



Global Health Initiative Strategy 2011-2016

South Africa

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Acronym List

AEF	Aid Effectiveness Framework for Health
ANC	Antenatal Care
ASSA	Actuarial Society of South Africa
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
CPA	Central Procurement Authority
CYCW	Child and Youth Care Workers
DALY	Disability-Adjusted Life Years
DBE	Department of Basic Education
DCM	Deputy Chief of Mission
DHS	District Management Team
DMT	District Management Team
DBE	Department of Basic Education
DoD	Department of Defense
DoS	Department of State
DSD	Department of Social Development
DR-TB	Drug resistant tuberculosis
FDA	Food and Drug Administration
GCF	Gender Challenge Fund
GDD	(CDC) Global Disease Detection
GF	Global Fund for AIDS, Tuberculosis, and Malaria
GHI	Global Health Initiative
HAART	Highly Active Antiretroviral Therapy
HCT	HIV Counseling and Testing
HEARD	Health Economics and HIV/AIDS Research Division
HAST	HIV/AIDS, Sexually Transmitted Infections, and Tuberculosis
HRH	Human Resources for Health
LCD	Local Capacity Development
IP	Implementing Partners
KZN	KwaZulu Natal
MCC	Medicines Control Council
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR	Multi-drug Resistant
MEPI	Medical Education Partnership Initiative
M&E	Monitoring and Evaluation
MNCWH	Maternal, Neonatal and Child and Women's Health

NEPI	Nursing Education Partnership Initiative
NCD	Non-communicable diseases
NDOH	National Department of Health
NIMART	Nurse-initiated Management of Anti-retroviral Therapy
NSDA	(National Department of Health) Negotiated Service Delivery Agreement
NSP	National Strategic Plan on HIV, STIs, and TB, 2012-2016
OIH	Office of International Health (PEPFAR Secretariat)
OVC	Orphans and Vulnerable Children
PF	Partnership Framework
PFIP	Partnership Framework Implementation Plan
PHC	Primary Healthcare
PMTCT	Prevention of Mother to Child Transmission
RH/FP	Reproductive Health/Family Planning
RPCRV	Returned Peace Corps Response Volunteers
SAG	South African Government
SA	South Africa
TB	Tuberculosis
USAID	United States Agency for International Development
USG	United States Government

I. South African Government's Vision for Health

Under the Global Health Initiative (GHI), the U.S. Government (USG) South Africa health team is aligning with the South African government (SAG) to support Outcome Two of the Medium Term Strategic Framework (2009 – 2014) – A Long and Healthy Life for All South Africans – to improve the health status of the entire population. The GHI Strategy will contribute to the SAG vision and reflects and supports the four strategic outputs of the Health Negotiated Service Delivery Agreement (NSDA) adopted in January 2010 that the health sector must achieve:

1. Increasing life expectancy;
2. Decreasing maternal and child mortality;
3. Combating HIV and AIDS and decreasing the burden of disease from tuberculosis; and
4. Strengthening health system effectiveness.

The SAG aims to broaden and deepen the extent and scope of community involvement and social mobilization in all aspects of health provision at the local level. The USG South Africa health team, consisting of the Centers for Disease Control and Prevention (CDC), Department of Defense (DoD), the Food and Drug Administration (FDA), Department of State (DoS), Peace Corps, and the United States Agency for International Development (USAID), will support these efforts through a “whole-of-government” approach that aims to improve overall national health outcomes. Given that USG resources in South Africa are primarily funded through PEPFAR to support HIV/AIDS programs (99%), South Africa's GHI strategy will look to leverage HIV/AIDS programs to support and strengthen the systems overall at national, provincial, district, and local levels. In the context of South Africa's Partnership Framework (PF) with the United States (signed December 14, 2010), the SA GHI Team will work to foster country-ownership and sustainability and promote smart integration as USG transitions the balance of programs from direct service delivery to technical assistance. During the development, of the PF, the SAG emphasized that it should be rooted in the GHI. The GHI Strategy will therefore align with the NSDA and the PF to focus on targets and outcomes for HIV/AIDS and TB as well as linkages with MCH, nutrition, and reproductive health/family planning (RH/FP). This will be done in the context of the SAG shift to strengthen their District Health System (DHS) and its implementation of the new Primary Healthcare (PHC) model. Transition of programs to support these models will allow the USG to leverage the PEPFAR platform to create strong linkages with other health areas, achieve greater impact on overall health problems, and contribute significantly to health and social system strengthening. Thus, the South Africa GHI strategy will focus on three strategic focal areas: **(1) supporting PHC re-engineering, (2) improve management, and financial systems, and (3) integrate management of TB, HIV, and other diseases.**

II. GHI Priorities and Context for South Africa

Context

South Africa has four concurrent epidemics that heavily burden the health sector – HIV/AIDS and TB, poverty related illnesses (perinatal, neonatal, childhood, and maternal diseases), non-communicable diseases, and violence and injury. Although South Africa is considered a middle income country and spends more on health than many other developing countries, its health outcomes are worse than those in many lower income countries. This is reflected in South Africa's lack of progress to achieve Millennium Development Goals (MDGs) 4 and 5, relating to child and maternal mortality. Child mortality initially increased from the MDG baseline in 1990 of 60 deaths under the age of 5 years per 1,000 live births, peaked at 82 deaths/1000 births in 2003, and finally decreased to 57 deaths/1000 births in 2010. The maternal mortality ratio is an estimated 625 maternal deaths per 100,000 live births. HIV and its related diseases contribute significantly to maternal mortality (50%) and mortality under five years of age (35%).

Key Indicator	
Adult mortality rate (per 1000 adults 15-59 years both sexes)	496
Under-five mortality rate (per 1000 live births)-both sexes	62
Maternal mortality ratio (per 100000 live births)	410
Life expectancy – Male (years)	54
Life expectancy – Female (years)	55
Stunting Prevalence -Children under 5 (percentage)	28
DTP3 immunization among 1-year olds (percentage)	62
Health workforce-Nurses & Midwives (per 10000)	40.8
Health workforce-Physicians (per 10000)	7.7
Tuberculosis prevalence (per 100000 population)	808
HIV prevalence (per 1000 adults 15-49)	178

Source: sASSA andSource: WHO South Africa Health Profile. Updated: 4 April 2011.

While the burden from infectious disease (namely HIV/AIDS and TB) in South Africa steadily persists, non-communicable diseases (NCDs) are on the rise, particularly for impoverished populations. NCDs accounted for 35% of the disease burden in 2000. While chronic disease is most prominent in the urban poor population, it is increasingly emerging in rural areas as well.

Many South Africans are affected not only by HIV and TB co-infection, but also have co-existing non-communicable diseases such as hypertension and diabetes. Rising death rates from diabetes, hypertensive and kidney disease, and prostate cancer demonstrate the need for increased measures to prevent and mitigate the impact of chronic disease and create comprehensive chronic care models at primary care and community levels.

HIV/AIDS is a leading cause of morbidity and mortality in South Africa with an adult HIV prevalence of 16.9% and approximately 5.6 million people living with HIV/AIDS. South Africa's health system is heavily burdened by the epidemic, which severely affects a wide range of the population's health outcomes including life expectancy, currently at 54.9 years for men and 59.1 years for women.ⁱ South Africa is a country that exemplifies the relationship between HIV and gender-based violence; gender-based violence has contributed to women and girls bearing 60% of the HIV disease burden.

PEPFAR's significant contribution to the SAG's HIV/AIDS and TB program has led to positive effects on life expectancy, infant mortality, and HIV-related mortality. Though still low, life expectancy has increased as noted above over the 2007 rates at the start of the previous NSP [50.9 years for men and 54.9 for women]; it is estimated that deaths due to HIV/AIDS have fallen by nearly 25%, from 257,000 in 2005 to 194,000 in 2010. Infant mortality also dropped from 46.9/1,000 live births in 2008 to 37.9, and by mid-2010 there were 1.2 million maternal AIDS orphans, down from 1.6 million projected for 2010.ⁱⁱ

South Africa continues to grapple with massive health inequities, a legacy of the apartheid. There are marked differences in rates of disease and mortality between races (National Planning Commission Report, 2011), and the South African public healthcare system is experiencing a major crisis due to growing demands on limited resources, primarily due to HIV and TB. From 2004 to 2011, PEPFAR expended \$3.2 billion to support health system strengthening and the scale-up of prevention, care, and treatment services for HIV and TB. Since 2009, the SAG, under the leadership of President Jacob Zuma and Minister of Health Aaron Motsoaledi, has dramatically increased financial support and currently funds approximately two-thirds of the HIV/AIDS response. In 2005, there was coverage for 8% of people requiring ART, but by 2010, 80% coverage was achieved for those with a CD4 < 200. Data from the National Department of Health (NDOH) indicate that currently 1.7 million people are on treatment, with 470,000 newly initiated in the last 12 months, of whom 100,000 are children. PEPFAR provides 35 - 40% of funding needed for the antiretroviral treatment program, and other donors provide <5%). The South African healthcare system is experiencing a major crisis due to growing demands on limited resources:

- Demand for health and particularly HIV services has moved away from the PHC level, significantly limiting access;
- Reliance on hospital and facility-based delivery models with little capacity at the primary care level;

- Serious human resource challenges are reflected in severe staff shortages and inadequate capacity of existing staff;
- Major capacity and coordination challenges exist among national, provincial, and district levels of the public health system and between SAG, civil society, and non-governmental organizations that deliver health services and promote community systems to improve health;
- Major weaknesses in physical infrastructure and supply chain management are driven by inadequate health management information systems, budget forecasting, and strategic planning;
- Life threatening challenges with infection control; and
- Inadequate information management for decision-making (collection, reporting, and data use), particularly at clinic and district levels.

