Energizing the Fight against HIV/AIDS in South Africa

Trip Report of the CSIS Delegation to South Africa, February 2016

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Introduction²

South Africa lies at the epicenter of the global HIV/AIDS epidemic.³ There are an estimated 6.8 million People Living with HIV (PLHIV) in South Africa and the prevalence rate among the 15–49 age group is almost 19 percent.⁴ Most worryingly of all, an estimated 340,000 people are newly infected each year.⁵ Furthermore, South Africa’s HIV epidemic is fueled and compounded by an epidemic of tuberculosis (TB). In 2014, of the 295,000 newly

¹ This report draws on observations made by the delegation during its visit to South Africa, supplemented by additional research carried out by CSIS, which has sole responsibility for the contents.
² The delegation’s trip and this report were made possible by the generous support of the Bill & Melinda Gates Foundation. CSIS would also like to thank staff from the U.S. embassy in Pretoria for helping facilitate the visit, in particular Chuck Pill, South Africa PEPFAR coordinator; Catherine Brokenshire-Scott, team lead for HIV/AIDS care and treatment, USAID Southern Africa; Dr. Amy Herman-Roloff, senior epidemiologist, division of global HIV/AIDS, CDC; and Dr. Nancy Knight, CDC country director, South Africa. The team would like to thank Dr. Angeli Achrekar, chief of staff at the Office of the U.S. Global AIDS Coordinator, for briefing the research team before its departure and offering feedback on a draft of the report. Finally, the research team is grateful to Dr. Brian Brink for his invaluable advice and assistance in planning the visit.
⁵ Figures from presentation by senior staff from Office of the Global AIDS Coordinator to CSIS delegation, Washington, DC, February 3, 2016.
diagnosed TB patients given an HIV test, 61 percent tested positive. This coinfection rate is far above the global average of 12 percent.

Despite these grim statistics, South Africa has made steady progress in tackling its HIV epidemic. In particular, it has rapidly increased the number of people receiving antiretroviral therapy (ART). An estimated 3.4 million people were on ART in early 2016, making the national HIV treatment program the largest in the world. The most impressive progress has been in preventing mother-to-child transmission of HIV, which dropped from 3.8 percent in 2010 to 1.5 percent by 2014–15. This effort is largely sustained by the South African government, which in 2013–14 provided 77 percent of the funding for the overall HIV response.

Figure 1: Key HIV Statistics

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8 Number provided by Yogan Pillay, deputy director-general, HIV/AIDS, TB, and MCWH, Department of Health, Pretoria, February 18, 2016.
11 See tables in appendix for exact numbers and information about the sources.
The United States has been South Africa’s most important external source of health assistance. It is no exaggeration to say that the United States’ partnership with South Africa to tackle HIV has saved millions of lives. The President’s Emergency Plan for AIDS Relief (PEPFAR) is the single-most influential U.S. policy intervention in South Africa since the advent of multiracial democracy in 1994. Although the government rarely acknowledges PEPFAR’s efforts in public, the people and health professionals who have directly benefited from its efforts constantly applaud the program. Despite a budget decline in recent years, PEPFAR continues to commit enormous resources to South Africa, and funding for 2016 has rebounded to more than $500 million due to new programs aimed at preventing HIV among the most vulnerable populations.

From the outset, the PEPFAR relationship has been in almost perpetual transition. This reflects the fast-moving, ever-shifting nature of the HIV epidemic, strategic changes at the Office of the U.S. Global AIDS Coordinator (OGAC), and the fluid, unpredictable South African political landscape. PEPFAR in South Africa began as an almost undercover program circumventing a resistant host government under President Thabo Mbeki (1999–2008). These unique origins led PEPFAR to set up what amounted to a parallel health system for the delivery of emergency HIV assistance. Since then, the operating environment has radically shifted and PEPFAR now enjoys a productive partnership with its hosts. It has in stages transferred responsibility for providing care and treatment services from U.S. institutions and South African NGOs to the South African public health system. PEPFAR has stepped back from front-line service delivery in favor of technical support. A series of agreements have formalized this process, notably the Partnership Framework Implementation Plan, which lays out the mutual commitments of each country to the HIV response over the period 2012–17.

