication with patients and communities will be implemented to mitigate the impact of COVID-19 on essential HIV services. Moreover, evidence-based best practices, lessons learned and recommendations from the implementation of C19RM 2020 will be systematically applied to mitigate the impact of COVID-19 on essential HIV services through community-based targeted approaches e.g., integrating COVID-19 screening with HIV testing services (HTS), intensifying HIV self-testing services (HIVSS), initiating PrEP in mobile / outreach HIV services, particularly at HTS sites and tertiary institutions, same-day ART initiation, scale-up of differentiated ART service delivery, expansion of CCMDD, delivery of ARVs using existing modalities like community outreaches, virtual patient follow-up, adherence, psycho-social care and support for HIV, home-based treatment, care and support for HIV patients, etc.

GF PRs and SRs will continue to provide GF-supported AGYW, SW, MSM, TG and PWID services through existing community platforms e.g., safe spaces, drop-in centres, CBOs, to enhance accessibility and availability of these essential services to key and vulnerable populations during COVID-19. Innovations and lessons learned from the C19RM implementation e.g., classroom-based jamborees, integrated HIV, TB, and COVID-19 service delivery, virtual trainings, dialogues, advocacy, and social mobilisation activities, etc. Lastly, there is need to develop and implement innovative strategies to monitor and evaluate HIV programming and ensure the national HIV response gains are not reversed by the COVID-19 constraints, thus supporting SA to remain on track towards HIV epidemic control.

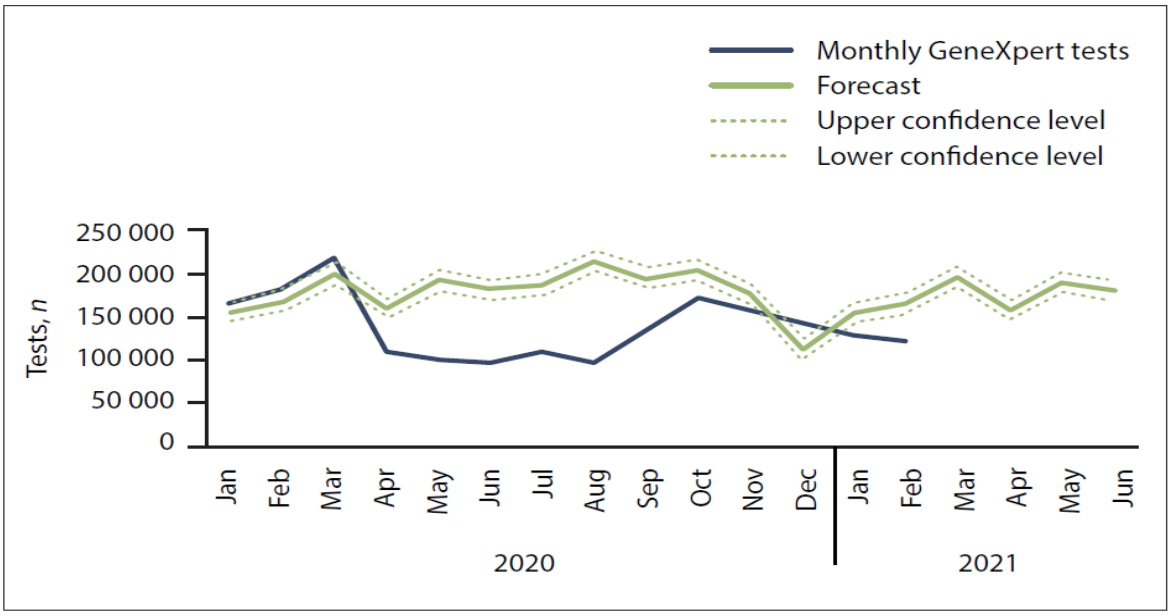
2.3.2 Provide information on disruption of **TB services** (**particularly for key and vulnerable populations**) and describe how identified gaps, challenges and needs, including decline in TB/DR-TB notification, are being/will be addressed by the C19RM Full Funding Request and/or through other funding sources (including Global Fund grant funds). *(Where relevant).*

Likewise, the implementation of SA's risk-adjusted COVID-19 strategy let to the disruption of routine TB services. The concomitant diversion of health resources to the COVID-19 response also meant that human resources were deployed for COVID-19 contact tracing, screening, testing as well as treatment of hospitalized COVID-19 cases. Additionally, the diagnostic and laboratory capacity needed for TB diagnosis

was severely curtailed because TB molecular diagnostic tools were repurposed for COVID-19 and laboratory TB staff redirected to COVID-19 efforts.

Between March and December 2020 access to public health services was restricted in varying degrees across all nine provinces, and access to TB testing and notification were severely affected with a 50% average weekly decrease in GeneXpert testing among presumed TB cases. See ***figure 8*** below, which shows the TB GeneXpert testing trends for the period January 2020 to February 2021 versus the expected number of tests.

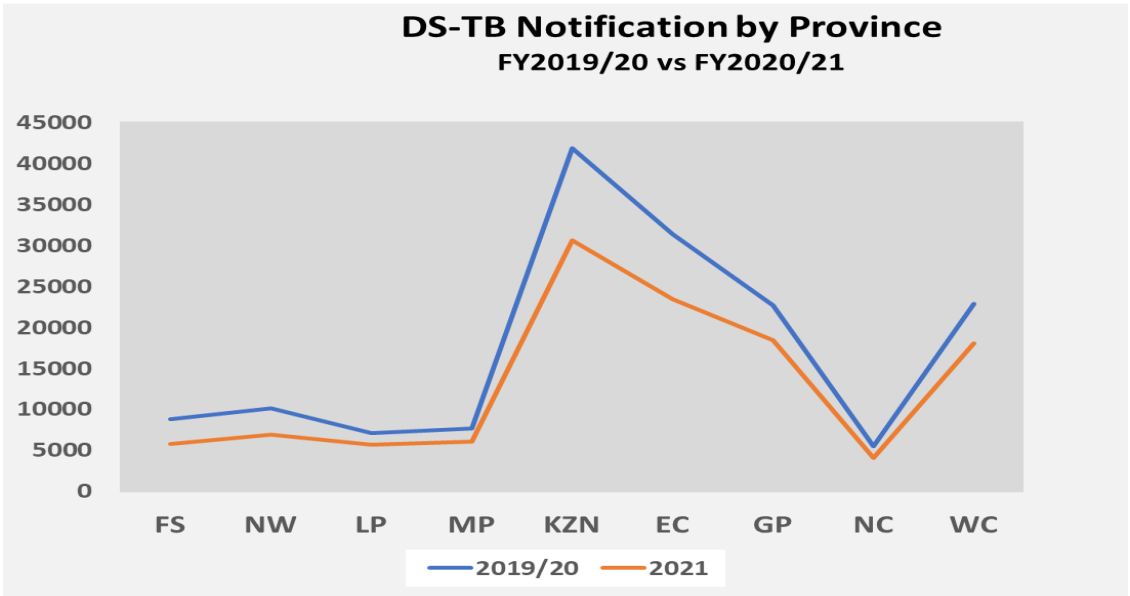
Figure 8: Number of GeneXpert tests done for TB between January 2020 and February 2021 compared with the expected number.



Source: Moultrie et. al. NHLS, 2021

Drug-sensitive TB (DS-TB) notification declined across all nine provinces in financial year (FY)2020/21, compared to FY2019/20, confirming the negative impact of COVID-19 on TB notification. See ***figure 9*** below for more detail.

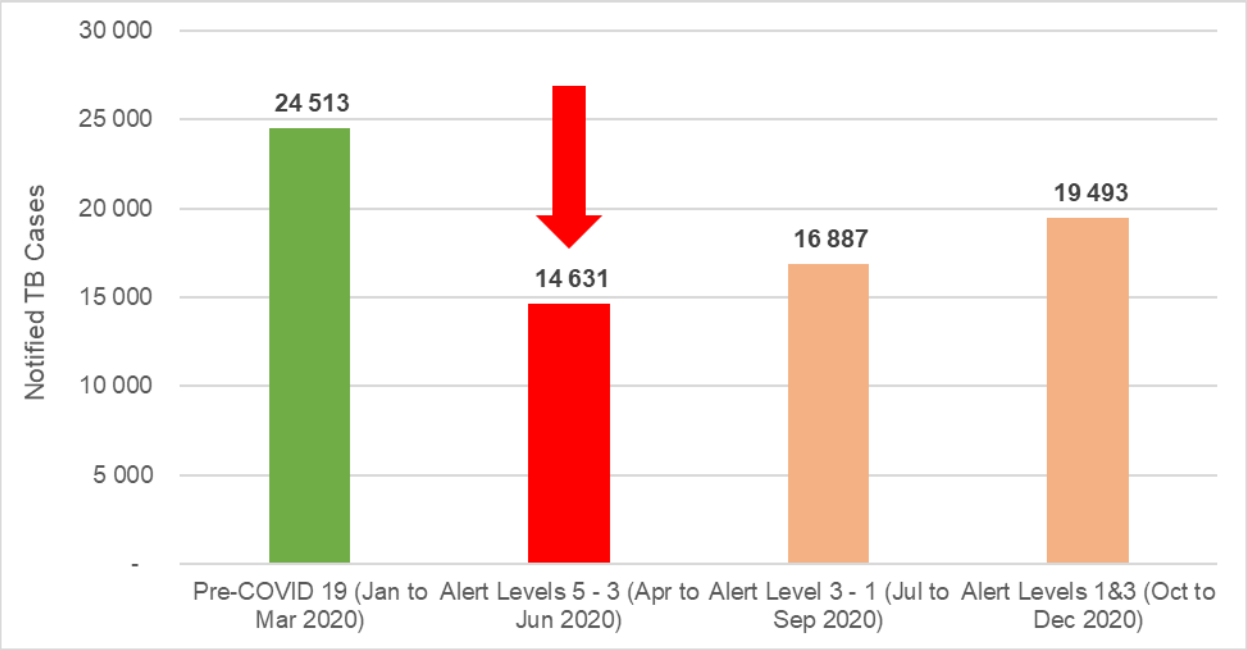
Figure 9: DS-TB notification by province: FY2019/20 versus FY2020/21



Source: NDoH, 2021

Preceding the COVID-19 outbreak and lockdown restrictions, the number of notified TB cases in the **nine GF supported districts** was 24 513 for the period Jan to March 2020. This number dropped by 40% to 14 632 during the period April to June 2020, after the introduction of stringent lockdown regulations, see ***figure 10*** below.

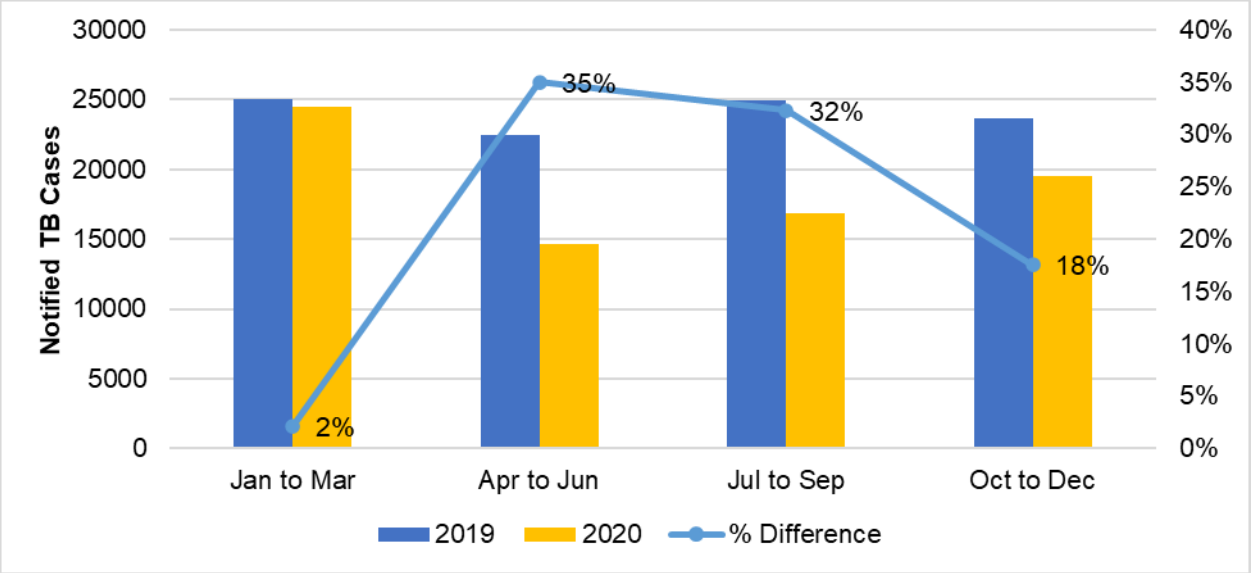
Figure 10: Notified TB cohort data for the period January to December 2020



Source: NDoH, 2021

For the period July to September 2020, TB notification started rising from 14 631 to 16 887 and subsequently to 19 493 for the period October to December 2020. The improvement observed from June 2020, can be attributed to the implementation of the TB Recovery Plan activities, quality improvement plans (QIPs) and contact tracing by enrolled nursing assistants and community health workers. As presented in ***figure 11*** below, quarterly notified TB cases for 2020 revealed decreases of 2%, 35%, 32% and 18% compared to the same intervals in 2019, and these reductions are because of the COVID-19 lockdown restrictions.