Alignment with the SAG Health Plan

The South Africa GHI Strategy is aligned with the country's health plan defined in the Health NSDA and the multisectoral National Strategic Plan for HIV/AIDS, STIs, and TB (NSP). A Bilateral Team was established for the development of the PEPFAR Partnership Framework (PF) and its Implementation Plan (PFIP). This team will also be responsible for overseeing the implementation of the SA GHI Strategy to ensure country ownership and country-led planning for joint activities. The three focus areas outlined in the GHI strategy represent critical factors that must be addressed for South Africa to achieve its health goals. While PEPFAR funding will focus directly on combating HIV/AIDS and HIV/TB co-infection, the PEPFAR platform will be used to enhance and leverage activities that strengthen the overall health system, thereby affecting the four Health NSDA strategic outcomes and facilitating implementation of PHC re-engineering.

US Government-South Africa Health Sector Funding* by Source, FY2011

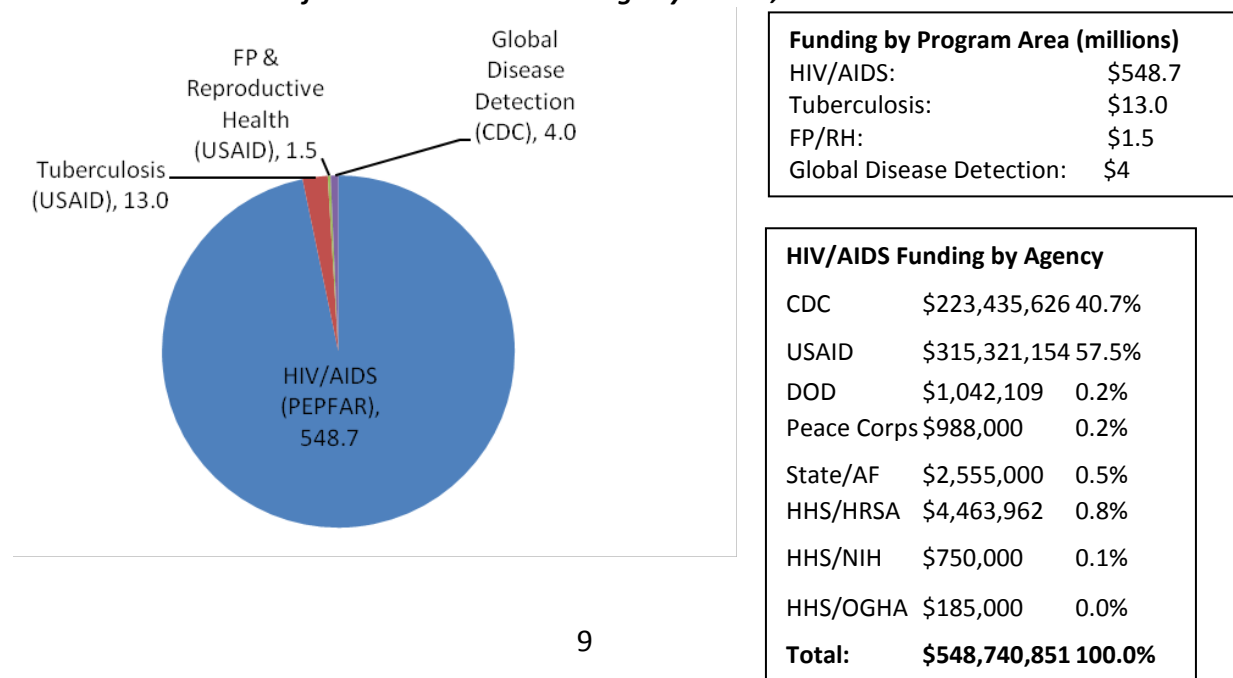


Table 2: USG Geographic Coverage

Province	% of PEPFAR Budget (April 1, 2010 - March 31, 2011)	HIV Prevalence (2+ Years)	Share of ANC Prevalence	Share of Total Population	Estimated district total population according to DHIS 2009	Estimated HIV-infected persons identified	Percent of New Infections Identified
KZN	19.0%	15.8	14.96	20.9	10,077,620	483,359	29.7%
Gauteng	18.8%	10.3	12.89	20.2	9,859,543	344,956	21.2%
Eastern Cape	12.0%	9	11.58	14.4	6,884,482	181,592	11.2%
Mpumalanga	8.5%	15.4	14.39	7.4	3,646,123	168,757	10.4%
Limpopo	7.0%	8.8	8.7	11.3	5,357,949	135,573	8.3%
Western Cape	6.5%	3.8	4.32	10.1	4,945,732	61,089	3.8%
North West	5.6%	11.3	12.7	7.1	3,229,078	112,871	6.9%
Free State	4.6%	12.6	13.64	6.2	2,972,983	118,922	7.3%
Northern Cape	1.6%	5.9	6.82	2.3	1,108,599	19,939	1.2%
National	16.4%		100	100	48,082,109	1,627,057	100%

USG HIV prevention, treatment, and care and support programs will contribute to the SAG efforts to increase life expectancy, both directly and through integration with other services at the PHC level. Prevention of Mother to Child Transmission (PMTCT) and programs for orphans and vulnerable children (OVC) will help decrease maternal and child mortality. Integration of nutrition programming will further enhance the pediatric interventions and will improve clinical outcomes for patients on treatment. USAID's family planning and reproductive health supports will further bolster efforts to improve maternal and infant morbidity and mortality statistics. Both PEPFAR health system strengthening activities and the CDC Global Disease Detection efforts to improve disease surveillance will be leveraged to strengthen health system effectiveness and monitoring of trends in diseases. All PEPFAR- and TB-funded activities will directly support the SAG (National Department of Health, Department of Basic Education (DBE), Department of Social Development (DSD), SA National Defense Force (SANDF), and other departments) in combating HIV and AIDS, decreasing the burden of disease from TB, and strengthening health and social systems that impact health outcomes. The formulation of the SA GHI Strategy and its implementation and monitoring create an opportunity to intensify overall

health efforts and health outcomes through our alignment with the integrated district health system (DHS) and PHC re-engineering.

At the PHC level, four priority health areas have been identified:

1. Maternal, neonatal, and child health: integrates FP; antenatal care (ANC); postnatal care, counseling; HIV Counseling and Testing (HCT); TB, PMTCT and HAART; oral rehydration therapy; immunization and growth monitoring; integrated management of childhood illness; and school health.
2. HIV and TB
3. Chronic non-communicable diseases
4. Violence and injuries.

The continuum of care begins with a Community Based Team consisting of Community Health Workers who are each responsible for 500 – 1,000 households, PHC Clinics staffed by professional nurses, and Community Health Centers and District Hospitals that are staffed by family physicians and provides a cascade of healthcare from the individual household to more specialized health services at the District Hospital. District-based specialist support teams will include family physicians that will be responsible for strengthening a district by assisting the district in developing a district specific strategy, an implementation plan for clinical governance, and provide the technical assistance necessary to support quality of clinical services and M&E. Three pillars of PHC re-engineering are the PHC outreach teams that will spend part of their time in the community and part in the clinic, the School Health Program that is being reintroduced, and the Specialist Teams for maternal, neonatal, child, and women's health (MNCWH).

Currently there are multiple types of “community health workers” (CHWs) working in parallel through vertical programs conducting numerous, separate visits to each household. They have multiple designations, training, and skill levels and unstable employment conditions and variable remuneration. The PHC vision is to integrate the approach to households and the roles of CHWs by making them part of the PHC teams. In this context, CHWs will provide comprehensive services to households, communities, schools, and early learning centers in the four priority health areas (maternal, neonatal, and child health; HIV and TB; chronic non-communicable diseases; and violence and injuries). A CHW specialized curriculum needs to be developed and certified for their new role. Roles for other “community workers” are being considered. Facility based counselors will do HCT, counseling for other needs, and case management for chronic diseases. Supplementing home-based care-givers with additional lay workers for labor intensive palliative care and activities for daily living is under consideration. Within the social welfare workforce, South Africa has three regulated categories of workers, social workers, social auxiliary workers and child and youth care workers who provide services to vulnerable children and their families. In addition, the community care giver is central to South African's response to HIV and AIDS. The CCG is a community member who is a lay person and who provides care and

support to the primary caregivers of vulnerable children and the children themselves. There are 17,000 CCG registered with the Department of Social Development in addition to the 60,000 community health workers registered with the DOH. The primary challenge to strengthening South Africa's social welfare workforce is the scarcity of social workers and ancillary workers. Several factors make it difficult to recruit and retain sufficient numbers of workers in this field.