The latest phase of PEPFAR is centered on extracting maximum impact with more modest resources.12 Popularly known as PEPFAR 3.0 or the PEPFAR pivot, the strategy emphasizes the use of data to identify the populations and locations that drive the HIV epidemic and direct resources toward them in a more targeted way.13 Rather than spread support evenly across the nation, PEPFAR will saturate areas of high HIV prevalence with extra assistance while scaling back in areas with a lower burden.

The unveiling of PEPFAR 3.0 triggered a lengthy and occasionally contentious round of negotiations with the South African government, which felt it had not been sufficiently consulted and was unenthusiastic about the prospect of yet another set of disruptive program changes. During the past 18 months, both governments have endured a tiring process of almost continual review, reevaluation, and negotiation. There have been many bumps along the way but the relationship has remained strong throughout and there is a spirit of cooperation on health that is lacking in other parts of the bilateral relationship. The South African government has fully embraced the pivot, known by local PEPFAR officials as

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12 In the case of South Africa, expected declines in PEPFAR expenditure did not come to pass in 2016 because of the addition of funding related to the DREAMS initiative.

the Focus for Impact strategy, but the real test is yet to come as the process of operationalizing the plan gathers momentum.

Purpose of the Study

In February 2016, CSIS researchers and congressional staff visited South Africa to examine the HIV response and situate it within broader efforts to reform the health system. During a wide-ranging trip that took in parts of Gauteng, KwaZulu-Natal, and Mpumalanga provinces (see Appendix 2), the team examined the new strategy adopted by PEPFAR in South Africa, took an early look at the implementation process, and considered the opportunities it presents and the challenges it will face. The delegation met with U.S. embassy staff; South African government officials at the national, provincial, and district levels; health professionals; U.S.-funded health program implementers; representatives of nongovernmental organizations; academics; researchers; journalists; and leaders from the South African private healthcare sector.

The purpose of the trip was to enhance understanding of the U.S.-South Africa health relationship by examining how the new PEPFAR strategy is being implemented. By observing a range of U.S.-supported health programs and initiatives, including some that had successfully transitioned to full South African ownership, the delegation sought to weigh the significance of PEPFAR’s contribution in South Africa, and by extension the broader southern Africa region, where efforts to tackle HIV depend upon progress in South Africa. Delegates also considered the likely impact of the program’s strategic shift on the country’s HIV burden. It is not possible to look at HIV in South Africa without looking at TB, given the very high coinfection rate among patients. The delegation considered the extent to which the new PEPFAR strategy reflects the reality that TB has become the number one cause of death from disease in South Africa.

In its efforts to tackle HIV, one of the biggest challenges South Africa faces is preventing new infections, particularly among at-risk populations such as young women and adolescent girls, female sex workers, and men who have sex with men. The failure to stem the flow of new infections undermines the excellent progress South Africa has made on the care and treatment front. Therefore, the delegation spent part of the trip examining HIV prevention activities, including the new U.S. public-private partnership to help girls become Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women, known as DREAMS.

Finally, the delegation examined issues around the sustainability of the wider health system in South Africa. Healthcare delivery in South Africa is impaired by systemic weaknesses including low human resource capacity, inefficient use of resources due to mismanagement or corruption, underperforming drug supply chains, and poor knowledge management. In addition, South Africa faces the pressure of financing rising demand for health services while the national economy continues to underperform. Therefore, the delegates learned more about South Africa’s plan to reform the health system with a view to introducing National Health Insurance (NHI) and considered what, if any, role the United States can play in supporting this effort. This line of inquiry provided an opportunity to
reflect upon U.S. strategies for strengthening South Africa’s health system, looking at—for example—the extent to which U.S. support through vertical disease programs such as PEPFAR has had beneficial broader impact.