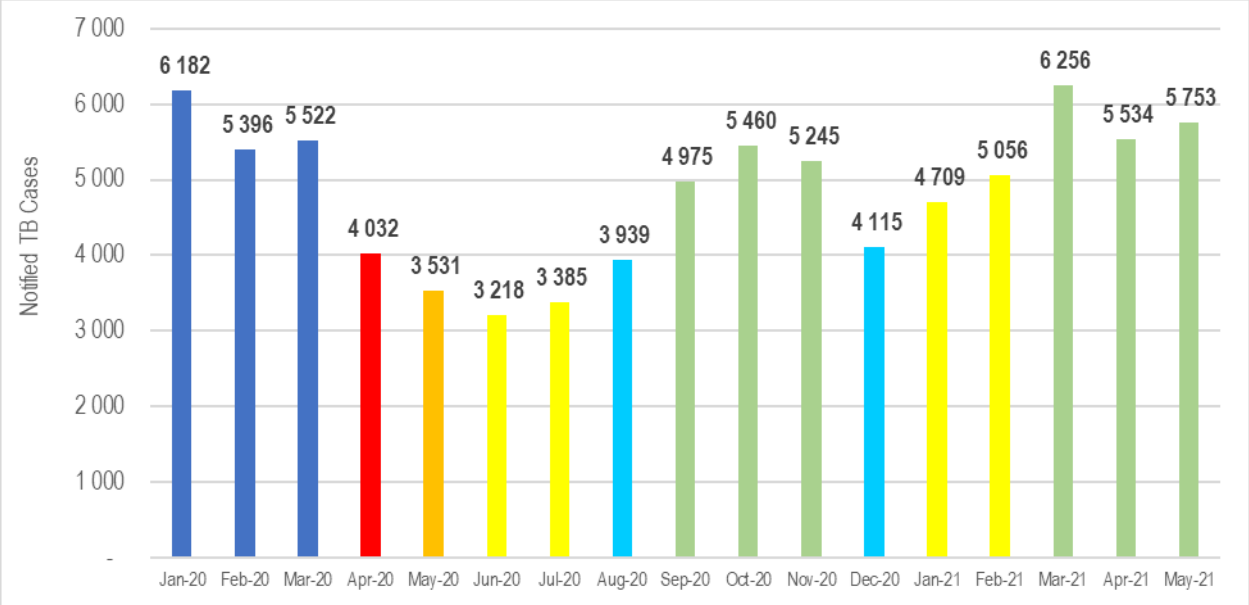
Figure 11: Comparison of notified TB cohort data for the period January to December 2019 vs 2020



Source: NDoH, 2021

Similarly, monthly TB data presented in ***figure 12*** revealed sharp reductions in TB notification in April 2020, which coincided with the declaration alert level 5 i.e., the highest level of movement restrictions. The lowest TB notifications were reported in June 2020 when the country was on alert level 3 lockdown. Thereafter, TB notification slowly began to rise until it peaked at 5 460 notified TB cases in October 2020, when SA was at alert level 1. The implementation of TB Recovery Plan activities, QIPs and contact tracing by ENAs and CHWs accelerated the abovementioned TB notification recovery. Conversely, TB notification declined to 5 245 in November 2020 and then to 4 115 in December 2020 – this coincided with the festive season and SA's second COVID-19 surge. From the 29th December 2020 to 28th February 2021, the country was in adjusted alert level 3 to tackle the second surge. An upturn in TB notifications was observed from January 2021, peaking at 6 256 in March 2021. This increase in TB notification was higher than the pre-COVID-19 TB notification reported in January 2020.

Figure 12: Monthly DS-TB notification for the period January 2020 to May 2021

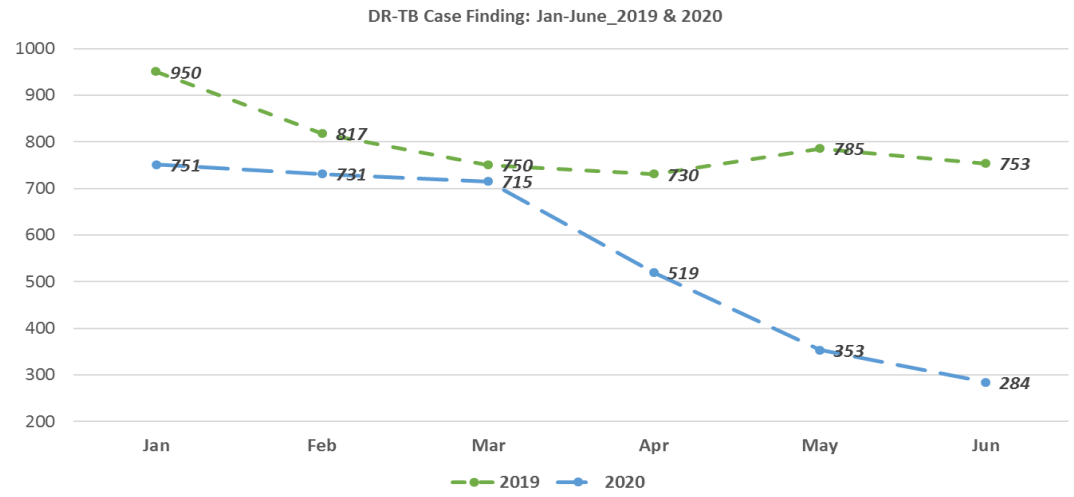


Source: NDoH, 2021

COVID-19 Alert Levels				
Alert Level 5	Alert Level 4	Alert Level 3	Alert Level 2	Alert Level 1

Regarding drug resistant TB (DR-TB), case notification was also drastically affected by the COVID-19 pandemic. It dropped from a total of 715 in March 2020, to 284 in June 2020. ***Figure 13*** below, clearly illustrates the significant decline over a period of three months i.e., March to June 2020.

Figure 13: National DR-TB Notification: January to June 2019 versus January to June 2020.



Source: NDoH, 2021

Due to the COVID-19 pandemic, the number of laboratory-diagnosed DR-TB dropped significantly from Q1-Q4 2020, compared to Q1-Q4 2019, as shown in ***figure 14a*** below. In 2019, a total number of 12 852 patients tested positive for DR-TB, compared to 9 528 in 2020. Likewise, the number of DR-TB initiated on treatment markedly decreased from Q1-Q4 in 2020, when compared to Q1-Q4 in 2019 as depicted in ***figure 14b*** below. The total number of patients initiated on DR-TB treatment in 2019 were 9 372, and in 2020 the number had dropped to 6 824. Such reduction in DR-TB treatment initiation poses high risk of transmission of DR-TB in communities, as well as high risk of mortality because of untreated DR-TB.

Figure 14a: Laboratory diagnosed DR-TB patients

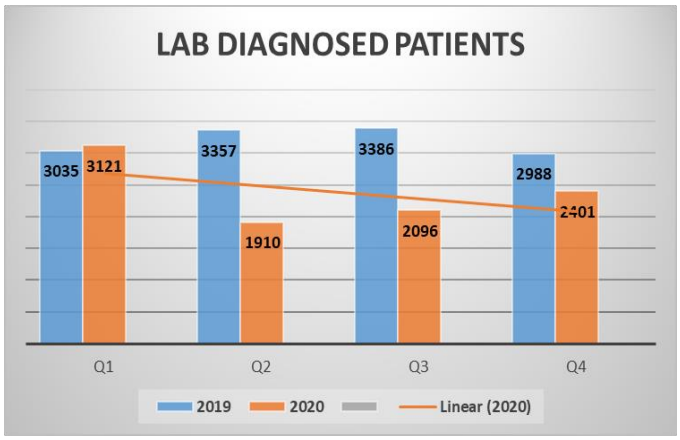
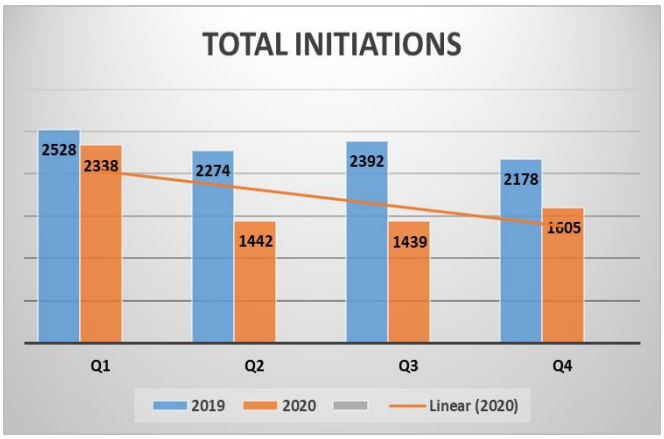


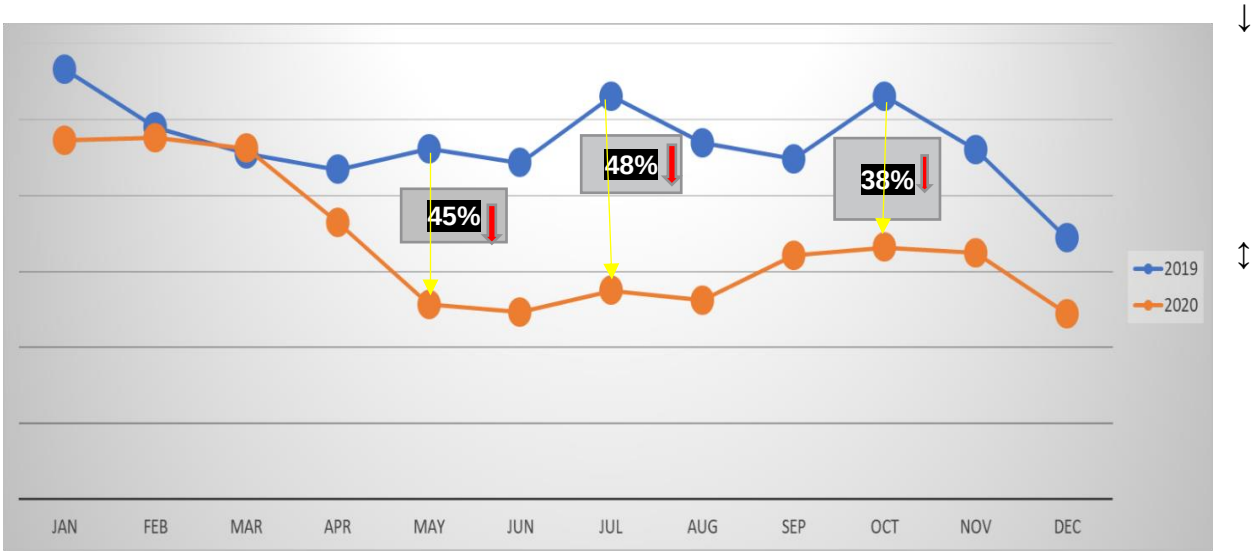
Figure 14b: Quarterly total DR-TB initiations



Source: NDoH, 2021

As illustrated in ***figure 15*** below, the percentage variations of patients initiated on DR-TB treatment i.e., a decrease of 45% when comparing May 2019 to May 2020, a 40% drop when comparing July 2019 vs July 2021, and 38% decline when comparing October 2019 to October 2020; could be attributed to fewer patients visiting the facilities during the lockdown. At this stage, the NDoH does not have treatment outcomes of patients treated during the year 2020 yet.

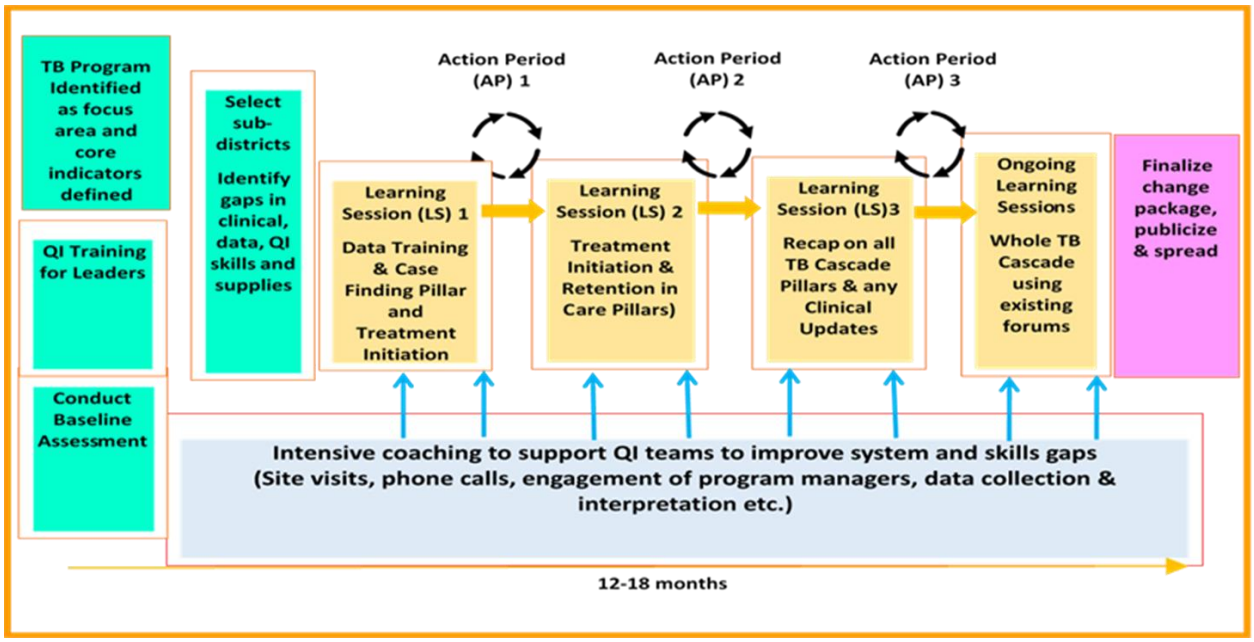
Figure 15: Monthly DR-TB treatment Initiation, 2019 vs 2020



Source: NDoH, 2021

The NDoH adopted the application of TB quality improvement (QI) to close the gaps in the TB care cascade and ensure that the 90-90-90 targets are attained by 2020. Additionally, the NDoH aimed to reduce TB incidence and deaths by ensuring early TB detection, linkage to treatment for all those diagnosed with TB, as well as strengthen the implementation of strategies for retention on TB treatment. District and facility level staff were trained on the rationale, importance, and application of QI methodologies in the TB program using the Institute for Healthcare improvement (IHI) Breakthrough Series Collaborative depicted in ***figure 16*** below.

Figure 16: IHI Breakthrough Series Collaborative



Source NDoH, 2021

Implementation of TB QI activities was initiated across nine districts (a total of 10 subdistricts) in KZN-Natal, EC, WC and GP, since these are the provinces with the highest burden of TB in SA. A total of **291** facilities were targeted ranging from PHC clinics, community health centres (CHCs) and hospitals, see ***table 3*** below.