Current Scope of USG Programs in South Africa

The Global Health Initiative in South Africa will be supported by PEPFAR, USAID TB and RH/FP, and CDC TB and Global Disease Detection funding. As 99% of USG funding in SA is PEPFAR funding, PEPFAR will in large part support the activities outlined in the strategy. USAID and CDC funding for TB will contribute to strengthening tuberculosis (TB) activities in South Africa, including drug-resistant TB, surveillance, treatment and management, as well as TB/HIV integration. The USAID RH/FP funding will be used to assist the SAG in developing policies for FP/RH, such as contraception, and to support operational research on the use of tenofovir gel microbicide in family planning clinics for improved HIV/FP integration. The three focus areas of this strategy represent critical limiting factors that must be addressed in order for South Africa to achieve its health goals.

While PEPFAR funding will be directly focused on combating HIV/AIDS and HIV/TB co-infection, the PEPFAR platform will be used to enhance and extend activities that strengthen the overall health system, thereby impacting the four NSDA strategic outcomes and assisting with implementation of PHC re-engineering. USG HIV prevention, treatment, and care and support programs will contribute to SAG's efforts to increase life expectancy, both directly and by integration with other services at the PHC level. PMTCT and programs for orphans and vulnerable children (OVC) will help decrease maternal and child mortality. Both PEPFAR activities and CDC Global Disease Detection efforts will be leveraged to strengthen health system effectiveness. All PEPFAR- and TB-funded activities will directly support the SAG in combating HIV and AIDS, decreasing the burden of disease from TB, and strengthening health and social systems that impact health outcomes. The formulation of the SA GHI Strategy and its implementation and monitoring create an opportunity to intensify overall health efforts and health outcomes through alignment with the integrated DHS and PHC re-engineering.

Strengthening SAG Capacity for Disease Detection

The creation of a CDC Global Disease Detection (GDD) Regional Center in South Africa in July 2010 provides a unique opportunity to strengthen local capacity through existing and new programs. The South Africa GDD Center is a bilateral partnership with the SAG that currently comprises three CDC programs, each of which contributes to GHI core principles. The Field Epidemiology and Laboratory Training Program has been in place for five years and trains local public health professionals in field epidemiology to increase the national public health workforce and strengthen South Africa's public health system. The Influenza Program has

supported work in South Africa for four years and works with SAG to conduct surveillance and develop policy to prevent influenza and respiratory disease, the leading killer of children in South Africa. The International Emerging Infections Program, the newest GDD program, supports the development of sustainable capacity for infectious disease surveillance, outbreak response, and other public health priorities in South Africa.

SAG Partnership with Peace Corps

The Peace Corps Response is a program within the Peace Corps that mobilizes Returned Peace Corps Volunteers (RPCVs) to provide short-term humanitarian service to countries worldwide. The program was formally established in 1996 as the Crisis Corps and to date more than 1,100 Volunteers have served in over 40 countries. Peace Corps Response assignments are short term in length - generally three to six months, but may extend up to 12 months.

To date, Peace Corps South Africa has placed nine Peace Corps Response Volunteers (PCRVs). These volunteers have provided assistance and support for the Department of Education in the Eastern Cape, PEPFAR funded partners, and the Provincial Department of Health in Limpopo and the Western Cape.

Services provided for the Department of Education in the Eastern Cape included organizational development support for the Educational Leadership Institute and curriculum development in the area of math, science, literacy, and numeracy. Support provided for various PEPFAR partners includes organizational development, strategic planning, and financial systems development so they can adequately manage donor funds. The volunteers assigned to the Provincial Department of Health Offices will assist with data capturing and monitoring and reporting of PEPFAR support provided to the provinces. This innovative program will be enhanced and increased in scope to support some of the key goals of the GHI Strategy and the PEPFAR Partnership Framework within that.

SAG Partnership with the Food and Drug Administration (FDA)

The FDA has an important role to play in offering its assistance to the SAG. FDA has just established a Sub-Saharan Africa Regional Office in South Africa located within the US Embassy in Pretoria. The FDA has over a three decades history of working with its foreign regulatory counterparts and their respective governments throughout Africa. Their new regional office provides the opportunity to work more closely with the SAG and other neighboring countries on a variety of public health and regulatory strengthening initiatives. One of those initiatives relates to FDA's mandate to help regulatory authorities enhance their ability to review and register medical products under PEPFAR, a program which now resides under the GHI umbrella. This augments the work highlighted above on strengthening national commodities overall.

A principal goal of the FDA under PEPFAR is to share expertise to facilitate proper registration of medical therapies. It has become apparent that often manpower to accomplish the registration

task can be as lacking as the scientific expertise itself. The SAG has asked for support from the FDA to strengthen the Medicines Control Council and the new regulatory entity that will be introduced in South Africa in the near future. The FDA will work with the SAG to develop a plan to train a cadre of regulatory affairs professionals to become medical product reviewers. One of the approaches will be to determine if there are opportunities for leveraging or borrowing from programs such as Medical Education Partnership Initiative (MEPI) and to work with academic institutions, professional societies, and others to create a curriculum for regulatory affairs professionals that will build this cadre in a sustainable way.

Department of Defense Collaboration with SAG

HIV and AIDS is a strategic risk to the SA military human resources and therefore to mission readiness and operational capability. The US DOD in collaboration with the SA National Defense Force (SANDF), the DOD HIV Prevention Program (DHAPP) and PEPFAR supports the SANDF's Masibambisane HIV/AIDS Program to optimize the implementation of HIV Prevention, Treatment, Care and Support programs targeting approximately 74,000 military personnel and about 350,000 dependants. Besides provide ongoing construction and renovation of clinics, pharmacies, and hospices; to date, approximately 35 000 military health workers have been trained in various aspects of HIV care over the years and about 1300 members enrolled on ART. Areas of particular focus include: improving quality of health services and revitalization of infrastructure, upgrading pharmacies and clinics; providing mobile health services through mobile clinics in rural and deployment areas; increasing access to HIV Testing and Counseling (HTC) and Prevention services; and improving access to HIV Treatment and Care services. Moving forward this collaboration will include conducting a sero-prevalence survey to strategically inform future programming, strengthening HIV prevention activities through collaboration and partnering with Population Services International/Society for Family Health, providing Voluntary MMC as part of overall prevention program accessible to all male military members - focus on new recruits, and strengthening HIV prevention activities at both internal and external deployment areas including border patrol areas.

III. GHI Objectives, Program Structure, and Implementation

Overview

The SA GHI strategy reflects a multi-year roadmap (2011-2016) that is in line with the country's PF (2012 – 2016) and illustrates how the application of GHI principles will increase efficiencies, accelerate health outcomes, and use resources

South Africa and the GHI Principles

The GHI Strategy for South Africa is firmly rooted within the GHI principles of:

- Focus on women, girls, and gender equality
- Encourage country ownership and invest in country-led plans
- Strengthen and leverage other efforts
- Increase impact through strategic coordination and integration
- Build sustainability through health systems strengthening
- Promote learning and accountability through monitoring and evaluation
- Accelerate results through research and innovation.

This strategy document will outline how GHI South Africa will integrate GHI principles into USG health investments, and how GHI South Africa will continue to engage in dialogue and collaboration with the SAG and other key partners.

more efficiently. This period represents a transition during which USG funds will decrease, our current programs will be adapted to sustainable and affordable models in partnership with SAG, and the SAG will increasingly take over HIV/AIDS programs that the USG has been supporting for the last 7 years as our program increasingly focuses on technical assistance. During the course of the next five years, the SA GHI team plans to support SAG to achieve its objective of a long and healthy life for all South Africans. In line with this strategy, GHI will strengthen SAG technical and managerial capacity to assume responsibility for implementing a strong HIV/AIDS prevention, care, and treatment program and to improve other health outcomes through stronger health and social systems.

Application of GHI Principles

The SA GHI Strategy focuses on critical elements that must be strengthened in order to sustain the significant HIV/AIDS gains supported by PEPFAR and enable overall improvement in health outcomes. These include information systems; health and social systems; financing, planning, procurement and supply chain management systems; and transfer of health service delivery from a facility based model to an integrated district-based PHC model.

Women, Girls, and Gender Equality. The GHI core principle of focus on women, girls, and gender equality is particularly relevant in the South African context given that interpersonal violence is the leading risk factor, after unsafe sex, for loss of DALYs.ⁱⁱⁱ An estimated 55,000 rapes of women and girls are reported to the police each year^{iv}; however it is estimated that the actual number is nine times higher.^v Gender-based violence and intimate partner violence are important risk factors for many of the country's most prevalent and serious health problems, including HIV and sexually transmitted infections.