Based on its examination of these broad topic areas, the delegation made the following observations:

1. **South Africa’s political and economic plight constrains its response to HIV**

South Africa is an atypical PEPFAR partner. While it has enormous need as the center of the global epidemic and the country with the largest number of PLHIV, it is also better placed than other PEPFAR recipients to lead an effective response, thanks to the considerable economic and human resources at its disposal. These resources are spread unequally between the public and private health sectors and urban and rural communities. They are also used inefficiently because of mismanagement, corruption, nepotism, and the complexity of working through South Africa’s quasi-federal system of government. Even so, South Africa largely funds its own HIV programs and has a strong core of health professionals, scientists, and technocrats whose combined efforts provide drive and strategic direction.

Currently, South Africa is struggling with a twin crisis—a prolonged economic slump and a profound political malaise—that places constraints on its ability to optimize the HIV response. The mood of national despondency is palpable and there is a gulf between public demands from the state—for jobs, quality services, and social progress—and the ability of the African National Congress (ANC) government to meet these expectations. The CSIS visit was bookended by a raucous State of the Nation Address in which President Jacob Zuma’s speech was disrupted by opponents from the Economic Freedom Fighters party, and a closely watched budget statement by recently reappointed Finance Minister Pravin Gordhan.

South Africa’s straitened circumstances limit its ability to meet its health challenges. The government has been distracted from policy implementation by constant infighting and put on the defensive by the incessant questioning of President Zuma’s fitness for office. Its budgeting options have substantially narrowed due to a combination of factors including a forecast for low economic growth, the weak Rand, rising public-sector wages, the increasing cost of borrowing, and the need to finance an emergency response to a devastating regional drought. Meanwhile, private-sector firms—particularly the mining companies that have played an important role in the HIV response—are now entirely

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14 A week earlier, lawyers for Jacob Zuma conceded during a hearing of the constitutional court that the president should pay back some of the public money used to make improvements to his family homestead.

15 Gordhan first served as minister of finance from 2009 to 2014. He was reappointed in December 2015 to mollify the markets following President Zuma’s decision to replace his successor, Nhlanha Nene, with a little-known ANC official, David van Rooyen.
focused on survival and have a waning appetite for sustaining costly health benefits to employees and their families.\textsuperscript{16}

While these are a significant set of challenges, they create strong incentives for South Africa to find ways to use its still-considerable health resources more effectively. Major savings can be made by cutting inefficiencies, tackling corruption and nepotism, and rooting out mismanagement. In multiple meetings with CSIS, health officials described the need for more efficiency at all levels of the health system. While there is a genuine commitment at the National Department of Health (NDoH) to this objective, the level of buy-in at the provincial and district level remains open to question.

2. NHI is a laudable aim but a distant prospect

South Africa’s commitment to undertake a wholesale reform of its health system, with the objective of achieving universal health care, represents a potential step forward. The hugely ambitious plan would introduce a National Health Insurance scheme over a 14-year period. As part of the preparations, an NHI Fund will be established that will provide a package of health services free of charge at the point of delivery. The fund will be financed by taxpayers’ mandatory contributions and other—yet-to-be-agreed-upon—sources. Services will be provided through a consolidated, unitary system in which accredited health facilities in both the private and public health sectors take part. There are still many details to be determined, notably how exactly NHI will be financed. The success of the scheme is also reliant upon major improvements to the standard of healthcare currently offered in the public system, particularly at the primary health care (PHC) level. Pilot projects are under way to kick start this process in 11 of the worst-performing health districts.

To date, progress on the road to NHI has been slow, due in part to the ambitious nature of the proposal and apparent confusion about key elements of the plan.\textsuperscript{17} Far more political will, cooperation, urgency, and funding will be required to turn the vision into reality. However, the government deserves credit for its desire to iron out the inequities that result from the fact that half of national health expenditure funds a private healthcare system that is used by only 16 percent of the population.\textsuperscript{18} A big, sustained push will be required to improve a public healthcare system that in a majority of South Africa’s nine provinces is failing, especially in rural areas. However, reform will not succeed without efforts to address

\textsuperscript{16} In December 2015, one of the largest companies in South Africa, Anglo American, whose HIV healthcare plan has been an industry leader, said it would reduce its workforce from 135,000 to 50,000 as part of a radical restructuring plan.