Table 3: DoH facilities targeted for TB QI

Province	District	Subdistrict	No. of facilities
KZN	▪ Zululand ▪ UMgungundlovu ▪ EThekwini	▪ Nongoma ▪ UMsunduzi ▪ South	**15** **36** **62**
WC	▪ Cape Winelands ▪ West Coast	▪ Drakenstein ▪ Cederberg	**26** **7**
EC	▪ OR Tambo ▪ Nelson Mandela Bay	▪ Nyandeni ▪ Region C	**53** **25**
GP	▪ Sedibeng ▪ Ekurhuleni	▪ Emfuleni ▪ North 1 ▪ North 2	**32** **18** **17**
TOTAL NUMBER OF FACILITIES			**291**

The TB QI enactment was further extended to 12 additional districts by USAID and GF partners. These districts are Sarah Baartman, Mangaung, Fezile Dabi, City of Johannesburg, City of Tshwane, Sekhukhune, Waterberg, uMkhanyakude, City of Cape Town, King Cetshwayo, Ugu and Buffalo City. A total of **396** high burden health facilities were prioritised in these districts. The main thrust of implementation has been on improving facility processes such as patient flow, record flow, etc.; improving the quality of clinical TB services, strengthening data management, and documentation of approaches that work for scale-up.

During the COVID-19 lockdown, movement of people was restricted and thus most people were unable to access health facilities. This resulted in the drop in the number of people screened and tested for TB, and an increase in the number of people who interrupted TB treatment. Even though QI was becoming institutionalised at facility level, the patient flow processes had to be adjusted to incorporate COVID-19 screening and testing, health care workers were spread thin and/ or redeployed to support COVID-19 services e.g., data capturers prioritised capturing COVID-19 than TB data. Poor integration of COVID-19 and TB services negatively affected TB service provision whilst staff rotation compromised the quality of TB care rendered because of the redeployment of TB experienced nurses to COVID-19 services provision. The slow TB data capturing led to severe backlogs (especially in high burden facilities) and incomplete TB data in the District Health Information Systems (DHIS) and TIER.Net. Lastly, quarterly learning sessions for facility clusters could not be convened and mentorship visits by district DoH and partner QI mentors could not be conducted.

Through the C19RM 2021 grant, the national TB program will be strengthened to ensure routine essential TB services are not significantly disrupted during future COVID-19 surges. Thorough planning by the service providers, active resurgence planning and monitoring and optimal RCCE with patients and communities are required to alleviate the impact of COVID-19 on essential TB services. Proven approaches, best practices, learnings and recommendations from implementing C19RM 2020 activities, including the flagship QI lessons learned, innovations and best practices from the GF New Funding Model 2 (NFM2) implementation will be accelerated to mitigate the impact of COVID-19 on essential TB services through adapted facility and community-based approaches e.g., integration of COVID-19 and TB prevention, screening, contact-tracing and diagnosis, use of virtual platforms for patient follow-up, adherence, psychosocial care and support, making that there is no duplication of efforts with other funded TB activities. Also, there is necessity to develop and implement innovative strategies to monitor and evaluate TB programming and ensure the national TB response gains made to date are not undone because of COVID-19, thus keeping SA on track towards epidemic control of TB.

2.3.3 Provide information on disruption of **malaria services** (case management, vector control and chemoprevention; particularly for key and vulnerable populations) and describe how identified gaps, challenges and needs are being/will be addressed by the C19RM Full Funding Request and/or through other funding sources (including Global Fund grant funds). Specifically, indicate if there is a malaria campaign during this period (IRS, ITN and/or SMC). If so, specify if the relevant PPE and adaptations are part of this funding request or if these are covered through Global Fund grant funds and/or other funding sources, or if there is insufficient funding. *(Where relevant).*

Not applicable.

2.3.4 Describe the impact of COVID-19 on **gender-based violence and human rights.** If the C19RM Full Funding Request does not include interventions to respond to identified community, rights, and gender (CRG) gaps, challenges and needs, please include details of how they are being separately addressed.

Although SA has one of the highest rates of violence against women and girls globally, and a femicide rate that is five times the global average, a significant increase in the number of gender-based violence (GBV) cases have been recorded since the country began the nationwide lockdown in response to the COVID-19 pandemic. Civil society organizations (CSOs), community groups, and social movements, including the South African Human Rights Commission (SAHRC), the Social Justice Coalition, and Lawyers for Human Rights created a platform to track and monitor human rights violations and abuses during the lockdown. Numerous human rights complaints have been reported since the first day of lockdown, with the SA Military Ombudsman receiving complaints from the public of excessive force, physical abuse and brutality by the military. Similarly, the Independent Police Investigative Directorate (IPID), which monitors misconduct or abuse of human rights by police has registered cases of complaints of police wrongdoing, during the national COVID-19 lockdown. COVID-19 has exposed SA's shortcomings in advancing its democracy and human rights.

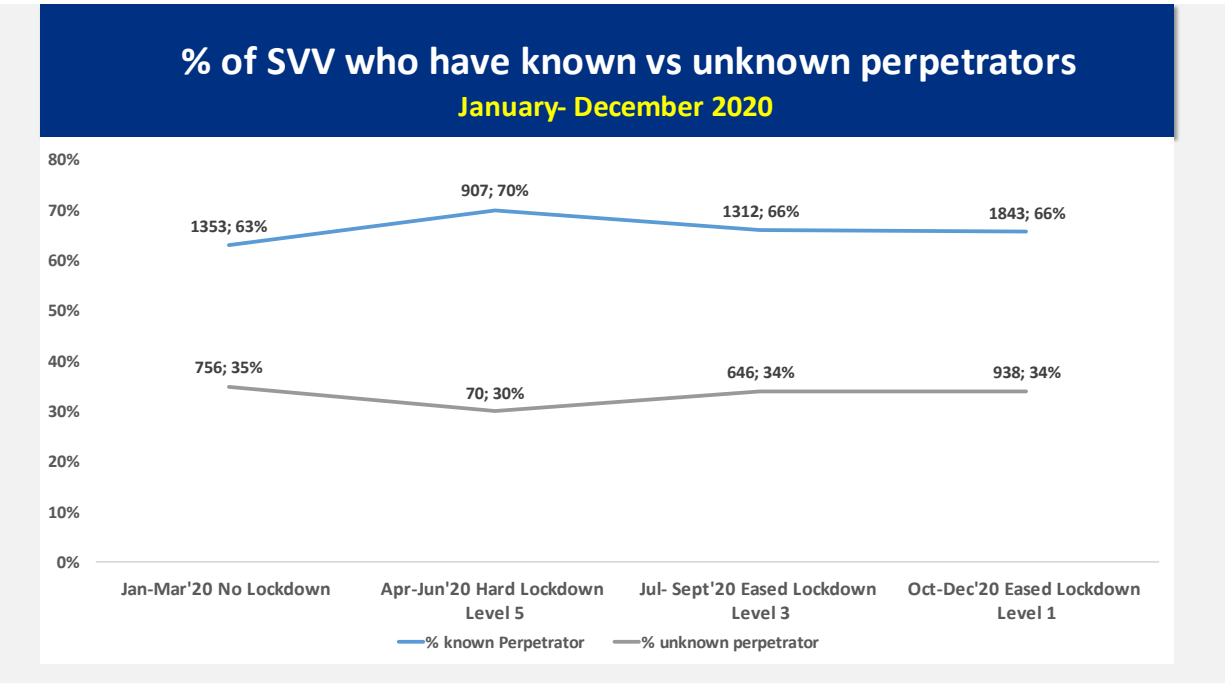
According to the international human rights organisation, Amnesty International, SA government has come under sharp criticism for the violation of its citizens' rights under the COVID-19 lockdown, as outlined in the *State of the World's Human Rights Report.* The government was rebuked for among other things: the use of excessive force by police and the military in enforcing lockdown regulations; exclusion of refugees and asylum-seekers from COVID-19 relief programmes; failure to properly protect health workers with the provision of sufficient PPE; misappropriation of COVID-19 relief funds; cancellation of the country's school feeding scheme which supported nine million children; illegal evictions of people occupying municipal land; not classifying CBOs and paralegals as essential workers who would have been able to alleviate access to justice issues; increased instances of police brutality when enforcing lockdown regulations; inadequate assistance to victims following an explosion of sexual violence against women and children who have been forced to "lockdown" at home or in the same communities with their abusers at a time when services to support survivors have been disrupted or made inaccessible, gross negligence in protecting detainees from COVID-19 infection and access to medication by people living with HIV, TB, etc. has been hampered.

The *State of the World's Human Rights Report* shows how existing inequalities and inequities have left marginalized communities, refugees, older people, health workers, and women disproportionately negatively affected by the pandemic. COVID-19 lockdown meant closure of brothels implying that sex workers have faced loss of income and inability to provide for themselves and their families. Lockdowns and physical distancing also threaten to undermine the centrality of peer-based support for optimizing health outcomes in most of the vulnerable populations supported under the GF grant including MSM, TG, AGYW, SW and PWID. For many in the Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) community, the family home/ community may not be a safe place since family and/or community rejection and abuse are prevalent. Isolation in close accommodations with often unaccepting family members has exacerbated queer people's anxiety, triggering painful memories and depression, hopelessness, and suicidal ideation. Restrictions on access to key services for PWID had potential to increase overdose risk as individuals cope with increased social isolation, increased HIV, and hepatitis C virus (HCV) transmission

due to diminished or suspended harm reduction services, and high drug related deaths, and health conditions related to injecting drugs. According to TB and HIV-affected communities, social protection systems remained inaccessible, and likewise much-needed health services i.e., reduced supply of medicines and shortage of staff.

Pre-existing social norms and inequalities, economic and social stress caused by the pandemic, coupled with restricted movement and social isolation measures, have led to an exponential increase in GBV cases, as many women and girls have been forced to "lockdown" at home or in the same communities with their abusers at a time when services to support survivors were disrupted or made inaccessible. The government's GBV and Feminicide Command Centre, a call center to support victims of GBV, recorded more than 120,000 victims in the first three weeks of the lockdown, with rape and sexual assaults increased nearly three times the rate prior to lockdown. The Vodacom's support call centres saw a 65% increase in calls from women and children confined to their homes during lockdown and in need of urgent help. This prompted the President to refer to GBV as SA's second pandemic, in the midst of COVID--19. ***Figure 16*** below shows the percentage of sexual violence survivors (SVV) who have known versus (vs) unknown perpetrators for the period January to December 2020, under the NACOSA GF program.

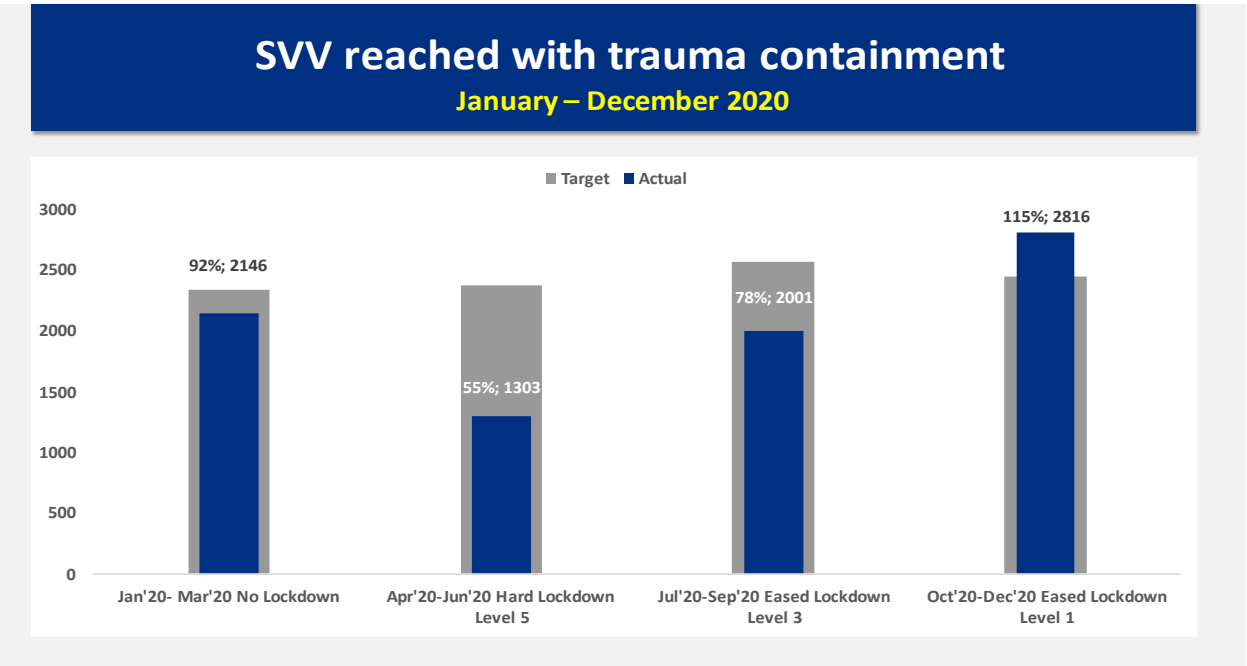
Figure 16: Percentage (%) SVV who have known vs unknown perpetrators - January to December 2020.



Source: NACOSA, 2021

Although violence prevention and response services have been severely disrupted during COVID19 lockdown, dedicated Thuthuzela Care Centres, providing a one-stop service for victims of sexual violence at state hospitals have remained open during lockdown, proactive efforts by the South African Police Services (SAPS), government departments and CSOs to lend support to victims of domestic abuse during the lockdown have included online and additional telephonic reporting and counselling services, including a national GBV hotline. The numbers of SVV reached with trauma containment for the period January to December 2020, under the NACOSA GF program are depicted in ***Figure 17*** below.

Figure 17: SVV reached with trauma containment - January to December 2020



Source: NACOSA, 2021

During COVID-19 lockdown, the Department of Social Development (DSD) worked closely with shelters run by non-governmental organisations (NGOs) to ensure that services remain accessible and available to victims of domestic violence. Shelters instead created safe spaces for women in need and partnered with Uber to transport them to shelters, hospitals, or doctor visits. Uber was also used to bring ART and chronic medications directly to patients. The SAPS increased the number of Family Violence, Child Protection and Sexual Offences (FCS) units to respond to threats and acts of violence during the national lockdown, and the DSD increased the number of social services professionals to assist during this time. The NGOs took their advocacy and awareness raising work online with events, discussions and campaigns highlighting the impact of COVID-19 on vulnerable groups including women and girls.