In 2010, PEPFAR designated \$8 million in FY'09 funding to support the scale up of gender programming, \$1.5 million of which has been allocated to South Africa as part of the Gender Challenge Fund (GCF). PEPFAR has supported and will be supporting a range of programs with GCF funds, including the development and implementation of KZN's Provincial Strategic Plan on gender, HIV and sexual reproductive health services for girls and women in KZN, the adaptation of evidence-based interventions for HIV positive women, an economic empowerment micro-lending program for women, and other programs. Work supported by the GCF furthers the GHI's focus on women, girls and gender equality by integrating issues of HIV, SRH, gender-based violence (GBV), education and economic strengthening into new and existing programs. All efforts will be measured by PEPFAR's Next Generation Indicators. The main anticipated outcomes of PEPFAR SA's GCF work include:

- 1) Increased number of people reached by interventions that address male norms and behaviors;
- 2) Increased number of people reached by GBV services and prevention efforts;
- 3) Improved access to income and productive resources for women and girls;

- 4) A clear understanding of the magnitude of SA's GBV problem through supporting research on GBV prevalence.

Encourage country ownership and invest in country-led plans. As the South African Government (SAG) has demonstrated commitment to mitigating the impact of HIV/AIDS in their country by funding their national AIDS response at rapidly increasing levels, USG has taken steps to integrate the vast network of prevention, treatment, care, and health systems strengthening activities into the broader strategic vision of the SAG. In 2011, working with external consultants, the South African government, civil society, and PEPFAR program staff, discussed challenges and priorities. As a result of these discussions, the stakeholders developed a road map toward country ownership, with a focus on coordination, planning, information management, HR capability and capacity, and financial management and sustainability. This road map laid the framework for the South Africa GHI Strategy, which is aligned with the country's health plan and bilateral planning and management. As USG programs transition from direct service to technical assistance, country ownership will be demonstrated through oversight and management structures, which are aligned to current SAG strategy and platforms and will include representation from the USG.

Strengthen and leverage other efforts. In response to an OGAC request for an Expression of Interest, the SA PEPFAR Team submitted a proposal to support collaboration with the GF. This will support strengthening of the GF Country Coordinating Mechanism (CCM) to manage and oversee the GF grants and develop a shared platform that will introduce the GF Dashboard to the CCM and link it to the inventory of PEPFAR partners' activities. This will allow better planning between the GF and PEPFAR to minimize duplication, address gaps in coverage, and support GF sub-recipients. Collaboration and coordination with the GF can be used to also include efforts of other development partners, such as the European Union program to strengthen PHC. This initiative will strengthen and leverage other development partner efforts.

South Africa is a country rich in local capacity and may serve as a model for developing local capacity in the region and around the world. The 2009 USAID NGO Sustainability index gave South Africa the highest score of all African countries assessed, classifying it as a "Sustainability Evolving" country. Sixty-five percent of PEPFAR implementing partners in South Africa are local. In FY2010, PEPFAR provided \$336 million to local NGOs, representing 65% of total funds provided through grants and contracts. Four local PEPFAR partners receive awards that total more than \$100 million combined.

Increase impact through strategic coordination and integration. The transition of HIV care and treatment from USG supported NGO based clinical staff (working in SAG public health facilities), to SAG funded positions in the PHC re-engineering model (PHC clinic, community, and the vertical referral levels) to manage integrated comprehensive care will occur slowly over the five

year period of this strategy as capacity is built to support this effort. This will be guided by a transition plan that will be developed during FY 2012 with the SAG. The PHC re-engineering will not only extend reach of the HIV/AIDS and TB program into the community and health context but will also allow expansion of HIV programs and integration into a comprehensive healthcare package. It will align the focus of HIV intervention (currently at a larger facility level) and the TB intervention (currently located within the PHC system) to improve TB/HIV integration. In addition, the integration of all elements of maternal and child care and chronic disease management will allow the large expansion of SAG funding for HIV/AIDS to impact more broadly on the overall burden of disease. This will lead to significant efficiencies not only for SAG but also for PEPFAR to support the shift to a more affordable model of healthcare delivery.

Build sustainability through health systems strengthening. The SAG has been strengthening the PHC system to make it more accessible and responsive to the existing burden of disease, including major HIV and TB epidemics. However, major challenges exist to effectively respond to the health needs of the population, including poor emphasis on disease prevention, health promotion, weakness in laboratory services, and community participation. Service delivery and utilization patterns still lean heavily towards a curative high-cost healthcare approach rather than focusing on primary prevention. In addition, referral systems and integration of disease management need significant improvement.

Recognizing these gaps in the PHC system, the NDOH recently released a plan to reengineer PHC to focus on health promotion and primary prevention at the household and community level and improve integrated school health services. Major emphasis is being placed on strengthening the cadre of CHWs to implement such services. The CHW will understand the specific needs of a designated community and assist to improve access to integrated prevention and care services. Currently, there is no clearly defined comprehensive care package at household and community levels. The functions of several cadres of community workers currently working in vertical programs and separately accessing households will be streamlined and integrated into the duties of this new cadre of CHWs. Special curricula for training of CHW will be developed and accreditation of the cadre will also be achieved. Other community worker cadres will be identified and training and accreditation will be developed to support these positions. South Africa is experiencing an acute shortage of social services professionals and has not been able to produce social worker professionals in sufficient numbers to meet the social service's needs.

Promote learning and accountability through monitoring and evaluation. A key Strategic Information focus is to support and strengthen the management of M&E and Quality Improvement (QI) across the HIV and TB response in South Africa. Specific examples include: 1) technical assistance to the NDOH with the national HCT and PMTCT campaigns through designing and coordinating training, development, and review of guidelines and the monitoring of the implementation of the campaigns at all levels on a continuous basis; 2) direct support by technical experts from CDC, USAID, as well as others to the National TB Surveillance system; 3)

financial and technical support to the National Health Laboratory Services (NHLS) for strengthening its national data warehouse and decision support systems to facilitate delivery of its national priority programs; 4) technical support to the NDOH for the electronic ART register and the DHIS system; 5) development of Quality Assurance and QI tools for national and provincial level DOH, and 5) development of a Partner Information Management System (PIMS) that is designed to assist PEPFAR SA implementing partners and the SAG to strengthen the flow and quality of clinic-level results to the DHIS, as well as to allow transparent and user-friendly access to routine health information for both USG and SAG managers. Additionally, the PIMS system facilitates routine reporting on PEPFAR expenditures and staff supported by PEPFAR, both of which provide data that is essential to the PEPFAR transition for both the SAG and USG.

Two projects aimed at improving the TB surveillance program were launched during the last 12 months: the ETR.Net Informatics Review and the ETR.Net Data Flow and Reporting Review. The ETR.Net Informatics review was completed in 2011 and the findings were reported to the NDOH. The report lists specific recommendations to improve the informatics component of the ETR.Net system. Some of the recommendations are being implemented including: 1) upgrading computer hardware at NDOH and KZN DOH; 2) drafting of an implementation plan for ETR.Net (version 2.0) roll-out; and 3) finalization of algorithms for reports.

As a result of the National Health Council's decision to implement the 3-Tiered ART monitoring system nationally, PEPFAR SA implementing partners are rolling out Tiers 1 and 2: 1) supporting implementation of the paper or electronic ART register; 2) designing data exchange protocols between existing electronic patient management systems (PMS) and the TIER.Net system in order to transfer data from PMS into TIER.Net (i.e. an electronic data exchange standard (DES) will be made available to partners); 3) refraining from developing new systems and reducing the existing systems; and 4) planning for transitioning to the new system.

Accelerate results through research and innovation. South Africa is home to some of the world's finest research institutions and PEPFAR has contributed to building research capacity through supporting local organizations, including: HSRC, MRC, CAPRISA, WHRI, HEARD, CADRE, and Right to Care. Key HIV/AIDS-related innovative local research conducted to date includes: a randomized controlled trial at Orange Farm that established male circumcision as a protective factor for HIV transmission, and CAPRISA 004 trial showed that the microbicide gel containing the antiretroviral drug tenofovir reduces a woman's chances of acquiring HIV by 39% and genital herpes virus by 51%.

Besides the Global Disease Detection research, the Medical Education Partnership Initiative (MEPI), and the South African Research Ethics Training Initiative (SARETI), currently, there are several USG research activities underway:

- Microbicides, PrEP and ARV drug combinations

- FACTS 001 (Follow on Africa Consortium for Tenofovir Studies): Confirmatory trial funded by USAID, SAG, and Gates Foundation to confirm results of CAPRISA 004 and meet SA registration requirements for product introduction
- VOICE (Vaginal and Oral Interventions to Control the Epidemic): Study that compares daily use of an ARV tablet (Truvada) to a vaginal microbicide containing tenofovir in gel form (NIAID)
- Project Phidisa: HIV clinical research program in South Africa funded by the National Institute of Allergy and Infectious Diseases (NIAID)
- South African Research in Trauma Training Program
- Research Training in Lung Diseases
- Non-Communicable Disease Research Leadership Program
- HIV and TB clinical trial networks
- International Epidemiologic Databases to Evaluate AIDS (IeDEA)

Under GHI, current and future research will include implementation study for the roll out of tenofovir gel, qualitative studies on enhancing positive male norms and health seeking behaviors, increasing access to PEP, reducing GBV through economic empowerment, and global disease detection research (rotavirus, pneumonia, influenza).