\textsuperscript{17} For example, shortly after the publication of the NHI White Paper, Health Minister Aaron Motsoaledi distanced himself from a major part of the plan, which states that private medical schemes will not be allowed to duplicate services provided under NHI. In an interview, he said that patients should retain the freedom to opt for private coverage if they wish to do so. See Tamar Kahn, “Motsoaledi does not want NHI to limit choices,” Business Day, February 1, 2016, http://www.bdlive.co.za/national/health/2016/02/01/motsoaledi-does-not-want-nhi-to-limit-choices.

the root causes of failure, which include poor governance and entrenched patronage networks, particularly at the provincial and district levels.

For NHI to become a reality, the South African government will need to adopt a more pragmatic approach that takes incremental steps toward its ultimate objective by targeting easy wins in the PHC system rather than first tackling the most difficult health districts. More effort will be required to get the skeptics on board with the strategy by diluting the ideological tone and adopting a more flexible attitude. In this regard, it makes sense to look for ways to harness the capacity of the private health system rather than antagonize it through an unnecessarily confrontational policy. The private system has spare capacity—extra hospital beds and underutilized equipment such as MRI scanners—that could be used by public patients if flexible solutions were found. The United States is monitoring the NHI but the political and economic uncertainties surrounding the scheme have precluded substantive engagement. A regular, formal mechanism should be found for the two countries to engage on NHI so that the United States can keep abreast of developments and offer assistance if opportunities arise.

3. South Africa’s health challenges are compounded by weak systems and low human resource capacity

Important reforms of South Africa’s health system are urgently required, regardless of whether or not NHI becomes a reality. Using HIV as an example, a leading doctor who set up clinics in two of South Africa’s poorest provinces told the delegation that each case he dealt with represented a system failure, whether it was a failure to track down and test an HIV-positive case, a failure to initiate treatment in a timely manner, a failure to ensure regular supply of ARV drugs, or a failure to follow up with patients who had defaulted on treatment.

The dire state of human resources for health is a chronic problem that must be prioritized. Each year, 1,800 new doctors graduate from medical schools in South Africa but more than 5,000 are required to meet demand. Of these 1,800, a majority choose to practice overseas or work in the private sector. Simply increasing the supply is not the solution. The delegation heard that seven of South Africa’s nine provincial governments had reportedly frozen recruitment of health staff due to end-of-year budget constraints. Health worker retention is another big problem, particularly in rural areas.

South Africa has made creative use of the limited human resources at its disposal, adopting a flexible attitude toward task shifting. For example, it quickly realized that the scale of the HIV epidemic meant it was not possible for doctors to have sole responsibility for administering ART. Clinical guidelines were relaxed to clear the way for nurse-initiated and managed antiretroviral treatment (NIMART), a policy that has been hugely successful. During its visit, the CSIS delegation witnessed the work conducted by Clinical Associates (CAs), a mid-level cadre of health workers who take the burden off doctors at district hospitals, primarily in rural areas, by conducting patient examinations and carrying out basic

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clinical procedures. Initial studies have shown that CAs are cost effective, efficient, and have higher retention rates. However, the safety and sustainability of these types of initiatives depend upon clear clinical guidelines, frequent training, mentoring, and supervision, and a career path that allows for advancement.

Opportunities are being missed at the lowest rung of the health system, where a more systematic approach toward community health workers (CHWs) is required. CHWs are a cadre of support staff that have had a beneficial impact in other developing countries but have been less effective in South Africa. The current system is muddled, with each province adopting its own hiring practices, scope of practice, and salary structures (if their CHWs are paid at all). Many CHWs have built up skills, particularly in the HIV response, often thanks to U.S. investment, but a formula has yet to be found to successfully integrate them into the health system.