To facilitate debate on gender issues, during the 2020 commemoration of 16 Days of activism against GBV, Parliament, in partnership with the South African National AIDS Council (SANAC) and the DSD, under the banner of the Takuwani Riime Men's Movement, hosted a two-day Men's Parliament. This event brought together about 250 men and boys from across the country to engage them to become agents of change and integral partners in the prevention and response in tackling the spread of HIV, GBV and femicide and other social ills. Through the Solidarity Fund, 321 CBOs and 11 large Public Benefit Organisations (PBOs) received R61.25 million and R9.99 million respectively, to strengthen the national GBV response amidst COVID-19. The SA government's COVID-19 aid programs including food parcels, overlooked people with disabilities, refugees and asylum seekers and many lesbian, gay, bisexual, and transgender (LGBT) people during national lockdown. Sex worker rights groups also noted that this vulnerable population had been left out of relief planning.

To contribute to the mitigation of human rights violations among vulnerable and key populations, the three civil society GF PRs employed community workers to document incidents that threaten rights of key and vulnerable populations. According to the collected evidence in the REAct database, the main violations of the rights were: discrimination, misconduct, violence by law enforcement agencies, denial of access to health services and medication, physical violence against women by sex partners, relatives, and police officers. To address the unintended impact, SA continued to implement and scale up programs to remove human rights related barriers to HIV and TB services during COVID-19 response. These included paralegal services operated by moving to online and phone-based consultations, mobilized and supported patient and community groups preserving access to HIV and TB services and reproductive health services, implemented online human rights training for vulnerable populations and police, as well as disseminated user-friendly information on COVID-19 services, the rights of persons diagnosed with COVID-19, and the

rights of those who are isolated or quarantined. The GF PRs continued to facilitate campaigns for legal literacy across the 25 GF supported 25 districts.

In this CR19M 2021 funding request, it is proposed that PRs will be supported to collaborate with DSD in employing extra social services workforce that will provide GF beneficiaries with psychosocial support, including mental health services and counselling required due to COVID-19. Women and affected key populations-led organisations will be contracted or engaged to facilitate linkages to access legal redress or justice for human rights violations experienced from COVID-19 restrictions. The use of the *"Communities Matter*" App will be scale-up, community leaders will be engaged to raise potential rights-violations awareness, and HIV and TB community paralegal programs will expand their scope to include COVID-19 emergency response and redress. Other GBV and human rights interventions will be supported through other existing GF grants.

2.3.5 Describe the approach used for the **prioritization of interventions** and activities and link the C19RM Full Funding Request to the pillars of the NSPRP.

SA is currently funded by GF through the NFM2 (April 2019 to March 2022) and subsequently received C19RM 2020 award (August 2020 to June 2021), to strengthen SA's national COVID-19 response. This C19RM 2021 (August 2021 to December 2023) funding request will be additional and complementary to the GF NFM2 grant and C19RM 2020. In addition, the country is the process of developing the NFM3 (April 2022 to March 2025) funding request, and therefore activities proposed in this C19RM 2021 funding request will be prioritsed with non-duplication considered. Priority interventions and key activities presented under the base and above allocations are guided by the following:

1. Situational and Gap Analysis

To provide the rationale for prioritisation of key activities in this C19RM 2021 funding request, as well as fully appreciate all financial and in-kind contributions to the national COVID-19 response, a rapid situational analysis was conducted. GF PRs and SRs current mitigation and adaptation activities were appraised to consolidate lessons learned and best practices, as well as determine which activities will be concluded end June 2021 and which activities warranted continued C19RM funding until December 2023. Over and above government COVID-19 response efforts, United Nations (UN) agencies namely, WHO, UNAIDS, UNICEF and others have been supporting the national COVID-19 response. Specifically, WHO health experts are deployed at national and provincial level to work closely with the NDoH through the Offices of the Minister and Director-General (DG), to provide the much-needed technical support required to guide SA through the challenging period of managing a global pandemic of unparalleled magnitude using their technical know-how, global large-scale outbreaks' work experience, lessons learnt and best practices to help strengthen the NDoH COVID-19 response across the emergency preparedness and response pillars, including resurgence planning and monitoring. Likewise, WHO health experts are also deployed to the provinces, in accordance with the provincial epidemiological scenario and emergency response technical support needs.

Developmental partners including United States Government (USG) and other donors, and the private sector contribute to the national COVID-19 response at all levels including participation in the national IMT workstreams, vaccine roll-out forums and through implementing partners at provincial, district, facility, and community level. Within their respective geographic areas of support, USG-funded district support partners (DSPs) are providing facility and community-based integrated services including COVID-19 screening, contact tracing, testing, case management, RCCE, advocacy and demand creation. As of February 2021, USG-funded DSPs are supporting vaccine roll-out with human resources, training, direct service delivery (DSD), IPC (i.e., PPE), transport, computers, printing, supplies and equipment (freezers, cooler boxes, gazebos, etc.) as applicable. CSOs and CBOs are supporting COVID-19 screening, contact tracing, advocacy, RCCE and demand creation activities, and there is room for improvement as regards optimal engagement of CSOs/ CBO to mount strong local COVID-19 responses and enhance health and community systems.

Considering the current surge, emergence of new variants of concern and in anticipation of possible future surges, and the mammoth task of vaccinating millions of people to achieve herd immunity, areas of need persist across the four phases of the epidemic i.e., preparedness, containment, mitigation and recovery at national, provincial district, facility, and community level. Gaps remain in terms of geographical areas i.e., non-GF and non-PEPFAR supported districts/ subdistricts, national and provincial emergency response coordination and planning, human resources, IPC (incl. PPE), surveillance, epidemiological investigations, contact tracing, diagnostic test kits, case management plus medical oxygen, human rights, GBV and post violence care, as well as vaccine services delivery systems support, community systems strengthening including community-led monitoring, advocacy, social mobilisation, and CBO capacity building.

2. Stakeholder Consultations.

Facilitated discussions were conducted with principal recipients, relevant government departments, development partners, and private sector; intra-action reviews (IARs) were facilitated with various stakeholders including Provincial Councils on AIDS (PCAs) and their multisectoral stakeholders as well as civil society sectors; and key informant interviews (KIIs) also were conducted; followed by primary data analysis. Secondary data was analysed by reviewing relevant reports, plans, strategies, and policy documents; and where applicable, data verification was carried out.

3. National Plan for COVID-19 Health Response – South Africa

Guided by SA's National Plan for COVID-19 Health Response, the proposed interventions and activities cover all **nine** pillars or strategic priorities of the national response namely, a) Provide effective governance and leadership, b) Strengthen surveillance and strategic information, c) Augment health systems readiness: d) Enhance community engagement, e) Improve laboratory capacity and testing, f) Clarify care pathways, g) Scale-up infection prevention and control (IPC) measures, h) Boost capacity at ports of entry, I) Expedite research and introduction of therapeutics, diagnostics, and vaccines.

4. South African COVID-19 Vaccine Strategic Plan, May 2021.

The national COVID-19 Vaccination Plan has **two** main objectives namely,

a) Significantly reduce severe disease hospitalisation and death due to COVID-19.
    - *Strategy*: Vaccinate all persons above 60 years of age including those in the congregate settings such as care homes and other specific populations at higher risk.

b) Build population ("herd") immunity as rapidly as possible.
    - *Strategy*: Mass vaccination of every person over 18 years of age as quickly as possible.

Attainment of these objectives is expected to facilitate the return to full economic activity and greater stability in communities.

In summary, the priority interventions and key activities for this funding request were prioritised with non-duplication of donors, private sector, and government efforts in mind. Including the *rollover* amount of **US $11 705 631** and a *base allocation* of **US $80 514 995**, the total approved C19RM funding is **US $92 220 626.** In addition, SA is requesting an *above base allocation* of **US $80 514 994**. For financial year (FY) 2021/22, the National Treasury has allocated a total of ZAR 21,65 billion to the COVID-19 response - *72% of the projected SA COVID-19 response budget based on the South African COVID-19 Modelling Consortium estimates*. Donors and private sector contribute an additional 15% and as such the current funding gap is 13%, see section 2.5.1 and 2.5.2 for more detail.

2.3.6 Based on the COVID-19 Modular Framework, provide a brief description/justification for the proposed interventions and key activities in the **C19RM Base Allocation** portion of the C19RM Full Funding Request, including expected outcomes of these interventions and how these interventions will support grant targets. These should be in line with the C19RM Technical Information Notes and Guidelines[3], applicable WHO guidance (including on COVID-19) and the NSPRP.

[3] Link forthcoming

a. COVID-19 control and containment interventions	
Intervention & Key activities	As reflected in the funding landscape analysis in section 2.5.1 below, SA has pooled financial resources to bolster the national COVID-19 response and received financial and in-kind support from donors and the private sector, yet the funding gap remains. Thus, SA continues to mobilize resources, engage relevant stakeholders to help close the gap. Activities prioritised in the **base allocation** include new support needs and enhancements or further development of existing interventions including continuation of activities currently supported through C19RM 2020. **Intervention 1**: **Country-level coordination and planning** ***Key activities:*** 1.1 Strengthen NDoH Project Management Office (PMO) capacity to manage and coordinate the national health COVID-19 response. • Support the PMO to take stock of contributions made to support the national health COVID-19 response and establish the funding gap, which in turn will inform resource mobilisation efforts and emergency response planning. • Support the PMO to monitor and properly coordinate COVID-19 related donor and private sector assistance to supplement government COVID-19 resources. • Augment PMO secretariat capacity to provide sound COVID-19 response coordination and administrative support to the PMO. 1.2 Facilitate enhanced coordination of the national and provincial Incident Management Teams (IMTs) COVID-19 activities • Support the national and provincial IMTs to conduct COVID-19 response intra-action reviews (IARs) and use the lessons learned and best practices to inform future emergency response planning, coordination, and reporting. • Enhance the provincial DoH ability to continuously review, refine, implement, and monitor provincial resurgence plans in accordance with the epidemiological scenario and health system capacity, and respond appropriately. 1.3 Provide financial support to civil society COVID-19 governance and coordination structures to strengthen civil society involvement at national, provincial, district and local level. • Support civil society COVID-19 governance and coordination structures to convene meetings with all civil society constituencies. • Facilitate civil society representatives' participation in national, provincial, district and local multisectoral COVID-19 response platforms (i.e., travel, accommodation, and other travel related costs. 1.4 Bolster the multisectoral COVID-19 response coordination at provincial, district, subdistrict, and community level. • Strengthen provincial and district multisectoral response i.e., Provincial/ District-JOINTs, Provincial/ District-JOCs and involvement of other departments (esp. education, SAPS, etc.) in the response. • Assist provincial COVID-19 response coordination bodies (COVID-19 Command Councils or equivalent) to take stock of the COVID-19 response contribution from donors and the private sector, to fully appreciate and optimally utilize the extra support on hand to strengthen the provincial, district, subdistrict, and community level COVID-19 response. • Work closely with the provincial COVID-19 response coordination bodies to improve the involvement of multisectoral stakeholders (including civil

	society and private sector) in the provincial, district, subdistrict, and community level COVID-19 response. 1.5 Strengthen SANAC CCM coordinating structures for robust C19RM implementation oversight and performance monitoring and to improve PR and implementers' accountability. **Intervention 2**: **COVID-19 diagnostics and testing** ***Key activities:*** 2.1 Support NHLS to procure COVID-19 related laboratory reagents and other consumables. 2.2 Support the maintenance and servicing of diagnostics and testing health equipment. **Intervention 3**: **Case management, clinical operations, and therapeutics** ***Key activities:*** 3.1 Strengthen the DoH capacity to ensure uninterrupted availability and supply of oxygen for COVID-19 patients at district level, including during COVID-19 surges. • Procure and install PSA oxygen plants in the 30 priority district hospitals to improve oxygen infrastructure and ensure uninterrupted availability and supply of oxygen for COVID-19 patients. • Acquire a comprehensive maintenance plan for the 30 PSA plants, including spare parts and remote monitoring by the manufacturer. • Train and mentor relevant district hospital staff on safety and effective management of medical oxygen sourced from the PSA plants. 3.2 Support real-time monitoring of medical oxygen supply, demand and cylinder mapping at hospital, provincial and national level through the implementation of the oxygen dashboard to facilitate Immediate automated reporting on current oxygen level, consumption / utilization, and cylinder mapping. • Train managers and operational staff on the oxygen dashboard purpose, value, logistics and the importance of the e-ordering tool as the key oxygen cylinder ordering and input data tool. • Train all the supply chain managers, artisans / tradesmen, and the officials responsible for oxygen ordering at institutional level on the dashboard and the e-ordering tool. • Mentor facility managers, operational managers, and clinicians on data interpretation and the use the data for decision making. • Appointment of provincial technical managers to manage oxygen supply and demand. 3.3 Support capacity building of lower-level health facilities to monitor oxygen levels in patients in order to detect hypoxia early and take appropriate action to improve treatment outcomes. • Procure and distribute pulse oximeters to lower-level health facilities for detecting early hypoxia among patients. • Train health workers in lower-level health facilities on how to properly use pulse oximeters as part of case management to improve treatment outcomes. 3.4 Monitor medical surge capacity in line with COVID-19 epidemiological scenario and health services network context. • Train identified health care workers on patient monitoring i.e., vital signs including oxygen saturation level especially for at risk groups (> 60 years). • Deploy and supervise home monitoring teams and provide them with pulse oximeters and other needed home monitoring tools. • Support linkage of the HBIC with facilities through the ambulance services, for prompt referral on deteriorating patients. • Facilitate linkage of lower-level health facilities to specialized facilities for prompt referral of deteriorating patients (e.g., hypoxia).

Intervention 4: Surveillance, epidemiological investigation, and contact tracing

Key activities:

4.1 Strengthen contact tracing, active case finding, isolation, cluster investigation, and testing at all levels.

- Support optimal utilisation of digital contact tracing tools e.g., *CovidConnect.* by procuring additional computer hardware/ software.
- Hire additional staff for contact tracing, epidemiological investigation, surveillance, as necessary (e.g., most affected districts).

4.2 Support social cluster government departments and private sector to provide COVID-19 prevention education, screening, and contact tracing.

- Department of Basic Education (DBE) - learners, educators, SMTs and SGBs.
- Department of Social Development (DSD) - beneficiaries at DSD supported places of safety.
- Department of Correctional Services (DCS) - inmates and correctional services staff.
- Private sector - People Living in the Street, waste pickers, taxi drivers and informal traders.

4.3 Train COVID-19 case investigators and contact tracers (e.g., community health workers) to integrate TB screening, HIV self-testing, linkage to ART and tracing of HIV and patients lost to follow-up in their service package.