IV. Supporting a Primary Healthcare Approach

Since 1994, South Africa has built an additional 1,800 PHC clinics and community health centers with the objective of improving coverage and implementing PHC as the foundation of the public health system accessed by the majority of the South African population. Today 95% of the population can access healthcare through one of the 4,000 PHC clinics within a 5 mile radius of their homes. However, following apartheid many individuals sought care in larger facility-based clinics to access what they perceived to be better care, moving away from what they thought were second-class health services imposed by apartheid at the primary care level. As a result, these larger facilities are overburdened and inefficient as they struggle to accommodate this shift and the enormous increase in demand for services due to the upsurge in the dual epidemics of HIV and TB. In addition, people present very late in their illness due to the long distances they must travel to reach these facilities and the lack of access to affordable transport. The successful implementation of the ambitious plan for PHC Reengineering is faced with challenges relating to lack of adequate financial and human resources. Development partners have been requested to assist in carrying out this vision and are expected to play a crucial role in its implementation. As the primary development partner in South Africa, USG investments will support the move to PHC in many ways. As the PEPFAR program transitions from direct service provision, the focus will be on strengthening the capacity at provincial and district level, including the district health system, and the district management teams (DMTs) along the WHO six building blocks listed below:

- **Strengthening governance** at district and sub-district level and in particular leadership skills to coordinate, manage, implement and monitor and at the same time scale up these programs in the face of the change in funding and support.
- **Human resource development** to improve the quality of care while at the same time scaling up treatment, care and support services at the PHC level.
- **Supply chain management** for pharmaceuticals and improvement of laboratory services at district level and facility level requires much attention for improved quality of care.
- **Health financing:** There is a need to strengthen capacity at provincial and district level for financial management to increase efficiency and effectiveness of resources.
- **Health information systems** need to be strengthened within the public health system.
- **Health service delivery innovation:** Continued support is required in setting a national research agenda to inform service delivery models and new treatment guidelines.

Adopting the Isibindi Model

Recently, the Minister of Social Development Bathabile Dlamini announced that government would formally adopt the Isibindi model and ten thousand community child and youth care workers (CYCW) will be recruited, trained and deployed to support the development of 1.4 million vulnerable children at 400 sites across the country within five years. The Isibindi Project recruits and trains unemployed people (mostly women in rural areas) to provide developmental and emotional support to vulnerable children. The project's key proposition is to keep children together in their family homes – with the support of professional child and youth care workers – rather than splitting them up and sending them to children's institutions and/or foster homes.

In South Africa there is a need for more professionals and paraprofessionals with social work knowledge and skills to deliver child-centered, community-based services for highly vulnerable children. There is a growing gap between policy and practice due to the lack of quality child welfare services provided by a workforce with sound social work practice skills. With support from PEPFAR, Child Welfare South Africa, a national training and mentoring organization, will support the training and supervision of 1000 social auxiliary workers and 30 social workers over the next four years.

District Level Strengthening

Although PEPFAR began as part of an emergency plan and provided substantial direct service delivery, recently PEPFAR implementing partners providing clinical services have been guided to refocus support to a district or sub-district, rather than to specific facilities where their work is currently focused, in order to support PHC re-engineering. In this context, we implemented an alignment process for our PEPFAR-funded clinical implementing partners, identifying District Support Partners for each district, and in larger districts, for each sub-district. More specialized

implementing partners are assigned to work at a provincial level to provide technical support in specific areas to the province and districts as needed. The goals of this alignment are to not only improve efficiencies, reduce duplication, and thus extend coverage, but also to build the capacity of District Management Teams (DMTs) to deliver healthcare services. This includes enhancing district management, planning, and operations at a central level; improving data collection, reporting, quality, and use by assisting PHC and other facilities to implement the NDOH Tier 1 and 2 system for antiretroviral treatment; developing a tool to merge data from vertical NDOH data collection systems to facilitate data entry into the DHIS; strengthening integration of TB, HIV, maternal child health (MCH) services, and other services based on the PHC re-engineering plan described in section I; promoting community access of care at the lowest levels; and thus improving overall health outcomes.

Capacity Support of Multiple Health and Social Cadres

Significant support is being provided to improve the healthcare and social workforce through PEPFAR. This includes task shifting between and across different cadres of healthcare workers to address the problem of scarce resources. One of the key SAG initiatives supported by PEPFAR is the NDOH led nurse-initiated management of antiretroviral treatment (NIMART). PEPFAR has also funded local universities through the NDOH to train Clinical Associates, a new mid-level cadre of healthcare workers. Through two Medical Education Partnership Initiative (MEPI) programs in South Africa at the University of KZN and Stellenbosch University, pre-service training of doctors, nurses, pharmacists, and other cadres of health workers, (e.g., pharmacy assistants to work in rural areas) will be supported. While the initial focus of the MEPI projects was to largely extend HIV/AIDS and TB training and competencies for doctors and other clinical health cadres, both centers have expanded their focus to respond to the rural health context in SA that includes not only HIV and TB, but also MCH, non-communicable diseases, and violence and injuries, through overall curriculum reform for physicians and nurses. Targeted courses in specific areas of need are being developed or expanded, including prevention of maternal and child mortality and training of pharmacy assistants who will manage the pharmacies at the PHC clinics.

Finally, while PEPFAR has trained more than 650 nurses to provide NIMART, very few of these nurses are initiating ART at the PHC clinics. PEPFAR partners will provide mentoring for NIMART trained PHC nurses and extend current in-service training programs that have focused on facility based staff for HIV and TB management and infection control. An overall plan for health and social system strengthening to support PHC re-engineering will be developed during the first year of the SA GHI Strategy in partnership with NDOH, the Department of Basic Education (DBE), and the Department of Social Development (DSD) and adapted to the specific needs of provinces and districts. Training curricula will be developed and clinical providers will be trained on the use of CHWs as part of the team of health workers (doctors, nurses, and CHWs) to improve access to healthcare. Training curricula for CHWs will be developed to include practical

Thogomelo Project: Enhancing the Capacity of Community Caregivers

The Department of Social Development Africa with PEPFAR support have implemented the Thogomelo Project, a nationwide, five-year initiative based on two core strategic objectives in the form of in-service training interventions to “enhance the capacity of caregivers to meet the challenges they face in protecting, caring for and supporting orphans made vulnerable to HIV and AIDS”; and secondly to “strengthen effective and efficient child protection responses by increasing the capacity and engagement of civil society and state OVC service providers”. A third strategic objective was incorporated to “build provincial implementation, capacity development and sustainability plans.” A CCG psychosocial support (PSS) curriculum and materials have been developed and 1,000 CCG trained. In doing so, the Thogomelo Project hopes to improve retention of Community Caregivers and potentially support them to pursue careers in social welfare work (i.e., by gradually increasing their qualifications to serve as CYCWs, Community Workers, or Social Auxiliary Workers through ongoing training). The national government currently provides some Community Caregivers with stipends and intends to extend stipends to all Community Care Givers.

training on social mobilization as the primary community activity with basic public health education including the full spectrum of the community burden of disease of the community.

Under the SA GHI Strategy, these initial plans and efforts will intensify and be guided by a joint SAG – USG plan for USG capacity building to support PHC Reengineering that will be developed during the first year of the SA GHI Strategy. We plan to jointly develop health system and information system strengthening plans to support the transition of clinical services to PHC and the transition of HIV treatment and care services to the SAG. In addition, training of cadres to provide social support for orphans and vulnerable children (with DSD) and link with school health programs (with DBE) have been initiated. District support partners have been asked by NDOH to work with District Management Teams to conduct a baseline assessment and system strengthening, including relevant social system strengthening. This

effort will be adapted to meet individual district needs. The National Association of Child Care Workers has a winning model of community service, the Isibindi Model, for holistically responding to the needs of vulnerable children and families implemented through the Department of Social Development with experienced social service professionals as mentors. The program includes support and gender awareness for girl children and women-headed households, psychosocial support and protection for caregivers and children, and a disability program that includes assessment and therapy.

The NDOH has developed a measurement model that includes eight indicators for TB, HIV, and MCH that are included in the M&E section below. These will provide short term evaluations of impact. In the longer term the indicators adopted by SAG in the NDOH NSDA that include MDG

indicators and the goals to be achieved by 2014 will be used and these are also described below. Once the new National Strategic Plan is finished (expected in December 2011), the goals and indicators it defines will be used.

This effort aligns with a number of GHI principles in that it encourages country ownership of our program and enables USG investment in country-led plans; it increases impact through strategic coordination and integration by adopting this new model; it builds sustainability through health and social systems strengthening; and promotes learning and accountability through M&E.