4. **PEPFAR’s Focus for Impact strategy is an ambitious and logical response to South Africa’s HIV epidemic**

Turning to the fight against HIV, South Africa, the United States, and the other major stakeholders agree that the next five years represent a window of opportunity to make a decisive breakthrough. In a welcome development, the main players have largely succeeded in aligning their strategy and resources to this end. Reaching the UNAIDS’s fast-track 90–90–90 goals have become the benchmark for measuring success from now until 2020, the PEPFAR pivot is based around achieving them, and the South African government has plugged these targets into the framing of its so-called HIV Investment Case.

The fiscal challenge, however, is enormous. While South Africa’s budget envelope envisages a modest increase in the allocation for HIV in 2016–17 (from ZAR 21.1 billion to ZAR 21.7 billion), officials acknowledge that the outlook is uncertain. South Africa’s HIV Investment Case is an attempt to examine sustainable financing options that—among other things—take into account the scale of the HIV burden, flat-lining donor contributions, the gloomy domestic economic outlook, and the impact of new guidelines from the World Health Organization that recommend initiation of ART as soon as patients test positive for HIV, regardless of their CD4 count. It then weighs up these factors to decide how best to allocate its limited resources. It is a thorough, thoughtful exercise that makes a stark conclusion: *The total cost of funding the epidemic will continue to rise irrespective of what*

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21 The UNAIDS target sets a deadline of 2020 for 90 percent of people with HIV to know their status, 90 percent of people diagnosed with HIV to receive antiretroviral therapy, and 90 percent of people on antiretroviral therapy to have achieved viral suppression.


23 CD4 cell counts are used to test the strength of a person’s immune system. The Strategic Timing of AntiRetroviral Treatment (START) study, funded by the National Institutes of Health, found that people with HIV had less chance of developing AIDS if they took ARVs early rather than waiting for their CD4 count to decrease. The World Health Organization took up the findings in new treatment guidelines, issued in September 2015. See WHO, *Guideline on When to Start Antiretroviral Therapy and on Pre-Exposure Prophylaxis for HIV* (Geneva: WHO, September 2015), http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf?ua=1.
course of action is taken due to the generalized nature of the epidemic and the fact that current resources are already allocated in a fairly efficient manner. Nevertheless, the investment case identifies several interventions that provide the best value for money while at the same time offering the best chance of meeting the 90-90-90 targets by 2020. They include conducting at least 35 million HIV tests per year, putting up to 900,000 additional people on ART every year until 2019, and—as far as possible—moving ART from clinical to community settings.\textsuperscript{24}

These findings underline the importance of matching a strategic approach with a relentless drive for efficiency savings and innovations. Success will depend upon the ability to gather reliable data and act upon it. In that sense, PEPFAR’s Focus for Impact strategy in South Africa hits the right notes. The data clearly support a more focused, strategic approach. Approximately 5.6 million PLHIV reside in 27 of South Africa’s 52 health districts. Together they comprise more than 80 percent of the national HIV burden.\textsuperscript{25} PEPFAR is engaging in what it calls “aggressive scale-up” in these districts with the intention of hitting the 90-90-90 targets ahead of schedule—as early as 2017. Scaling up will mean dramatically increasing the number of PLHIV initiated on ART, ramping up HIV testing and counseling (HTC) services, bolstering support for orphans and vulnerable children (OVC) and intensifying outreach to other key populations such as young men aged 15–34 through HIV prevention activities such as voluntary medical male circumcisions (VMMCs). The overall effort will be made possible by freeing up resources by transitioning out of South Africa’s remaining 25 health districts.

Efficiency savings are possible in South Africa’s HIV response but a balance must be struck between cutting costs and ensuring that quality services are maintained. Money can be saved through better procurement practices for ARVs, condoms, and other medical supplies, and major progress has already been achieved in negotiating better prices for ARVs (although the decreasing value of the Rand threatens to undermine these gains). On the treatment front, PEPFAR is pondering savings in a number of areas; for example, do stable PLHIV require viral load testing more than once a year and do patients need to pick up their ARVs once a month or can they instead collect them every two to three months or even more infrequently? Do they need to collect them in person or could they receive them directly by mail? The South African government is considering how these proposals can be adapted to the local context but cautions that an overly aggressive efficiency drive could lead to adherence rates dropping. Attention will be required to ensure that other efforts to promote adherence are maintained and strengthened. These include community adherence clubs and the use of cellphone technology such as SMS to remind patients to take their medication.