Intervention 5: Surveillance systems

Key activities:

5.1 Strengthen the DoH/ NHLS/ NICD capacity to implement COVID-19 surveillance and routine reporting in alignment with existing HMIS platforms; and support the DoH to track and monitor vaccination coverage.

- Hire additional staff for DATCOV and Electronic Vaccination Data System (EVDS) implementation at national, provincial, district and facility/ community level; as well as support NHLS to employ additional call centre staff to track, manage and report vaccine adverse events.

Intervention 6: **Infection prevention and control and protection of the health workforce.**

Key activities:

6.1 Assess the national IPC program, develop a strategic plan/ an operational plan as appropriate.

6.2 Assess of IPC best practices and implementation of corrective measures in healthcare facilities.

6.3 Provide mentorship and supportive supervision in healthcare facilities.

6.4 Implement tools and strategies for prevention, identify, monitor, and manage health workers exposed to COVID-19 patients and those with COVID-19.

6.5 Review the national IPC guidelines, then validate, and disseminate.

6.6 Augment the provision of personal protection equipment (PPE) for frontline and essential facility-based and community-based health care workers based on the national IPC protocol.

6.7 Train health care workers on IPC measures and rational use of PPE in COVID-19 context.

Intervention 7: Health products and waste management systems

Key activities:

7.1 Support civil society PRs to hire a full time PSM specialists to manage the increased demand for strengthen health products procurement HPP and related grant activities.

Rationale	On 10th June 2021, SA officially entered *"third COVID-19 wave"* and therefore it is critical that control and containment measures are intensified. Structures and systems exist across all COVID-19 control and containment interventions referenced above but they need to be reinforced and sustained. The proposed activities will optimize COVID-19 management, coordination, and planning at all levels to mitigate the impact of the third wave on the health system, economy as well as individual and society levels. Resurgence planning and monitoring, emergency preparedness and rapid responsiveness lessons learned and effective approaches from the first and second waves will be considered and scaled up as applicable, to mount adequate COVID-19 response to the third wave. With the evolving pandemic, surveillance continues to be central to SA's COVID-19 response, to allow for evidence-based planning and implementation. COVID-19 screening, testing, and contact tracing are essential to managing the pandemic and the DoH has been on track in implementing globally accepted innovative approaches to bolster the COVID-19 cascade, working closely with the NHLS and the NICD. Furthermore, the unprecedented large-scale national COVID-19 vaccine roll-out in progress demands urgent vaccine delivery services support to fast track vaccine delivery and protect SA citizens from COVID-19. Barriers to vaccination include the high global demand, emergence of variants and vaccine hesitancy and thus effective and innovative national strategies are vital. There is need for additional HR and logistics for rapid rollout of the vaccine in the rural districts to ease access for vulnerable populations. As part of the National Health Insurance (NHI) planning, SA established the DATCOV system, which has been adapted to allow for other HMIS platforms to feed COVID-19 response data into DATCOV, including the national EVDS. As such, the capacity to fully implement DATCOV needs to be strengthened and sustained through additional HR for data input, analytics, and reporting, to ensure availability of quality real-time data for decision-making, planning and continuous quality improvement (QCI). Increasing the utilization of digital tools for contact tracing (*COVIDConnect*) will improve the quality of data and provide real-time to inform the national COVID-19 response. As the COVID-19 surge and vaccine roll-out gains momentum, IPC in the context of COVID-19 and other infectious diseases becomes critical as the PHC level workload increases. For optimal control and containment, continued implementation of IPC activities funded under C19RM 2020 is crucial. Coupled with IPC, health facilities will require ongoing assessment for COVID-19 emergency preparedness and rapid responsiveness, and all COVID-19 related health products and waste management systems will be adequately supported. To augment PR procurement expertise and improve efficiencies, each civil society PR will hire a full time PSM specialist. Using the newly established O_2 dashboard, O_2 supply and demand will be closely monitored to ensure constant availability. In summary, some of the interventions highlighted above have been implemented to varying degrees and as things stand, it is important that SA be supported to maintain or optimize these in alignment with the epidemiological scenario and health services network context.
Expected Outcome	It is anticipated that the COVID-19 control and containment activities prioritized above will limit SARS-CoV-2 transmission, allow the health system to adequately respond to the COVID-19 public health emergency, resulting in reduced COVID-19 related morbidity and mortality and a stronger public health emergency response system, well equipped to deal with future public health emergencies of this nature.

	Affected populations will be able to safely access essential health and social services as well as resume economic activities currently restricted due to COVID-19. The strain on the public health system will be lessened, allowing for the restoration and protection of the much-needed comprehensive primary health care (PHC) services. Upon the realisation of optimal control and containment, SA will continue with its quest towards universal health coverage (UHC) through the implementation of the NHI policy with aim of improving overall health outcomes. Most importantly, the strengthened COVID-19 control and containment will also allow GF PRs and SRs to implement Year 3 HIV and TB program activities and reach set targets with minimal service disruptions at facility and community level.
Expected Investment	The proposed GF funding amount for this intervention is **US $80 161 194** and this includes the *C19RM 2020 rollover* amount of ***US $9 634 988*** and the *C19RM 2021 base allocation* of is ***US $70 526 206*.**

b. COVID-19-related risk mitigation measures for programs to fight HIV/AIDS, tuberculosis, and malaria	

Intervention & Key activities	GF is currently supporting the national HIV response through the NFM2 grant as well as the C19RM 2020 grant, and thus the proposed HIV activities below are complementary to existing activities. Furthermore, activities prioritised in this section include new support needs and enhancements or further development of existing interventions including continuation of activities currently supported through C19RM 2020.
	
	To mitigate the impact of COVID-19 on HIV programming, the C19RM 2021 grant will be used to i) supplement government mitigation and adaptation efforts through direct funding to NDoH, and ii) support civil society PRs and SRs to strengthen mitigation and adaptation for GF-supported prevention programmes targeting key and vulnerable populations namely, AGYW, MSM, TG, SW and PWID.
	
	Mitigation for <u>HIV</u> programs
	Key activities:
	• Adapt HIV prevention, testing and treatment programming, prioritize and strengthen HIV community-based service delivery using focused and targeted approaches to support GF programming:
	  ○ Support enhanced PICT, HIV self-testing, community HTS and linkage to ART.
	  ○ Service integration – screening for HIV, TB, COVID-19, GBV, STIs, SRH and linkage.
	  ○ Promote same-day ART initiation; point of care testing VL / EID.
	  ○ Strengthen the implementation of differentiated service delivery models i.e., multi-months dispensing (MMD), CCMDD; for example, roll-out of the new NDoH differentiated service delivery guidelines (training, printing, distribution, etc.)
	  ○ Support virtual programming for HIV and TB prevention, adherence, psychosocial care, and support.
	  ○ Maintain access to essential HIV laboratory tests.
	  ○ Modify infrastructure and patient flow at facility or community-based HIV service points to limit COVID-19 transmission.
	• Strengthen OHS measures to minimize COVID-19 related disruption of essential HIV services.

	○ Train facility and community-based health care workers on HIV and COVID-19 i.e. IPC measures and rational use of PPE in COVID-19 context. ○ Support the DoH vaccine delivery services to ensure facility and community-based HIV health care workers receive the COVID-19 vaccination in accordance with the NDoH phased COVI-19 vaccine roll-out plan. • Train and mentor HIV program staff incl. DCS-based health care workers to integrate COVID-19 screening within HIV prevention, treatment, care, and support services. • Use routine HIV program data to monitor service disruptions and address service delivery challenges across the continuum of HIV care. • Involve/ engage civil society or community-based organisations including people living with HIV (PLHIV) - *in accordance with GIPA principles*, in the provision of additional/ services in the community.
Rationale	SA has the largest ART program in the world and had made good progress towards achieving the UNAIDS 90-90-90 targets. Disruptions of HIV services due to COVID-19 have resulted in a drop in the national HIV program performance as highlighted in ***figures 4, 5, 6 and 7*** above. Accordingly, activities proposed under the mitigation for HIV programs intervention above have been prioritised to restore and accelerate HIV service delivery, mitigate the impact of COVID-19 on HIV service provision and sustain the commendable gains made from the robust national multisectoral HIV response mounted in the past decade. Amidst COVID-19, adaptation and acceleration of HIV service delivery is key to getting SA back on track towards achievement of the 90-90-90 targets and ultimately HIV epidemic control. The client-centred, targeted, and focused community-based approaches to HIV prevention, treatment, care, and support i.e., door-to-door/ outreach/ mobile HTS (incl. HIV self-testing) plus COVID-19 screening, linkage to ART, same-day ART initiation, HIV treatment adherence, MMDs, etc. presented above are proposed to restore and protect essential HIV services thus mitigate the impact of COVID-19 on HIV program outcomes.
Expected Outcome	Sustained provision of HIV services proposed above will lead to the attainment of the 90-90-90 targets and eventually HIV epidemic control. In turn, sustained provision of HIV services implies that PLHIV will continue to receive HIV care services through client-centred differentiated models of care without any service delivery disruptions leading to improved HIV morbidity and mortality as well as optimal patient outcomes i.e., viral suppression. At population level, viral suppression translates to reduced HIV incidence. At health system level, in addition to the HIV burden, the intensified COVID-19 caseload puts a huge strain on the health system and negatively impacts the routine provision of essential HIV services. Adaptation and acceleration of targeted and focused community-based approaches will allow for the restoration and protection of the health system, to avoid overload and even total collapse. Implementation of the priority mitigation for HIV programs' activities above is expected to restore and accelerate HIV programming, thereby allowing GF PRs and SRs to achieve Year 3 targets and realize improved patient outcomes, and in turn advance towards HIV epidemic control.

Expected Investment	The proposed GF funding amount for this intervention is **US $7 181 932** which includes the *C19RM 2020 rollover* amount of ***US $1 429 395*** and the *C19RM2021 base allocation* of ***US $5 752 537*.**

Intervention & Key activities	GF has made huge investments in the national TB program through the current NFM2 and will sustain this support beyond the existing funding cycle through NFM3, wherein there has been a significant increase in the TB allocation. In addition, GF presently supports the national TB program through the TB Optimization grant which ends March 2022 as well as the C19RM 2020 grant as explained in section 2.3.5 above. Key TB activities under the three mechanisms comprehensively cover TB prevention, diagnosis, treatment, care, and support for DS- and DR-TB as well as HIV/ TB integration. Considering the above, SA is only proposing one funded activity in this section. Accordingly, PRs and SRs will also help facilitate and monitor the activities to mitigate the impact of COVID-19 on TB programming and this aspect does not require additional funding resources. **Mitigation for <u>TB</u> programs** ***Key activities:*** • Hire three adherence coordinators to support the distribution of anti-TB medication to patients on treatment, follow up and track patient progress. • PRs and SRs will help facilitate and monitor the activities to mitigate the impact of COVID-19 on TB programming by supporting: o Integration of TB, HIV and COVID-19 prevention, screening, contact tracing and diagnosis. o Strengthening of OHS measures to minimize COVID-19 related disruption of essential TB services. ✓ Provide virtual and in-person training for facility and community-based health care workers on TB and COVID-19 i.e. IPC measures and rational use of PPE in COVID-19 context. ✓ Support the DoH vaccine delivery services to ensure facility and community-based TB health care workers receive the COVID-19 vaccination as per NDoH phased COVID-19 vaccine roll-out plan. o Leveraging of available COVID-19 IPC resources to close gaps or address challenges related to optimal TB IPC implementation. o Use of routine TB program data to monitor service disruptions and address any service delivery challenges across the continuum of TB care. o Involvement of civil society or community-based organisations including persons living with TB (PLTB) - *in accordance with GIPA principles*, in the provision of additional services in the community.
Rationale	Essential TB services have been negatively impacted by COVID-19 as reflected in ***figures 9 to 15*** above. The activity proposed under the mitigation for TB programs intervention above aims to support the distribution of anti- TB medication to patients on treatment, follow up and track patient progress through the deployment of three adherence coordinators. In addition, it is also expected that all PRs and SRs will strengthen the integration of TB, HIV and COVID-19 screening as well as TB and COVID-19 prevention and diagnosis through targeted and people-centered approaches, virtual programming for TB prevention, adherence, and psychosocial support, strengthening OHS and leveraging available COVID-19 IPC resources to reinforce TB IPC.

	Implementation of the TB activities above will contribute towards restoring and accelerating TB service delivery, mitigating the impact of COVID-19 on TB service provision, and protecting the laudable gains made by the national TB program in the past decade. Execution of these activities will ensure uninterrupted TB service delivery, propel SA towards attainment of 90-90-90 targets for TB and ultimately end the TB epidemic.
Expected Outcome	Execution of the proposed priority TB activities described under the mitigation for TB programs will lead to the attainment of the 90-90-90 targets for TB and ultimately ending the TB epidemic. Sustained provision of TB services means PLTB will continue to receive TB care without any service delivery disruptions leading to improved TB morbidity and mortality and improved health outcomes e.g., improved treatment success rate, At the health system level, in addition to the TB burden, the amplified COVID-19 caseload puts a huge strain on the health system and negatively impacts the routine provision of essential TB services. Adaptation and acceleration of targeted and focused community-based approaches for TB service delivery will allow for the restoration and protection of the health system, to avert overburden and even total breakdown. Implementation of the priority mitigation for TB activities above is expected to restore and accelerate TB programming and enable GF PRs and SRs to achieve Year 3 targets and realize improved patient outcomes, and in turn advance towards ending TB epidemic.
Expected Investment	The proposed GF funding amount for this intervention is a *base allocation* amount of **US $141 397,** with no rollover amount**.**

c. Expanded reinforcement of key aspects of health systems and community-led response systems	
Intervention & Key activities	**Intervention 1**: **Infection prevention and control and protection of the health workforce.** ***Key activities***: 1.1 Support procurement of additional PPE for frontline and essential services facility and community-based staff in accordance with the national PPE protocol. 1.2 Train health care workers on IPC measures and rational use of PPE in COVID-19 context. 1.3 Employ IPC measures and provide COVID-19 response related training for community-based health care workers that support vaccine delivery e.g., mobile outreach vaccination teams. **Intervention 2: Surveillance systems** ***Key activities:*** 2.1 Support NHLS to repurpose its national call centre to include COVID-19 vaccination roll-out communication and active managed care support for HIV and TB patients. **Intervention 3: Laboratory systems.** ***Key activities***: 3.1 Support the NHLS to enhance mutualization of equipment for multiple testing protocols.