Expected outcomes through GHI:

- Increased access to and quality of integrated health and social services
- Increased demand for and utilization of services
- Adoption of health behaviors
- Increased availability and use of quality health information

V. Improving Management and Financial Management

At the macro level, the SAG has one of the best managed financial systems in Sub-Saharan Africa. Sound macroeconomic policy application and fiscal management has contributed to high SAG ratings by all the international sovereign rating firms. However, this expertise is not reflected in the management of public sector health programs. “Overhauling the healthcare system and improving its management” is one of ten priorities listed in the NDOH’s Strategic Plan and its 10 Point Plan discussed previously. Planning and budgeting; commodity management; and human resource management are weak throughout the health system. Provinces typically overspend budgets, which renders them unable to conduct some planned activities. Overspending also results in high levels of debt to drug suppliers and non-availability of some medicines. In some cases, provinces under spend in the face of enormous unmet needs due to lack of planning and financial management systems. Human resource management and performance is not consistently monitored. A 2008 University of KZN Health Economics and HIV/AIDS Research Division (HEARD) study reported that although the density ratios for medical practitioners and professional nurses within South Africa were above the minimum level proposed by the WHO, drastic shortages of Human Resources for Health (HRH) existed due to inequitable distribution of health professionals. Overall, 35.7% of health professional posts were vacant in 2008, with the highest vacancy concentration in the more rural provinces. The USG efforts to improve health management will focus on three specific areas.

First, the USG will build capacity at the provincial and district levels to plan and manage financial resources. The NDOH has requested support to improve the district health committees’ capacity to develop annual plans with clearly articulated objectives and strategies to reach these objectives. The USG has also been asked to strengthen capacity at the provincial level to manage the HIV budgets, including the conditional grants (e.g., for HIV), which have been

growing rapidly as South African Treasury has allocated larger budgets to provinces. In response to these requests, the USG will provide technical assistance and direct support in order to build the skills needed at the provincial and district levels to develop annual plans and corresponding budgets and to monitor the activities and expenditures.

Second, the USG will support strengthened management of commodities at the national and local levels. In response to a request from the South African government, the USG is assisting the NDOH to centralize the national pharmaceutical budget and develop a central procurement authority (CPA) for all drug products that will provide oversight. The CPA will manage pharmaceutical procurement contracts on behalf of the provinces and will assume primary responsibility for coordinating all issues pertaining to selection, procurement, distribution, use, and payment of pharmaceuticals within the public health system. At the provincial and district levels, the USG will build capacity in commodity logistics management by training and supporting improved management tools. The ultimate objective will be to eliminate stock outs of all drugs, which has been a perennial problem in South Africa.

Addressing the Human Resources for Health (HRH) Crisis

While solving the HRH crisis currently appears intractable, the USG will undertake a number of specific initiatives to assist the SAG to address the shortage of professional personnel. In the short term, USG will continue to support programs to import health professionals from developed countries on one or two year contracts as a stop-gap. Many of these professional stay well beyond their term. The USG will also work with the NDOH to improve the use of CHWs within health services aligned with PHC re-engineering. Task shifting of selected activities from health professionals to CHWs and mid-level workers will require redefining the scope and practice of health professionals. In the medium term, the USG will help to increase retention rates through interventions that increase the appeal of staying in South Africa. Over the longer term, USG will help accelerate production of professionals and mid-level cadres. For instance, the USG is already supporting the education of a new cadre of clinical officers with skills similar to nurse practitioners and through MEPI the number of health professionals trained has increased and they are being prepared for work in rural areas. The SAG has decided that the community worker cadres such as the CHWs should be employed by the SA government. As such, over the next year or two, the SAG will advertise these posts and some of the 19,545 community workers employed by PEPFAR will be eligible to apply and given preference as incumbents provided they qualify for the positions. As other standardized community cadres are identified by SAG, such as lay counselors, other staff currently supported by USG will be eligible to apply for these positions. Specific discussions and planning for this transition have just begun in Western Cape Province, for example. This initiative encourages country ownership by strengthening host country systems and builds sustainability by strengthening critical systems to support the enhanced SAG response.

Expected outcomes through GHI include:

- Built capacity at provincial and district levels to plan and manage financial resources
- Support strengthened management of commodities at national and local levels
- Addressed shortage of health professional personnel

VI. Improving Integrated Management of TB/HIV and Other Diseases

The current HIV/TB co-infection rate exceeds 70%. Due to late detection, poor treatment and management, and failure to retain TB patients on treatment, drug-resistant (DR) forms of TB (XDR-TB and MDR-TB) have increased significantly, with about 594 and 9,070 diagnosed, respectively, in 2009. SAG has revised its existing policy that hospitalizes all DR-TB patients until they are cured due to a lack of bed capacity. The Decentralization Framework Policy has been designed to provide guidance for management of MDR-TB patients in the community. The combination of TB, HIV and DR-TB has led to a situation where the current TB/HIV co-infection rate exceeds 70%. The combination of TB, HIV and DR-TB has led to a situation where TB is number one among common causes of death among infected South Africans (13 out of every 100 deaths). Although resources have been made available for TB control, treatment, and management, the bulk of these are routed as earmarked funds through different programs, such as district systems development, drug supply, and hospital management. As a result, a significant amount of the resources are utilized for other purposes, and it is increasingly difficult to track allocations, expenditures, and accountability of these funds.

Given existing challenges, the SA GHI team is working to strengthen integration of TB/HIV services through capacity building, M&E, policies, and research. This includes training for healthcare workers, improved reporting for better data quality, and accelerated implementation of the 3 Is (intensified case finding, isoniazid preventive therapy, and TB infection control for people living with HIV) across facilities. The SA GHI team is working with the SAG to evaluate existing tools, standardize a set of tools for TB/HIV integration, and synchronize tools for integration at the facility level. We are also working collaboratively to develop joint TB and HIV guidelines, monitor the implementation of national guidelines, expand and evaluate decentralization of DR-TB management, and promote use of the GeneXpert as a diagnostic tool. Finally, the SA GHI team will continue to conduct operations research and engage in TB surveillance to address programming gaps and strengthen TB/HIV integration overall. This activity that supports integration will increase the impact of the USG and SAG HIV funding by using the HIV platform to improve overall health.

Expected outcomes through GHI include:

- Strengthened referral linkages for the continuum of care
- Integrated TB and HIV services
- Integrated RH/FP, MNCH and Nutrition Services

- Expanded community-based services
- Implementation of innovative, high impact programs
- Better provision of services for vulnerable populations, especially focusing on women, girls and children (including OVC)
- Infection control, capacity building, expand HIV testing and health promotion, increase knowledge of disease prevention, community mobilization, and expansion of community-based outreach and services.

VII. New Activities and Innovative Ways for Scale-Up

Several new activities have been highlighted in previous sections, including strengthening leadership and management at the district level through capacity building for the District Health System and DMTs; health and social system strengthening to support the shift to a primary care model and transition of HIV care and treatment services to the SAG; strengthening financial management, planning, and oversight facilitating healthcare and social support services for orphans and vulnerable children to the SAG; and linkages among and integration of HIV, TB, other chronic diseases, ANC, MNCWH, and RH/FP. USG South Africa GHI's work in the education sector that has included peer education and life skills programs represents an important opportunity to reinforce key GHI principles to strengthen linkages and improve health outcomes.

Surveillance to establish HIV Incidence and Burden

Two best practices that are needed for appropriate planning and programming will be initiated. These include establishing accurate HIV Incidence data to support "Know Your Epidemic/Know Your Response" approaches and accurate information on how many people are HIV positive in South Africa will be supported. Secondly, incidence testing will be planned to learn more about new infections on a population level.

Partnership with the Department of Basic Education

The USG will build on existing partnerships and relationships established with the education sector through the Department of Basic Education (DBE) to scale-up the implementation of the SA GHI Strategy. The DBE is currently revamping the life skills curricula and establishing systems to develop and implement sexual reproductive health programs while promoting safety in schools. These systems are based on the DBE's Draft Integrated Strategy on HIV and AIDS, which includes delivery of sexual and reproductive health education; focuses on HIV as a mandatory, timetabled, and assessed subject in all South African schools; and requires the use of guidelines to provide a framework for implementing peer education programs in schools. This will support GHI principle 1 (focus on women, girls, and gender equity) and 2 through investment in a country-led plan.

These activities offer an opportunity for the USG to support the SAG in strengthening health programs within the education sector to improve health conditions and knowledge for school children, particularly adolescent and pre-adolescent girls. These programs promote healthy lifestyles, address risky behavior related to drug and substance abuse, discourage early sexual debut and teenage pregnancy, and build awareness and understanding of gender equity. School-based HIV prevention programs and programs targeting orphans and vulnerable children will include a specific focus on improving the overall health of women, girls and children and will help change the current under-representation of women in decision-making positions in the school. Programs include a focus on gender to examine the roles, relationships, and dynamics between men and women, address how these impact the needs for men and women, and empower young girls to make better decisions about their futures.