\textsuperscript{25} Numbers from presentation by senior staff from Office of the Global AIDS Coordinator to CSIS delegation, Washington, DC, February 3, 2016.
5. Implementing “Focus for Impact” will be a major logistical and diplomatic test

While the topography of HIV in South Africa justifies PEPFAR’s new approach, implementing the Focus for Impact vision is a daunting process that poses major operational challenges. Work began in October 2015, so it is still too early to judge its success. The key partners in the effort are district health officials, who have been tasked with drawing up strategic plans and budgets to achieve the 90-90-90 goals, managing what in some districts is a big influx of new resources and in others is a significant reduction. The entire process rests on the cooperation and professionalism of officials at the least-capable level of the health system. Most so-called District Implementation Plans (DIPs) were submitted at the end of 2015. U.S. officials told the CSIS delegation that they were of variable quality. Officials have already stated that they want to incorporate several missing elements in future DIPs, namely, including the private sector and additional relevant government departments in the process to see what assets they can bring.

In the 25 health districts where PEPFAR support is being scaled back, U.S. officials expressed confidence that the transition was being handled smoothly and efficiently. A transition group made up of U.S. embassy staff and South African government representatives has been meeting weekly to monitor the process and identify concerns. According to PEPFAR’s Country Operational Plan, PEPFAR was due to withdraw from 3,700 sites by the end of 2015, including 2,015 sites that provided care and treatment services. Officials told the delegation that this process had been largely completed without major hitches. Transition, however, is a delicate process that was conducted at lightning speed for this first set of sites. Utmost vigilance will be required to ensure service continuity in areas where PEPFAR has withdrawn or provide patients with alternative options nearby. Regular follow-up will be required to make sure that services taken up by South Africa’s provincial governments are maintained.

The Focus for Impact strategy will stand or fall on its ability to gather reliable, comprehensive, granular, “real-time” data down to the facility level and to adapt and shift resources according to what the data says about new and emerging hotspots. The PEPFAR team has initiated quarterly reviews with its partners in order to sift through this information and identify problems. However, the United States is reliant upon imperfect data from South Africa’s District Health Information System (DHIS), which lags one quarter behind. Going forward, it will be important to examine PEPFAR’s ability to respond to the emergence of new hotspots. The current approach is that resources will saturate existing hotspots, hit the 90-90-90 targets, and move to the next ones. But will the strategy be nimble enough to quickly respond to changing circumstances on the ground, for example, if the development of a new mining or construction operation outside an existing hotspot attracts an influx of migrant labor that leads to a spike in HIV cases?

6. **DREAMS is the leading edge of a much-needed emphasis on HIV prevention**

At the center of renewed efforts to reduce HIV prevalence among key populations, special emphasis is being placed on HIV prevention among young women and adolescent girls. The DREAMS initiative is a public-private partnership between PEPFAR and several foundations and companies that will work in sub-districts of five South African health districts with high HIV prevalence. The highly targeted nature of DREAMS provides opportunities to incubate and test approaches in relatively compact locations, to see what combination of activities works best, and where. A range of tools will be deployed, including biomedical, behavioral, economic, and social, in an effort to unpack the complex reasons why young females are so vulnerable to HIV exposure, mainly from older male partners. A budget of $67 million has been set aside for DREAMS activities and highly ambitious targets have been set to reduce HIV infections by 40 percent among adolescent girls and young women by the end of 2017 in the areas where it operates.

The key challenge will be to establish a framework for rapidly scaling up successful approaches. Good working relationships and coordination between the South African

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government and its donors will be important. In this respect, the early signs are positive. In April, the Global Fund to Fight AIDS, Tuberculosis, and Malaria was due to begin a new three-year grant cycle worth $62 million to prioritize HIV prevention among key populations, including young women and girls. This will involve replicating the DREAMS model in an additional 10 health districts. The German government has agreed to fund complementary activities in one additional district. Most importantly, the South African government has played the central role in designing DREAMS activities and the NDoH is poised to announce a new national plan for HIV prevention.