	3.2 Support NHLS to expand its point of care testing (POCT) capacity, building on the POCT lessons learned to date thus making HIV, TB, COVID-19 testing readily available within health facilities and in communities. 3.3 Develop a comprehensive set of POCT training materials and train health facility level end-users to conduct accurate POCT. 3.4 Develop and integrate test sets and items into the NHLS laboratory information system to enable real-time reporting. 3.5 Support NHLS to integrate digital health solutions into the laboratory value chain to improve HIV, TB, and COVID-19 patient care. **Intervention 4**: **Case management, clinical operations, and therapeutics** ***Key activities:*** 4.1 Use virtual and in-person training and supervision platforms to enhance health care workers' knowledge and skills and be able to: • Implement the COVID-19 clinical pathway for early initiation of treatment. • Conduct triaging and early detection of hypoxia at community and in primary health care facilities. • Assess critical patients and initiate early treatment or early referral. **Intervention 5: Gender-based violence prevention and post violence care.** ***Key activities:*** 5.1 Support PRs to collaborate with DSD to employ additional social services workforce that will provide GF beneficiaries with psychosocial support, including mental health services and counselling required because of COVID-19. 5.2 Provide virtual and in-person training for first responders on GBV identification and management. 5.3 Engage multi-media platforms to increase community mobilization and advocacy to continue to raise the visibility of increased violence against women and girls, demonstrating how the risk factors that drive violence are exacerbated in the context of COVID-19. 5.4 Engage CSOs to strengthen GBV advocacy and engagement of different actors to address violence against women and girls during COVID-19. 5.5 Engage/ contract women and affected key populations-led organisations to facilitate linkages to access legal redress or justice for human rights violations experienced because of COVID-19 restrictions. **Intervention 6: Respond to human rights and gender related barriers to services.** ***Key activities:*** 6.1 Support the scale-up of community-led monitoring (CLM) human rights violations documentation, equitable coverage, and access to C19RM funded tools i.e., expanding the use of the *"Communities Matter*" and ReACT Applications to facilitate linkages to access legal redress or justice for human rights violations experienced because of COVID-19 restrictions. 6.2 Strengthen the capacity of ProBono, Legal Aid SA and SAHRC to include the monitoring and respond to rights violations affecting PLHIV/TB/KVPs during -19 pandemic. 6.3 Engage community leaders to raise awareness on the potential rights-violations in the context of COVID-19 against key and vulnerable populations and engage them as part of the CLM and rapid response. 6.4 Fund HIV and TB community paralegal programs to expand their scope and include COVID-19 emergency response and redress. **Intervention 7: COVID-19 CSS - Community-led monitoring (CLM)** ***Key activities:***

	7.1 Adapt and implement the GF CLM Accountability Toolkit to track the availability, accessibility, acceptability, and quality of HIV, TB and COVID-19 services provided by SRs in the GF supported districts. 7.2 Provide IPOs with tools and equipment e.g., PPE for COVID-19 protection, tablets, airtime, etc. for CLM. **Intervention 8: COVID-19 CSS - Community-led advocacy and research** ***Key activities:*** 8.1 Train community leadership (i.e., traditional, religious, municipal wards, etc.) to support COVID-19 campaigns to increase prevention awareness, address vaccine hesitancy as well as tackle other barriers that impede registration. 8.2 Develop and disseminate simple advocacy materials on the importance of preserving access to HIV and TB services and reproductive health services during COVID-19. **Intervention 9: COVID-19 CSS - Social Mobilisation** ***Key activities***: 9.1 Support social cluster government departments to provide COVID-19 vaccine awareness and acceptance. • DBE and DHE - to learners, student, educators, SMTs and SGBs. • DSD - to the beneficiaries at DSD supported places of safety. • DCS – inmates and correctional services staff. 9.2 Contract / engage youth and women led CSOs / CBOs to support beneficiaries to register for the vaccination. 9.3 Procure data packs / IT support for CSOs / CBOs to aid registration of beneficiaries. 9.4 Engage CSOs/ CBOs to deliver community messaging that address COVID-19 testing, treatment, and vaccine hesitancy to improve community knowledge, perception, acceptance and uptake of COVID-19 contact tracing, vaccine, etc. 9.5 Use existing community platforms (drop-in centres, safe spaces, community-based clinics) as well as community networks to deliver integrated HIV, TB, and COVID-19 services. **Intervention 10: COVID-19 CSS - CBO institutional capacity building** ***Key activities***: 10.1 Train traditional health practitioners (THPs) to recognise HIV, TB, COVID-19 symptoms and refer to clinics. 10.2 Train faith-based sector to elevate their role as psychosocial support providers, as well as influencers in COVID-1 prevention. 10.3 Train CSOs to provide COVID-19 screening, testing, contact tracing in communities including KP hot spots and HTAs.
Rationale	SA's multisectoral COVID-19 response seeks to strike a balance between the biomedical, structural, and behavioural interventions for effective pandemic control. Key activities include protection of frontline and essential services workers to allow for the provision of COVID-19, HIV and TB essential services and minimal disruptions to ensure a sustained response. Facility and community-based supply of PPE remains a priority alongside the repurposing and use of existing laboratory structures for integrated COVID-19, TB, and HIV management. Considering the developing third wave, health products and waste management systems remain relevant. The interventions also require innovative and proven capacity building approaches including task shifting, training, mentoring and ongoing TA as

	informed by situation assessments of transmission levels as well as response capacity and performance that guide the national surveillance strategy. Community-based responses to COVID-19 are pivotal as majority of the proposed C19RM 2021 priorities focus on utilizing community-based systems and structures to mitigate the impact of COVID-19 on service delivery. Community response systems are acknowledged as the hub for implementation and thus should be strengthened to adequately respond to the changing demands as dictated by the evolving COVID-19 public health emergency. Under the C19RM grant and linking with the GF Community Response Systems (CRS) module, CBOs, and civil society sectors (CSS) will be contracted by PRs and SRs and capacitated to play a central role in community-based COVID-19 response including screening, contact tracing, advocacy, and social mobilization. Also, activities prioritised in this section aim to promote uptake of COVID-19 related services including vaccination, GBV and post violence care and linkages to access justice interventions or to legal redress for human rights violations experienced because of COVID-19 restrictions. Community response systems and structures have been set up through the local government, SANAC civil society sectors and the current GF implementation arrangements with SRs. It is critical that the C19RM 2021 prioritised activities be expanded to reach key and vulnerable populations in COVID-19 affected communities. The C19RM 2021 approach is informed by the various stakeholder consultations and C19RM 2020 learnings, which all clearly articulate the need for meaningful community engagement and active participation of community actors in national COVID-19 response thus improve reinforcement of key elements of health systems and community-led response systems.
Expected Outcome	Community response systems are critical for optimal civil society participation in the national COVID-19 response and as such, the successful implementation of the proposed approach will lead to optimal and sustainable health outcomes. This will contribute to reduced COVID-19 infections, increased recovery rates and advancement towards achieving herd immunity as more people get vaccinated. Community based service delivery approaches relieve the health facilities of the heavy workload and reduces health care workers burnout and COVID-19 infections. The multisectoral approach will ensure that all the 18 CSS and their constituencies actively participate in the C19RM 2021 response, leading to wider C19RM 2021 coverage and provision of essential health services. Community leaders and gatekeepers identified as “social influencers” will promote uptake of NPIs leading to reduction of the triple burden i.e., COVID-19, HIV and TB related morbidity and mortality. Lastly, community-led monitoring will enhance the monitoring of accessibility, acceptability and quality of HIV, TB, and COVID-19 services. All the proposed activities under this C19RM 2021 priority will culminate in the reinforcement of the health systems and community-led response systems. By implementing the proposed priority activities above, it is anticipated that the expanded strengthening of health and community-led response systems will enable GF PRs and SRs to implement Year 3 HIV and TB program activities and reach set targets, thereby contributing towards achieving HIV epidemic control and ending the TB epidemic.
Expected Investment	The proposed GF funding amount for this intervention is **US $4 736 103** which includes the *C19RM2020 rollover* amount of ***US $641 248*** and the *C19RM2021 base allocation* of ***US $4 094 855*.**

2.1.1 Provide a brief description/justification for the **high priority** interventions and key activities in the **C19RM Above Base Allocation Request**, including expected outcomes of these interventions and how these will support in achieving grant targets. These interventions and key activities should be in line with C19RM Technical Information Notes and Guidelines[4], applicable WHO guidance (including on COVID-19) and the NSPRP.

a. COVID-19 control and containment interventions	
Intervention & Key activities	As explained in section 2.3.6 above, SA has made available financial resources to strengthen the national COVID-19 response and received financial and non-financial support from donors and the business sector, however the funding gap remains. Activities prioritised in the **above allocation** include new support needs and enhancements of existing interventions including activities initiated through the C19RM 2020 grant. **Intervention 1**: **Case management, clinical operations, and therapeutics** ***Key activities:*** 1.1 Hire additional clinical staff to address HR capacity needs identified. **Intervention 2**: **COVID-19 diagnostics and testing** ***Key activities:*** 2.1 Use mobile units equipped with X-pert testing platforms to provide integrated COVID-19, HIV and TB testing services in hard-to-reach areas, to reinforce diagnostic capacity and as applicable, facilitate expansion of COVID-19 vaccination services. **Intervention 3: Surveillance systems** ***Key activities:*** 3.1 NHLS to employ temporary additional call centre staff to track, manage and report vaccine adverse events for a period of one (1) year. 3.2 Procure additional computer hardware for effective implementation of DATCOV and EVDS. 3.3 Support NICD to recruit temporary additional data analysts and epidemiologists for a period of one year to be sustained using domestic funding beyond C19RM2021 to facilitate real-time data analysis for evidence-based planning and decision making to guide the national COVID-19 response. 3.4 Support NHLS to enhance its genomic sequencing capacity to assess and monitor circulating variants of interest or concern i.e., sequencing supplies, equipment, service contracts or training. 3.5 Support DCS to appointment temporary Surveillance Officers in each region for routine COVID-19 surveillance within correctional services facilities for the period of C19RM2021 funding. **Intervention 4: Surveillance, epidemiological investigation, and contact tracing** ***Key activities:*** 4.1 Conduct local situation assessments to guide local, district, provincial and national COVID-19 response strategy i.e., transmission levels, response capacity and performance e.g., *why is Limpopo vaccine uptake higher than national average?*

[4] Link forthcoming

	Intervention 5: **Infection prevention and control and protection of the health workforce.** ***Key activities***: 5.1 Support DCS to appoint temporary IPC Coordinators per region for a period of 12 months 5.2 Support access to WASH services in public and community spaces most at risk, with special considerations for vulnerable populations e.g., schools, churches, traditional gatherings, SASSA pay points, etc. 5.3 Provide psychosocial support for frontline and essential facility and community-based health care workers. **Intervention 6: Risk communication** ***Key activities:*** 6.1 Involve affected communities, key and vulnerable populations, women and girls, men, or other groups in the development of culturally appropriate COVID-19, messages and information, education, and communication (IEC) materials, and integrate COVID-19 and TB messaging. 6.2 Prepare and disseminate culturally appropriate messages using relevant channels/ structures/ platforms and community networks/ influencers targeting key stakeholders.
Rationale	A significant portion of SA population resides in hard-to-reach areas that demand mobile health services. Through previous GF funding, NHLS invested in mobile units currently used for TB diagnosis and under the C19RM 2021 proposes to further develop its integrated mobile testing and POCT capacity to include TB, COVID-19, and HIV testing, as well as support the national COVID-19 vaccine roll-out. This will be made possible with minimal modifications to the mobile units, procurement of POCT equipment as well as fuel, maintenance, and servicing costs. Genomic sequencing helped SA uncover the circulation of the beta variant of SARS-CoV-2 which is crucial for decision making as it has implications of transmission outcomes as well as vaccine efficacy. Considering the ongoing emergence of new COVID-19 variants, it is critical that the NHLS/ NICD is supported to increase its laboratory genomic sequencing capacity to assess and monitor the circulation of variants of interest or concern. To further strengthen COVID-19 surveillance capacity, the DCS will be supported to deploy surveillance officers in the correctional services setting. All staff employed on a temporary basis are for the period of the grant and beyond that, contracts are terminated except for NICD whose positions will be sustained through available domestic funding. Local situation assessments will also be conducted to guide local, district, provincial and national COVID-19 response strategy based on the respective epidemiological contexts. IPC remains integral to COVID-19 control and containment within the health care setting, in institutions including correctional services setting, and in communities. Thus, access to WASH services in public and community spaces most at risk is vital. Anecdotal data on cluster outbreaks has shown that prisons and social gatherings (funerals, weddings, etc.) are super spreader events. Psychosocial support for frontline and essential facility and community-based health care workers is essential to prevent staff burnout and mental health challenges. Lastly, as vast, and diverse as SA is, the involvement of affected communities, key, and vulnerable populations in the development and dissemination of culturally appropriate messaging and IEC materials, and the use of appropriate

	community platform and networks will be employed to achieve optimal RCCE around COVID-19.
Expected Outcome	Successful implementation of the COVID-19 control and containment activities proposed to bolster the national COVID-19 response will in so doing also strengthen the health system i.e., COVID-19 diagnostics and testing, IPC and OHS and surveillance systems. Under C19RM 2021, the proposed activities will be extended to non-GF supported hot spots to reinforce the national COVID-19 response. Most imperative, adequate and sustainable COVID-19 control and containment will also create a conducive environment for optimal implementation of the existing GF programs targeting key and vulnerable populations including adolescent girls and young women (AGYW), men who have sex with men (MSM), transgender people (TG), people who inject drugs (PWID) and sex workers (SW) in the targeted geographic areas – thereby enable PRs and SRs to reach the set program targets by March 2022 and improving patient level and overall health outcomes.
Expected Investment	The proposed GF funding amount for this intervention is an *above base allocation* amount of **US $63 793 803.**

b. COVID-19-related risk mitigation measures for programs to fight HIV/AIDS, tuberculosis, and malaria	

Intervention & Key activities	**1. Mitigation for <u>HIV</u> programs**
	
	Key activities:
	• Support the development and implementation of sound HIV mitigation plans including service adaptations to ensure uninterrupted HIV service delivery including the following:
	  ○ In collaboration with PRs, DSPs, CBOs and private sector, develop/ review HIV mitigation plans to address program needs identified at all DoH levels, and implement key actions accordingly.
	  ○ Facilitate community-based integrated HIV prevention, treatment, care, and support service provision thus ensure continued access to HIV services across the continuum of care.
	  ▪ Establish adherence clubs and safe spaces as KVP community-based Pick-Up-Points (PUPs).
	  ▪ Scale up the registration / enrolment of stable ART clients onto CCMDD external PUPs.
	  ○ Promote the implementation of the appointment / booking system, particularly high-volume facilities with insufficient external PUPs.
	  ○ Prioritise monitoring and tracing of early and late missed appointments on Tier.Net using CHWs, to improve retention in care.
	  ○ Track progress in the implementation of mitigation plans, and use program data, lessons learned and best practices to continuously improve and sustain quality HIV service delivery.