NDOH is also utilizing the PHC reengineering framework to strengthen school health programs, which require the Departments of Health, Education and Social Development to mobilize resources and strengthen their systems to support school children. This will result in improved access and better operational systems to deliver healthcare services to the students in the public schools. DBE policies and programs offer a platform to integrate gender equity to ensure that gender related barriers in the education system are addressed and reduced through a specific focus on sexual harassment and violence. Students, teachers, education officials, and parents still require ongoing support to increase awareness and strengthen their understanding of gender equity. The integration of gender equity and HIV prevention to support women, girls, and children in schools will also contribute to the retention of girls in schools, completion of primary and secondary schooling and education female empowerment and life skills beyond just HIV.

Partnership with the Department of Social Development

Department of Social Development's policies and frameworks support vulnerable children and their caregiver at the community level. The USG will continue to support the DSD in achieving the goals of the National Action Plan (NAP) for Orphans and Vulnerable Children as well as supporting the monitoring and evaluation for the National Action Plan for Orphans and Vulnerable Children and Other Children Made Vulnerable by HIV and AIDS, 2009-2012 (NAPOVC) that allows DOSD to track progress against set targets.

- Improve care and support for OVCs -- operational efficiencies, use of evidence based models of care and availability and quality of service improved --Develop Quality standards to increase the capacity for cost effective, quality community based care in priority areas (provincial and district)
- Support district level OVC program implementation (improved coordination and functioning of Provincial and District Action Committees for children affected by HIV and AIDS, Child Care Forums and Child Protection Committees)

- Develop human capacity to strengthen the social service professionals' workforce system.
- Develop human capacity in the area of monitoring and evaluation for the national plan of action of OVC. Development of a centralized national reporting system for services provided to children using the current DSD Home Community Based Care Reporting System platform.
- Provide assistance in the development of a plan for a monitoring and tracking system for OVC services.

Accelerating Local Capacity Development of Local NGOs and Private Sector Partners

U.S. government agencies working in health have strong commitments to building local capacity and developing stronger ties to the private sector. Throughout the history of PEPFAR in South Africa, local South African partners—from government, local NGOs, and private sector—have been a majority among implementers. In 2004, approximately 47% of the US Department of Health and Human Services' (HHS) programmatic funding supported local SAG departments and parastatals and an additional 19% was awarded to South African non-governmental organizations. Currently in 2011, a total of 73% of HHS programmatic funding is being awarded to local NGOs, SAG departments and parastatals.

One example of increasing local capacity is the CDC transition from international Track 1 care and treatment partners in the first phase of PEPFAR to South African organizations, including private and faith-based clinical settings. Currently these partners receive approximately 11% of CDC's programmatic budget. These funds will shift to local partnerships by 2012.

Given the existing strength of the country's local capacity and the opportunities to further develop local capacity, USAID/Southern Africa was selected as a pilot mission in 2010 for USAID/Forward's Local Capacity Development (LCD) Objective 2: Strengthen local civil society and private sector capacity to improve aid effectiveness and sustainability. This effort cuts across multiple development sectors to address the multi-faceted roots of poverty alleviation. These include health, environment, agriculture, democracy and governance, and economic growth. This initiative is responsible for numerous local capacity development interventions and initiatives:

1. Working to apply simplified eligibility procedures for local nonprofit and for profit organizations, carry out capacity building training of local organizations, oversee solicitations for proposals, evaluate proposals and issue contracts and grants to local organizations;
2. Conducting NGO mapping of targeted sectors including enabling environments;
3. Identifying opportunities to work directly with local businesses to advance Mission foreign assistance objectives, including the use of local for-profits in capacity building activities; and

4. Establishing a M&E process that includes baseline data.

As of July, 2011 the LCD team has conducted outreach to partners of varying capacities, other donors, and small organizations that do not currently receive USAID funding to identify capacity development needs and ways that USAID can better support them. The team has also conducted numerous award applications and management trainings and will be hosting a regional training to expand the initiative's reach across the region. The team works closely with the Health Team, especially around the development of organizations currently funded through the capacity development of umbrella grant mechanisms to develop capacity and graduate partners to receive money directly from USAID.

VIII. Challenges and Opportunities Ahead for GHI South Africa and the SAG

While the SAG and GHI have clearly defined goals and priorities, weak management systems for implementation at the provincial and district levels and limited M&E systems in SAG health systems represent crucial barriers to achieving them. South Africa has very strong policies but limited ability to translate them into successful implementation. There has not been a Demographic Health Survey since 2003, accordingly South Africa has limited population-based data, impeding the country's ability to measure general health results and demonstrate impact. For HIV/AIDS, there is the Health Services Research Council household survey and the Johns Hopkins University communications surveys, both of which are population-based and can measure results and demonstrate impact. Recognizing the need for general health data, SAG has worked with their parastatals to combine all of the Demographic Health Survey modules into other existing national surveys to be completed every three years. Both the national household survey and the South Africa National Health and Nutrition Evaluation Survey will encompass relevant Demographic Health Survey modules in their next rounds of data collection.

The limited availability of human resources in the government for management, M&E, and service delivery represent another significant challenge to meet these goals. Finally, planning, forecasting of needs, financial planning and oversight, and procurement are significant factors that will limit the scale up of services and the sustainability of the response.

At the time of finalizing the PF, the NDOH expressed a strong interest in embedding the PF within GHI and welcomed the development of a GHI Strategy. In addition, the NDOH has asked us in the past to add childhood immunization to the duties of CHWs visiting households and to extend our activities to strengthen the health system overall. These activities will occur under this Strategy through our support for the DHS and PHC re-engineering. While the SAG would very much like additional USG funding and assistance for MCH, they are aware that this may not be available.

Despite clear challenges ahead, there are several opportunities for GHI to complement and support the SAG to achieve its priorities. The USG continues to collect best and promising practices through M&E of our programs, thereby promoting learning and accountability. For example, the Gender Challenge Fund assisted KZN in creating their Provincial Strategic Plan on Gender, HIV, and Sexual Reproductive Health Services for Girls and Women. This can be used as a model for other provinces. In addition, a recently completed independent PEPFAR/South Africa Treatment Program Evaluation guided by the NDOH identified a number of best practices that could be brought to scale. Once the final report is available, NDOH and USG will jointly review these and determine next steps for scale-up.

The PF represents a clear way forward for GHI to align with the SAG strategy to address the HIV/AIDS epidemic. The SA GHI team will continue to work closely with SAG counterparts to develop an implementation plan that can reflect the harmonization of GHI principles and goals with SAG priorities and programs. Strengthening systems, particularly through PHC re-engineering, HIV/TB integration with MCH and other services at the PHC level, and improved financial and HRH management, will facilitate scale-up of successful best practices and build SAG capacity to address not only HIV/AIDS but other emerging health problems that impact the country's population (e.g., non-communicable diseases).

The PHC approach, in particular, represents an opportunity to expand upon existing systems and service delivery platforms to improve access and quality of care. This represents a district-based approach to target interventions appropriately, reduce inequalities, and strengthen overall management. Several other development partners are working in close collaboration with the SAG to roll out PHC across the country. These coordinated efforts represent an opportunity to strategically integrate services, including prevention, and improve the implementation of policies and programs.

IX. Monitoring and Evaluation

The Results Framework describes both the logical transition from higher-level goals to the programs necessary to move South Africa towards those goals and the different tiers of indicators for monitoring and evaluating the success of the healthcare and social system. These indicators will be reported to USG through the FACTS-Info system for PEPFAR supported activities and through the FACTS system for USAID supported programs. The SA CDC Director reports on GDD activities directly to the CDC GDD program in Atlanta. In addition, the three strategic focal areas for South Africa will support the entire country health portfolio and can be monitored as outlined below.

Primary Healthcare transition and Health and Social System Strengthening

The PHC transition supports the GHI Principles of a focus on women, girls and gender equity, encouraging country ownership and investment in country-led plans, building sustainability through health and social systems strengthening, and promoting learning and accountability through M&E. The re-engineering of the PHC system will result in increased access to and quality of services, in particular for women and girls. This, in turn, will have a strong impact on maternal and child mortality, life expectancy, and access to HIV care and treatment services.