Still, there are important gaps to fill. Linkages must be improved between the NDoH and the Department of Basic Education on prevention activities in schools; a policy statement on sex education and condom distribution in schools is long overdue; and a decision must be made about whether to offer pre-exposure prophylaxis (PrEP) to adolescent girls. For the United States, new strategies will be required to strengthen the case to Congress on the importance of funding prevention activities, including better metrics that help demonstrate its positive impact in terms of lives and money saved.

7. **Universal Test and Treat is a potential game changer that is accompanied by serious risks.**

The results of the START (Strategic Timing of Antiretroviral Treatment) study and the new WHO treatment guidelines on early initiation of ART have given urgency to discussions about Universal Test and Treat (UTT). In conceptual terms, the merits of UTT are clear. Not only would it ensure that PLHIV—once diagnosed—remain healthy, it would also be a powerful prevention tool because people in the early stages of HIV feel healthy, they tend to be sexually active, and therefore pose a big risk to their partners. Officials in the NDoH want to proceed with UTT but at the time of the delegation’s visit were awaiting approval. PEPFAR supports UTT and has plans to pilot it in some of the sub-districts where DREAMS is operating.

On a practical level, major challenges would accompany any rollout of UTT. The cost of putting substantial additional numbers of PLHIV on ART is obviously a major concern but perhaps even more important is the need to ensure that the health system can cope with the demands of sustaining them on treatment for the rest of their lives. Is the drug procurement system and supply chain robust enough? And is the community-based support network strong enough to ensure high compliance rates? If not, South Africa faces the frightening prospect of increased levels of drug resistance and treatment failure, which would do irreversible damage to the HIV response. As one doctor pointed out: “We only have one shot at this, so it’s critical to get it right.”
8. **South Africa’s TB challenge is alarming and cannot be ignored**

TB is the leading cause of death due to disease in South Africa, killing 89,000 people in 2014, including 64,000 PLHIV.\(^{29}\) TB has attracted more high-level attention and resources in the past two years but still remains the forgotten killer. Multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB) are growing public health concerns.\(^{30}\) Compared with HIV, the tool kit for tackling TB is depleted, with relatively poor diagnostics and treatment options. Some progress has been made in elevating TB, with the South African government matching some of the urgency shown toward HIV by adopting equivalent 90-90-90 goals set by the WHO End TB Strategy. Efforts are being made to prioritize key populations who are most badly affected by TB, such as prisoners and mine workers. Progress has been made on integrating HIV and TB services—which must be a high priority given the high coinfection rate—but there is a long way to go. Innovative approaches are being taken to decentralize TB treatment, which particularly for MDR-TB patients is long and grueling, with higher default rates. The CSIS delegates saw these efforts first-hand during a visit to a district hospital in KwaZulu-Natal, one of 642 sites nationwide where nurse-initiated MDR treatment takes place. Despite these efforts, however, HIV continues to dominate the public health conversation in South Africa, with TB often inserted as an afterthought.

9. **PEPFAR must be flexible in order to take full advantage of the opportunities**

Since it began work in South Africa in 2004, PEPFAR’s single-minded focus on tackling HIV has reaped dividends. However, opportunities are being missed to fund activities that would help unblock bottlenecks in the broader development arena, with a positive knock-on for the battle against HIV. The delegation saw many instances where the HIV response was hindered by a weak supporting environment. They included the lack of transport for volunteers tracking down TB patients lost to follow-up in rural KwaZulu-Natal, unreliable power supply that left many rural clinics without electricity, and the difficulty of using PEPFAR funding for economic programs that support key populations, such as the small peanut farm run by a grandmother from her garden in rural Mpumalanga. She told delegates that income from the crops helped ensure that two orphan children in her care were adequately fed and able to pay their school fees. Going forward, PEPFAR should consider taking a more flexible approach or—most likely—building relationships with other agencies and donors to take better account of the fact that an effective response to HIV in South Africa means improving the overall health and development landscape.