Rationale	Provision of routine HIV services has been drastically impacted by COVID-19 and measures to mitigate the impact on HIV service delivery are highlighted in the base allocation, mitigation for HIV programs section, above. As the country continues to respond to new COVID-19 surges, it is imperative that robust mitigation plans are developed and implemented to ensure sustained HIV service delivery amidst current and potential future COVID-19 surges.

Expected Outcome	Current GF HIV programs provide comprehensive HIV services to key and vulnerable populations including AGYW, MSM, TG, PWID and SW whilst the DoH provides these services to all adults and children. To mitigate the impact of COVID-19 on HIV programs, the DoH in collaboration with PRs, DSPs, CBOs, and private sector will develop/ review and implement HIV mitigation plans to address program needs identified including facilitating community-based service provision, promoting use of booking systems as well as prioritising the tracking of early and late missed appointments to ensure continuous access to essential HIV services for key affected populations. Of note, it is anticipated that the uninterrupted HIV service delivery will ensure GF PRs and SRs achieve the program targets set, which in turn will lead to the achievement of overall GF program goals. Moreover, continuous HIV service delivery will improve patient outcomes for PLHIV, as well as contribute towards HIV epidemic control.
Expected Investment	The proposed GF funding amount for this intervention is an *above base allocation* of **US $ 7 419 932.**

Intervention & Key activities	**Mitigation for <u>TB</u> programs**
	Key activities:
	• Support the development and implementation of comprehensive TB mitigation plans to ensure continuous TB service delivery.
	  ○ In collaboration with PRs, DSPs, CBOs and private sector, develop / review TB mitigation plans to address program needs identified at all DoH levels.
	  ○ Facilitate community-based integrated TB prevention, treatment, care, and support service provision to minimise service disruption e.g.,
	  ▪ Home-based patient monitoring, counselling, and sputum collection.
	  ▪ Delivery of TB treatment through CCMDD or at home by community health workers.
	  ○ Screen all GF KVP program beneficiaries for TB using the TB Health Check app
	  ○ Monitor progress in the implementation of mitigation plans, and use program data, lessons learned and best practices to always improve and sustain quality TB service provision.

Rationale	As depicted in the ***figures 7, 8 and 9*** above, COVID-19 has negatively impacted TB service provision. In the backdrop of a high TB burden, accompanied by high HIV/TB co-infection rate (~60%), and a significant DR-TB caseload, SA cannot afford to have TB service interruptions amidst COVID-19 surges. As such, it is imperative that sound TB mitigation plans, including that promote community-based TB service delivery are developed and implemented, and implementation progress monitored to facilitate sustained TB service delivery which in turn will result in improved TB patient outcomes, and ultimately propel SA towards achieving its goal of ending the TB epidemic. As described in the mitigation of TB programs part of the base allocation section above, comprehensive TB prevention, diagnosis, treatment, care, and support are covered in the three current GF grants namely, the *SA HIV and TB grant*, the *TB Optimization grant* and the *C19RM 2020 grant*. Like the TB activities proposed

	in the base allocation section above, the single TB activity proposed in the mitigation of TB programs piece of the above allocation section is directed at mitigating the impact of COVID-19 on TB programming.
Expected Outcome	Effective implementation of comprehensive TB mitigation plans will ensure ongoing provision of TB services, which in turn will lead to improved patient outcomes, and progress towards SA's goal of ending the TB epidemic. The integration of COVID-19 services into routine TB programming will promote efficiencies as well as leveraging of COVID-19 IPC resources for TB IPC. Lastly, continuous TB service delivery will enable GF PRs and SRs to reach set program targets, leading to the achievement of overall GF program goals.
Expected Investment	The proposed GF funding amount for this intervention is an *above base allocation* amount of **US $3 679 169.**

c. Expanded reinforcement of key aspects of health systems and community-led response systems	
Intervention & Key activities	**Intervention 1: Laboratory systems.** ***Key activities***: 1.1 Support the NHLS to procure IT equipment and software to enhance programmatic data visualization via Business Intelligence Dashboards, to inform interventions (disease hotspots, treatment interventions and disease impact). **Intervention 2: COVID-19 CSS - Social mobilisation** ***Key activities***: 2.1 Support the DBE Multimedia Campaign to end gender-based violence (GBV), violence against children (VAC), sexual abuse and other forms of child exploitation - television and radio broadcasting. **Intervention 3: COVID-19 CSS - CBO institutional capacity building** ***Key activities***: 3.1 Build the capacity of private sector small enterprises members to comply with COVID-19 regulations as well as disseminate COVID-19 information within their networks. • Offer COVID-19 prevention education and awareness training to people living in the street, waste pickers, taxi drivers and informal, and help them use the new knowledge to improve compliance with national COVID-19 regulations.
Rationale	To enhance HIV, TB, and COVID-19 programmatic data visualization via business intelligence dashboards, and to inform interventions i.e., disease hotspots, treatment interventions and disease impact, NHLS will be supported to procure IT hardware and software. In addition, NHLS will be supported to integrate digital health solutions into the laboratory value chain to enhance HIV, TB, and COVID-19 patient care. The DBE Multimedia Campaign is an intervention designed to end GBV, violence against children (VAC), sexual abuse and other forms of child exploitation, which are endemic to SA. Considering the prevalence of the various types of violence and abuse among children, which is also aggravated by the COVID-19 related

	lockdowns, the DBE has identified the intervention as a priority for inclusion in this C19RM 2021 funding request. Small to medium business enterprises play a critical role in the economy and yet with COVID-19, many have either closed shop or are not operating in line with national COVID-19 regulations especially, the informal sector e.g., informal traders, waste collectors, taxi drivers, etc. Through C19RM 2021 grant, the informal sector members will be offered COVID-19 prevention education and awareness training, to improve their knowledge, understanding and application of COVID-19 prevention measures including NPI.
Expected Outcome	It is expected that the proposed NHLS activities above will enhance programmatic data visualization thus improve results delivery and shorten turnaround time, inform the COVID-19 response interventions as well as improve COVID-19 patient care, leading to improved patient outcomes. Successful implementation of the DBE Multimedia Campaign is expected to help address GBV, violence against children (VAC), sexual abuse and other forms of child exploitation which are exacerbated by the COVID-19 lockdowns, with the goal of ultimately ending the scourge. Offering COVID-19 prevention education and awareness training to members of the informal sector is expected to help them better understand the relevance and importance of using the new COVID-19 knowledge to improve compliance with national COVID-19 regulations including adherence to the NPIs. To conclude, all activities proposed above contribute towards strengthening the national multisectoral COVID-19 response. Furthermore, implemented effectively through the existing GF implementation arrangements, these activities will ultimately contribute to the grant targets of the GF PRs and SRs implementing the respective GF programs, and eventually the overall GF program goals.
Expected Investment	The proposed GF funding amount for this intervention is an *above base allocation* of **US $5 622 089.**

2.4 Implementation arrangements

2.4.1 Describe the proposed **implementation arrangements** and how these will ensure efficient program delivery. Please elaborate on:

a. **Health products management:** planned mechanisms for the procurement of COVID-19 health products. Describe entities responsible for forecasting/quantification, procurement, storage and distribution and monitoring of supply availability and delivery of COVID-19 specific health products to beneficiaries and service delivery sites (and clarify if these are different from current service delivery points for HIV, TB, and malaria. Please include a summary of any foreseen in-country supply chain risks, including any regulatory barriers.

Planned mechanisms for the procurement of COVID-19 health products.

NDoH:
The NDoH and its SRs will procure PPE using the service providers already contracted to supply PPE under the NDoH and SRs tenders. The NHLS will be responsible for the procurement of the SARS COV 2

test kits and equipment. The NHLS procurement processes will be utilised and an MOU between NDoH and NHLS executed to enable transfer of funds to NHLS to undertake the procurement.

Forecasting/quantification procurement
The NDoH and its SRs undertook the quantification and forecasting for the PPE. Quantification of the SARS-CoV-2 Test kits and equipment was undertaken by the NHLS.

Storage and distribution
The NDoH contracted a service provider to undertake quality assurance (QA), storage and distribution of health products (PPE and SARS CoV2 Test kits) procured with C19RM 2020 funds. The existing contract is for a duration of one year i.e., 14 January to 31 December 2021 however, additional bulk procurement of PPE to be undertaken with C19RM 2021 funds informs the need to extend the contract with the existing service provider to ensure continuation of the QA, storage, and distribution services.

Monitoring of supply availability and delivery of COVID-19 specific health products to beneficiaries and service delivery sites
The NDoH rolled out the Stock Visibility Solution (SVS) which includes a PPE Availability Dashboard for monitoring availability of PPE in the facilities. All the data feeds into the National Surveillance Centre. Facilities are expected to report PPE stock availability on a weekly basis. The PPE service provider has an established Warehouse Management System which includes inventory management. All orders for distribution of PPE to the provinces are shared with service provider by NDoH, and the service provider distributes the stock to a central location (Provincial Depots). The provinces are responsible for last mile distribution to the facilities based on the gaps in the provinces.

AFSA:
AFSA is recruiting a Health Products Management (HPM) Manager to oversee supply chain management (SCM) activities at PR level and support all AFSA-contracted implementers. All health products procurement (i.e., PrEP, RDTs, PPE, etc.) will fall under the HPM Manager's portfolio.

The incumbent will be responsible for forecasting /quantification, procurement, storage, distribution and monitoring of supply availability and delivery of COVID-19 specific health products to service delivery sites. Implementing organizations (SRs, SSRs, IPOs) will be responsible for on-site storage, distribution to end-user /beneficiaries and monitoring use and accountability. All implementing sites fall under current AFSA/GF subdistricts and are already implementing GF programs.

Critical products required for community-based COVID-19 prevention are face cloth masks, sanitizers (hand & surface) and these products are readily available. Supply has matched demand following the initial COVID-19 wave and supply shortages. PPE required at community level is basic, and no supply nor regulatory challenges are anticipated. Other important PPE required by clinical teams working at PHC setting include N95 masks, surgical masks and surgical gowns, face visor, surgical gloves, goggles, digital thermal scanner, head cover, plastic aprons as well as digital thermal scanners and batteries. These products are also readily available however to mitigate impact of stockouts, buffer stock will be stored at AFSA privately contracted warehouse. In addition, each implementer will have small-sized storeroom to ensure uninterrupted supply of basic PPE.

NACOSA:
Forecasting/quantification
Forecasting and quantification is initially done by the PR at budgeting stage. Throughout the funding period further forecasting and quantification of COVID-19 health products will be done by both the PR and implementers. This will be done on a needs / ad-hoc basis. Implementers are required to submit COVID-19 health products monthly reports to the PR.

Procurement
Decentralised and smaller / urgent procurement is done by implementers. Large procurement orders that may result in cost efficiencies due to economies of scale will be done by the PR.

Storage

Both the PR and implementers are responsible for sourcing adequate storage facilities for COVID-19 health products. Temperature and security control measures are considered as applicable.

Distribution
Distribution of COVID-19 health products to implementers following centralised / large procurements are performed by the PR. COVID-19 HPP delivery to DSD will be done by the PR to major depo's, from where the health products will be further distributed by DSD to their subsidised organisations.

Monitoring of supply availability and delivery of COVID-19 specific health products to beneficiaries and service delivery sites
Monitoring of supply availability and delivery of COVID-19 specific health products to beneficiaries and service delivery sites is done via monthly stock cards. Stock cards are maintained by implementers and submitted to the PR monthly. Existing service delivery points include implementer sites whilst additional service delivery sites include DSD sites.

Foreseen in-country supply chain risks, including any regulatory barriers.
There is a potential risk of national stock-out of certain PPE products. Foreseen risks also include corruption and thus COVID-19 PPE not reaching the intended beneficiaries. There is a risk of expiry dates of certain PPE stock being exceeded. Further risks include implementers non-compliance with regulatory requirements for PPE devices and products. Should supplier and delivery personnel contract COVID-19 this could result in delays in procurement and delivery of COVID-19 health products.

BEYOND ZERO
BZ in conjunction with district health management are responsible for forecasting/quantification. BZ is responsible for procurement, storage and distribution and monitoring of supply availability and delivery of COVID-19 specific health products to beneficiaries and service delivery sites. This is different to the current service delivery point as DOH procures from suppliers who deliver to a central depo and the distribution is through health facilities. BZ does not foresee any in-country supply chain risks or regulatory barriers.

b. **Financial flows**: When funding is received by the Principal Recipient, indicate which other local entities/government departments (if any) will also receive funding for the interventions proposed. Please include a summary of funds flow and internal control risks foreseen (if any).

The SA GF CCM endorsed four PRs to implement the current grant cycle i.e., April 2012 – March 2022, as follows:

- National Department of Health
- AIDS Foundation South Africa (AFSA)
- Networking HIV and AIDS Community of Southern Africa (NACOSA)
- Beyond Zero

It is proposed that the C19RM 2021 funding flow be channeled through existing PRs, thereby allowing them and their SRs to implement the C19RM 2021 new activities in addition to the C19RM 2020 activities. While the CCM will ensure optimal application of existing implementation arrangements to facilitate rapid and effective delivery of the C19RM 2021 interventions, new implementers will be considered in exceptional circumstances, with ability to implement proposed interventions with swiftness assurance.