The NDOH is developing a tool for a baseline assessment of the District Health system that is built on the WHO District Health pillars that include leadership; human resources; financing; technology, drugs, and innovation; information management; and service delivery. The District Support Partners will work with the District Management Teams to conduct the assessment. In addition, eight specific health indicators will be measured. The baseline assessment will guide the work that SAG and PEPFAR undertake together through annual District Health Plans and will serve as an important tool for annual assessments providing both short-term and long-term impact at a district, provincial, and national level. These eight SAG indicators are listed below:

MCH

- Early booking rate (< 20 weeks) at ANC for pregnant women
- Facility perinatal mortality rate
- Early Infant Diagnosis of HIV (PMTCT)
- Proportion of HIV positive mothers put on ART

HIV

- Number of new patients on ART (including pediatrics)
- Proportion of new patients on treatment after 12 months

TB

- Proportion of HIV positive TB patients on ART
- Proportion of sputum positive individuals who converted to sputum negative at 2 months of TB treatment

We will use the following additional indicators to monitor shorter term impact:

- Number of eligible people on ART
- Number of pregnant women who receive HIV counseling and testing for PMTCT and received their results
- Number of pregnant women who received a complete course of antiretroviral prophylaxis in a PMTCT setting
- Number of children born per woman
- Number of new sputum smear-positive patients successfully treated under DOTS
- Number of ANC visits attended by a skilled provider
- Number of deliveries attended by a skilled birth attendant

- Number of cases of child diarrhea/child pneumonia
- Number of new healthcare workers who graduated from a pre-service training institution
- Number of persons provided with PEP
- Number of OVCs served
- # of people reached by an individual, small group or community-level intervention that explicitly addresses gender norms related to health

The following indicators derived from the Health NSDA Indicators will also be used to monitor longer-term impact, but the key elements of long-term impact will be measured by higher level composites that are included in the Health NSDA as the major targets to be achieved by 2014 compared to the MDG country report estimates:

- Life expectancy must increase to 58 years for men and 60 years for females by 2014 (SA MDG Report – 53.9 for men and 57.2 for women)
- Maternal Mortality Ratio must decrease to 100 per 100,000 live births by 2014 (SA MDG Report – 625 per 100,000)
- Child mortality must decrease to 20 deaths (or less) per 1,000 live births (SA MDG report – 104 per 100,000)
- TB Cure Rate must improve from 64% in 2007 to 85% in 2014
- Eighty percent (80%) of eligible people living with HIV and AIDS must access antiretroviral treatment
- New HIV infections must be reduced by 50% by 2014

Longer-term indicators through 2016 will align with the goals of the new National Strategic Plan for HIV and TB 2012 – 2016. This strategy is currently under development and will be available by December 2011. Measurement of the long-term impact of health and social systems strengthening and the transition of care and treatment service delivery to the SAG will be developed jointly with the SAG during the first year of the GHI Strategy, the PF, and the PFIP. The USG and SAG will work together to formulate a plan for transition and health and social systems strengthening needed to support this with specific goals, timelines, and milestones defined. This will serve as a monitoring tool for this process. The goals from this process will be in line with the following PFIP goals:

- Reduce new HIV infections by at least 50% using combination prevention approaches
- Initiate at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation
- Reduce the number of new TB infections, as well as the number of TB deaths by 50%
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP
- Reduce self-reported stigma and discrimination related to HIV and TB by 50%
- Systems Strengthening
- Measuring the SAG/USG partnership.

Data availability and use

The focal area of data availability and use supports the GHI principle of promoting learning and accountability through M&E. While there are no internationally agreed upon indicators for this area, progress towards its successful implementation will be monitored through the development and implementation of data use and dissemination plans for key health priorities and by promoting a stronger environment of data sharing in the SAG and across USG agencies and the larger donor environment.

Financial management

Financial management, the third focal area, supports the GHI principles of encouraging country ownership, investing in country-led plans and building sustainability through health systems strengthening. The successful implementation of financial management activities will be monitored by assessing the proportion of the GDP that is expended on health and the increased amount of USG funds that is programmed directly through the SAG.

X. Communication and Management Plan

CDC, DoD, PEPFAR Secretariat, Peace Corps, State, and USAID have jointly planned, implemented, and reported on the PEPFAR program for several years. GHI South Africa will build on the recently reorganized management structure of PEPFAR SA to ensure effective interagency collaboration on all USG support to the health sector in SA. The Ambassador leads the Mission's health team in the GHI strategy through an Executive Health Committee of the DCM, Health Attaché, PEPFAR Coordinator, and agency leadership. The PEPFAR Coordinator also functions as the GHI Planning Lead. Six USG technical working groups jointly develop strategic direction, design new funding announcements, and implement and monitor the following program areas:

1. Prevention
2. Pediatric Care and Treatment, OVC, PMTCT
3. TB/HIV Care and Treatment
4. Health and Social System Strengthening
5. Strategic Information
6. Laboratory Services

An interagency Oversight Committee ensures integration between PEPFAR technical areas and identifies interagency opportunities that exist to support the broader GHI Strategy. The Committee also directs coordination with SAG and other donors to support the SAGs PHC approach. GHI will leverage the existing HIV/AIDS-focused structure to strengthen integration of services and a broader set of linkages. For example, the TB/HIV Care and Treatment TWG will provide a platform to continue to integrate programming of USAID and CDC's TB funding with PEPFAR programming. The technical staff addressing pediatric care

and treatment, OVC, and PMTCT will form a TWG to explore programmatic opportunities to improve health and social services for mothers and children. At CDC, combined funding will strengthen the collaboration between GDD and strategic information activities to support GHI.

South Africa's Aid Effectiveness Framework for Health (AEF), launched by Minister of Health, Dr. Aaron Motsoaledi in January of 2011, highlights the need for development partners to align with a single national health strategy and commit to supporting principles of country ownership and result-oriented management of resources. The GHI Strategy embraces the AEF principles of management and strengthens the USG commitment to a partnership with SAG to address the significant health burdens facing South Africa. Once again, GHI South Africa will build on the existing bilateral relations led by the Ambassador and Oversight Committee. Currently, the Ambassador and the Director General of Health co-chair a bilateral PEPFAR PF steering committee that includes NDOH, DBE, DSD, and the National Treasury. SAG-USG co-management is paramount for successful implementation of the GHI Strategy. USG will respect and work within existing host country management and coordination structures, in line with the AEF, the principles of the Three Ones, and the PEPFAR/SAG PF.

GHI South Africa Communications Strategy

GHI South Africa will reinforce existing interagency structures to implement a communications strategy that comprehensively addresses USG's support to the health sector in South Africa. Successful implementation requires dedicated collaboration from staff at all levels within the relevant agencies, including the Public Affairs Section of the US Embassy, USAID's Development Outreach and Communication team, and CDC's Communications Specialist. The interagency communications working group, chaired by the Public Affairs Officer, will guide GHI South Africa in maintaining one USG voice on issues related to health. There are four spheres of the communication strategy.

1. Internal GHI South Africa Communications: Strengthen USG interagency communication through reorganized management structure that ensures inclusiveness and enhanced participation and awareness at all levels.
2. GHI South Africa – HQ Communications: Proactively engage with GHI office and agency headquarters as needed for support with planning, implementation, and reporting.
3. Bilateral SAG-USG Communications
 - Enable and encourage effective communication to solicit SAG input during planning, implementation, and evaluation of USG supported health programs. CDC staff are embedded in the SAG to enhance capacity building in formulation of communication strategies.
 - Engage other relevant stakeholders, e.g. MCC/FDA (quicker registrations), Water and Sanitation, Agriculture/FAS (all lead to enhanced/better health outcomes).

4. External Communications with relevant stakeholders

- Engage other multilateral and bilateral donors (EU donor countries, Global Fund, UN, World Bank, etc.) through participation in the AIDS and Health Development Partners Forum to improve effective communication that drives collaboration.
- Interagency Communications Working Group will develop a clear Mission-wide communication, branding, and outreach strategy to ensure a consistent USG voice with all partners and stakeholders.

XI. Linking high-level goals to programs

The PHC focus offers an opportunity to leverage the PEPFAR platform not only to increase overall capacity, but also to create critical linkages among services that target the needs of the whole individual. In particular, we are working with the SAG to formulate a chronic disease model that would combine the care of HIV and TB with other chronic diseases, including non-communicable diseases. Once this is developed, it will be rolled out as a key component of this strategy. Ante-natal care (ANC), maternal, neonatal, child, and women's health (MNCWH) services as well as RH/FP are all located at the primary care level. This offers an opportunity to create linkages that not only address HIV and TB, but also allow access and integration of these services so that ease of access and comprehensive care are provided to mothers and children. Both male and female reproductive health programs are priorities for the NDOH, and we will work to create better access for individuals and incorporate elements into HIV prevention, care, and treatment programs. This integration model would result in greater synergies and efficiencies in programming and in impact, representing smarter investments in public health. In addition, we will support the development of policies to strengthen FP/RH such as a National Policy on Contraception.

ⁱ South Africa HIV & AIDS Statistics. Online. Internet. Accessed: July 2011. Available WWW: <http://www.avert.org/south-africa-hiv-aids-statistics.htm>.

ⁱⁱ Actuarial Society of South Africa (ASSA). 2008 and 2010.

ⁱⁱⁱ Norman R, et al. Revised burden of disease estimates for the South African Comparative Risk Assessment Collaborating Group. A comparative risk assessment for South Africa in 2000: Towards promoting health and preventing disease. *S Afr Med J* 2007;97; 637-41.

^{iv} South African Police Service. Crime Statistics 2005/6. http://www.saps.gov.za/statistics/reports/crimestats/2006/crime_stats.htm

^v Jewkes R, Abrahams N. The epidemiology of rape and sexual coercion in South Africa: an overview. *Soc Sci Med* 2002;55: 153-66.

The following graph shows the 2011 PEPFAR funded total staff estimates for South Africa broken down by cadre.