The C19RM 2021 grant will be integrated into current GF grants, and PR reporting on progress of implementation as well as financial performance will largely be provided as part of the current scheduled Progress Update and/or Disbursement Requests ("PU/DR"). This is further elaborated upon in the C19RM Financial Flows (Annex 8).

c. **Data flows**: The flow of information and reporting from service delivery points. Which entity in the country is responsible for collecting, collating, and reporting on national COVID-19 response related

programmatic indicators? What mechanisms are in place for the Principal Recipient to engage with this entity and report COVID-19 related data from service delivery sites? Please include a summary of indicators reported, data availability and reporting completeness and data quality risks foreseen (if any).

The overall data collection, collation and reporting on the national COVID-19 response related programmatic indicators is bestowed upon the NDoH as the custodian of public health programs. Working closely with the multisectoral COVID-19 response teams, the NDoH has developed a set of 23 indicators as outlined in the *SA National Plan for COVID-19 Health Response* ***(Annex 1).*** Whilst the indicators have different reporting frequencies, the NDoH publishes a daily "*Progress on COVID-19*: *South Africa's Public Health Response"* to communicate COVID-19 tests conducted, new and cumulative COVID-19 cases, COVID-19 related deaths, recoveries, and hospitalisations. COVID-19 data is collected at the point of service delivery using standardized data collection tools. The current GF SRs then submit the reports to their respective district DoH counterparts who then collate, consolidate, and report on district COVID-19 response prior submission to the provincial DoH. Ultimately, the provincial COVID-19 data is transmitted to the NDoH and forms part of the daily progress on COVID-19 report.

C19RM grant does not have a separate Performance Framework but rather uses the core GF programmatic indicators as proxy to measure the impact of C19RM funded interventions. The CCM has recommended that a performance monitoring framework be developed to assess C19RM 2021 performance, hold PRs and their SRs accountable and most importantly determine the value for money for this GF investment using various methods e.g., monthly/ quarterly reports, in alignment with the existing GF reporting processes and using GF and CCM accountability structures.

d. **Coordination and oversight**: The supervision and oversight mechanisms in place for the national COVID-19 response, including for quantification or needs assessment, procurement, storage and distribution of COVID-19 products. Which type of periodic reporting and monitoring (including community-led monitoring) will be done at each of the following levels: locally, regionally, to the national COVID-19 response taskforce and to the Principal Recipient? How will the CCM and Principal Recipient follow up on progress to implement the planned activities? Please include a summary of the governance and oversight risks foreseen (if any).

In line with current the GF grant implementation, the C19RM 2021 will be planned and coordinated with district, provincial and national stakeholders, and in close collaboration with the Provincial Councils on AIDS, District AIDS Council and civil society structures.

To further strengthen program delivery, funding is requested to strength the capacity of the Technical Support Unit (TSU), by recruiting a C19RM Technical Lead and the Finance Administrator. The C19RM Technical Lead will work closely with the PRs to provide oversight of implementation, monitoring, evaluation and review of the C18RM grant, working directly with the TSU to ensure alignment of efforts to provide GF-related technical assistance (TA) and capacity development to the PRs through the quarterly Operational Performance and Efficiency Coordination (OPEC) meetings, the six-monthly in-depth Country Portfolio Reviews (CPR) meetings for all program areas, the Oversight Committee and the SA CCM.

2.4.2 Describe the role that **community-based organizations** (CBOs) will play under the implementation arrangements. Please also indicate whether there are opportunities to reinforce the role and effectiveness of CBOs in the national COVID-19 response, including through supporting the most vulnerable communities, community tracing, supported isolation and addressing vaccine hesitancy.

Generally, CBOs are situated at the program implementation level, and thus well placed to play a very critical role in implementation of C19RM 2021 activities. CBOs in SA are often representative of the various civil society sectors and are closest to the people affected by COVID-19. As such, they are pivotal in

implementing community level advocacy and social mobilization activities to foster COVID-19 NPIs i.e., wearing of masks, social distancing, and hand hygiene, and promote routine uptake the of COVID-19 related interventions namely, COVID-19 screening, testing, contact tracing, supported isolation, etc.

A rapid assessment of the current SA vaccine uptake status reveals notable vaccine hesitancy and local CBOs are well poised to educate, demystify, and encourage COVID-19 vaccination services uptake through culturally appropriate and cost-effective RCCE, advocacy and social mobilization interventions. It is anticipated that through the C19RM 2021 grant, local CBOs will be contracted to implement community-based activities to promote uptake and sustainability of interventions to benefit the most vulnerable communities.

2.5 Funding landscape, efficiency and sustainability

2.5.1 Based on the analysis in the C19RM Funding Landscape Table, describe the funding need and available funding from domestic resources, loans, and donor grants for the different components of the health sector response to COVID-19, highlighting major funding gaps. Also, describe how national authorities will work to secure additional funding or new sources of funding for the COVID-19 health response, including any new applications to development banks and other donors that the applicant intends to submit or is pending approval.

Upon the announcement of the first case in SA, government took a deliberate decision to unlock funds to unleash a strong national COVID-19 response. The presidency established a funding mechanism through the Solidarity Fund to mobilise resources to respond to COVID-19. Business, development partners (including PEPFAR, KfW, BMGF, etc.), individuals and other stakeholders pledged their support to national COVID-19 response through financial and non-financial donations. Available National Treasury Budget Review 2021 data shows that SA raised an estimated ZAR 21,65 billion domestically, and the NDoH has received an excess of ZAR 4,5 billion in donations from various stakeholders.

GF issued a call for C19RM 2020 applications in April 2020 and SA responded as per CCM directive. Upon approval, SA received a total of US $36,059,867 to implement COVID-19 priority interventions in line with GF guidelines from August 2020 until June 2021. At this point, CCM is seeking GF permission to use C19RM 2020 unspent funds to implement outstanding activities until December 2021. C19RM 2020 grant was implemented by existing PRs using set implementation arrangements, refer to ***table 1*** C19RM 2020 expenditure with commitments as of 31 June 2021.

The emergent third wave and the rolling phased COVID-19 vaccination programme demand that SA government continues to mobilise resources for a sustained and well-balanced COVID-19 response. According to the "*Estimating cases for COVID-19 in SA modelling"* an amount of R30 billion was required to mount, reinforce, and sustain a solid national COVID-19 response. Based on the domestic financial COVID-19 allocation from the National Treasury and the external financial and in-kind support received to date, SA has managed to pool an estimated ZAR 26,15 billion to bolster the national COVID-19 response, ***a funding gap of ZAR* 3,85 billion** remains. SA is persistently on a resource mobilization mission and continuously engages donors, private sector, and individuals to bolster the national COVID-19 with both financial and non-financial support.

2.5.2 Briefly describe how the current government budget and medium-term health budget incorporates additional funding to mitigate the impact of the COVID-19 pandemic, with specific reference to measures taken to ensure that government commitments and plans for domestic financing of HIV, TB and malaria are not adversely impacted.

SA reported its first COVID-19 case in March 2020, the last month of the government's financial year (FY), which implies that there was limited, or no financial resources set aside to mount a comprehensive national response to the unforeseen large-scale COVID-19 public health emergency. However, as soon as COVID-

19 was declared a global pandemic, SA quickly mobilized and re-directed funds from various government budgets/ sources towards the national COVID-19 response. For FY 2021/22, a total of **ZAR21,65 billion** has been made available through the National Treasury and ***table 4*** below unpacks how these funds are apportioned.

Table 4: National Allocation - FY 2021/22

National Allocation	Amount in ZAR
1. NDoH - COVID-19 Vaccine Procurement and Distribution	**6,5 billion**
2. COVID-19 component of HIV, TB, and Malaria allocation	**3,4 billion**
3. Other Research for Vaccines	**1,25 billion**
4. South African medical Research Council (SAMRC) - Vaccine Research	**100 million**
5. PDoH – Vaccine Administration	**2,4 billion**
6. Provincial Allocation - equitable share through National Treasury in 2021/22 • *To enable PDoHs to continue their prevention, testing and treatment interventions, including managing hospitalisations resulting from the emergent third wave of COVID-19 infections, and PPE procurement.*	**8 billion**
Total	**21,65 billion**

2.5.3 Explain how the C19RM Full Funding Request reflects value for money, including specifying how the lowest costs of quality inputs required for COVID-19 response will be ensured, how the limited resources will be allocated and utilized strategically to maximize impact and how recurrent costs of Global Fund C19RM capital and system investments will be subsequently sustained by domestic funding.

NDOH

PPE Procurement

C19RM funding was prioritised for the procurement of PPE which is to serve as buffer stock thus enabling PPE stock piling. The status of availability of PPE from the National Surveillances Centre supports the informed push model with stock distributed to areas / provinces that report low levels PPE supplies as well as provinces that experience greater need when the impact of third wave (or potential future surges) is assessed nationally. Availability of sufficient quality PPE in the facilities is imperative to ensuring health workers are protected to undertake their roles and essential service provision is sustained. This is an ongoing activity that continues to add value in the national COVID-19 response. To cater for the constant need for PPE, PDoHs procure PPE through their existing mechanisms. Under NDoH, the National Treasury and NDoH have advertised a tender to appoint service providers to supply PPE enabling the continuity of supply of PPE through domestic funds.

Procurement of PSA Plants

The procurement of PSA plants for on-site oxygen production at selected district hospitals is identified as a priority input in the management of COVID-19 cases at district level. A review of the national surveillance system for laboratory-confirmed COVID-19 hospital admissions (DATCOV) revealed high mortality rates at peripheral and district hospitals, attributed to inadequate oxygen infrastructure. From the oxygen infrastructure assessments carried out at 128 DoH hospitals across provinces, 57 hospitals were deemed to require the installation of mini-bulk liquid oxygen tanks or oxygen concentrators. A further prioritisation of 30 hospitals was done based on i) *case load*, ii) *burden of disease*, iii) *rurality or remoteness of the facility* and iv) *status of access roads for bulk oxygen road tankers*. With the rolling surges and the emergence of new variants, the need to invest in district hospital oxygen infrastructure is more urgent than ever as medical oxygen remains the first line treatment for moderate to severe COVID-19 cases. The

procurement of PSA plants through this C19RM funding is meant to bolster the existing inadequate oxygen infrastructure without duplication of efforts nor creation of parallel systems.

The PSA plants to be procured using C19RM funds will be integrated into the current provincial oxygen supply framework and will be used to ensure the oxygen supply meets the demand and the gap identified at the 30 priority hospitals is addressed to strengthen the district COVID-19 response. This priority intervention is in line with the "*National policy on the use of medical oxygen in health care",* ***Annex 6*** and as such the recurrent costs of the proposed GF C19RM capital and system investments in oxygen supply infrastructure at the 30 priority district hospitals will be sustained by domestic funding beyond GF C19RM support.

NHLS SARS-CoV-2 Tests
To strengthen POCT in the public sector, the NHLS procured, equipped, and distributed mobile vans with the Gene Xpert machines countrywide. The Cepheid Xpert Xpress test kits used in these machines will be procured using C19RM funds. The bulk of the Cepheid Xpert Xpress test kits procurement is done by the NHLS, and the GF funds are used to procure buffer stock.

Genomic sequencing laboratories
With the evolution of the COVID-19 pandemic, new variants of the *SARS-CoV-2* are constantly emerging. As the preferred laboratory services provider for all public sector health facilities, the NHLS continues to lead the COVI-019 laboratory work. The NHLS proposes to enhance its laboratory genome sequencing, capacity to inform SA's response to the pandemic. The C19RM investment will be used to improve NHLS sequencing capacity, including costs associated with procurement of equipment, sequencing supplies, service contracts or training. Accordingly, the NHLS will be responsible for ensuring that the laboratory equipment procured is optimally utilised and always functional by investing in adequately trained and qualified staff to carry out the sequencing work.

AFSA
AFSA will incorporate C19RM activities within existing GF implementers (SRs, SSRs, CBOs, IPOs), except where this incorporation is deemed risky for achievement of SR core deliverables. AFSA will apply existing approved company procurement policies to procure lowest price for the same specification and quality and adhere to treasury guidance on items approved and recommended prices.

Good quantification and demand forecasting, bulk-buying, and warehousing will be used to obtain lowest costs possible and prevent emergency buying. AFSA will procure from local small businesses, women-owned and youth-owned businesses, to obtain low prices and minimize delivery costs. AFSA will also follow NDoH PPE guidelines to ensure compliance to approved standards and prevent inadequate protection and overuse of products not required for the level of risk anticipated within the setting. The AFSA PPE procurement plan, ***Annex 7***, will be popularized and institutionalized to improve compliance and adhere to stipulated AFSA procurement processes.

NACOSA
PRs were requested to use April 2020 Treasury pricing unit costs for budgeting for COVID-19 health products, however NACOSA's experience over the CA19RM implementation period showed that actual purchased COVID-19 health products' unit costs were much lower than Treasury guideline prices. NACOSA decreased quantities (where needed) in the C19RM 2021 budget to allow for anticipated lower prices which will enable us to effect value for money. The latter will be established by sourcing competitive pricing and following procurement processes as per NACOSA's procurement policy. NACOSA's COVID19 management unit will continuously monitor the need for PPE in implementation areas. NACOSA and its implementers needs will be considered in relation to national and provincial COVID19 needs and responses.

BEYOND ZERO
BZ's procurement policy will be followed in fulfilling C19RM 2021 activities. The policy is designed to ensure we obtain the best possible quality products and services at the best possible prices. First preference is for government to provide PPEs for testing sites and for the BZ to only provide PPEs where there are delays on government side.

2.6 Attachments supporting the C19RM Full Funding Request

Use the list below to verify the completeness of your application package:

☒	C19RM Funding Request Form
☒	C19RM Consolidated Budget (including C19RM Above Base Allocation Request)
☒	Quantification or needs assessment for COVID-19 health products (including contribution and projected pipeline from domestic and other sources of funding) (any format suitable to the applicant)
☒	COVID-19 National Testing Strategy
☒	C19RM Health Product Management Template (HPMT) per grant
☒	C19RM Funding Landscape Table
☒	CCM Endorsement of the C19RM Full Funding Request[5]
☒	Endorsement by the national COVID-19 response coordinating body of the COVID-19 control and containment interventions of the C19RM Full Funding Request (where relevant)
☒	National Strategic Preparedness and Response Plan for COVID-19 and budget (ideally for 2021)
☒	HIV, TB and malaria program mitigation plans (where relevant) `- (SANAC developing NSP catchup plans)
☒	List of Civil Society suggestions for inclusion in the C19RM Full Funding Request

[5] https://www.theglobalfund.org/en/funding-model/applying/materials/