**Recommendations**

PEPFAR has achieved an enormous amount of good in South Africa and saved countless—perhaps millions—of lives. During more than a decade of engagement, it has shown an

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\(^{30}\) MDR-TB is defined as TB that is resistant to the two best first-line TB drugs. XDR-TB is a severe form of MDR-TB that is even harder to treat.
ability to evolve to take account of changing political currents and the shifting nature of the epidemic. Genuine efforts have been made to promote host-country ownership of the HIV response. Now, as it embarks on another phase of engagement, it faces a new set of challenges and the pressures of hitting a set of ambitious new targets. As it undertakes this task, the delegation offers the following recommendations, divided into diplomatic, policy, and strategic approaches:

Diplomacy

Harness the diplomatic power of PEPFAR: PEPFAR’s relationship with South Africa demonstrates the power of partnerships. Thanks to PEPFAR, the health relationship is the strongest component of the bilateral relationship with South Africa, which is often strained. The delegation heard that the goodwill it generates has seeped into other, more contentious areas of diplomacy. For example, the minister of health reportedly made a useful intervention to help resolve a trade row that threatened South Africa’s renewed membership of the African Growth and Opportunity Act, a program that offers duty-free access to U.S. markets for thousands of African product lines. As PEPFAR continues to make the case to Congress about its enduring value, it should emphasize its diplomatic as well as its health achievements. U.S. diplomats should be forthright in using PEPFAR as a soft power tool in partner countries.

Foster dialogue between the public and private sectors. South Africa’s private sector should be doing more to help alleviate the national health burden, which weighs heavily on its own workforce and ultimately lowers its productivity. At the same time, a suspicious government frequently spurns the private sector’s overtures. The minister of health never misses an opportunity to bash the private healthcare sector, which admittedly is in need of reform. In its conversations with the government, the United States should advocate for a less confrontational approach to the private sector. There are pragmatic reasons for this. Absent a shift in attitude, ANC policy priorities such as the NHI stand virtually no chance of getting off the ground. The United States should look for ways to pass on its experience in developing public-private partnerships, aggressively seeking opportunities to support health-sector collaborations that bridge the public-private divide. The DREAMS initiative is promoting efforts in this area through its Innovation Challenge, a fund that gives organizations—including private-sector firms in South Africa—the chance to compete for grants to do HIV prevention work that goes beyond the core package of DREAMS activities. These kinds of efforts should be prioritized and nurtured.

Grasp opportunities to build on growing coordination with the South African government and other donors. Compared with years past, the main donors working on HIV are doing a better job of coordinating their activities with each other and the South African government. However, more can be done, particularly in today’s resource-stretched environment. The DREAMS initiative is a vehicle for making further progress because it aligns with the priorities of the United States, the Global Fund, and South Africa in reducing HIV infections among young women. Several events in the coming year provide additional opportunities for all partners engaged in the fight against HIV to galvanize efforts and set a common strategic direction. They include the International AIDS Conference that South
Africa will host in July and the process to write a new five-year National Strategic Plan for HIV, TB, and Sexually Transmitted Infections, due to be completed by the end of 2016.

Policy

Minimize the policy changes: It is hard to emphasize just how disruptive and time-consuming PEPFAR transitions have been for everyone involved. They place enormous strain on OGAC staff in Washington; embassy officials from PEPFAR and their implementing partners the United States Agency for International Development and the Centers for Disease Control and Prevention; and their provincial teams. Most of all, they put a huge burden on the host government that, even at the national level, lacks capacity. The uncertainty that preceded the announcement of PEPFAR 3.0 also led to a temporary drop in HIV expenditure because implementing partners were uncertain about their future involvement. Partners who have been transitioned out of PEPFAR support told delegates about the painful process of negotiating with provincial governments to take on services. In some cases their efforts were successful but in many cases they could only persuade local health officials to provide partial support, for shorter durations. Transitions are necessary but they are also inefficient. Quick transitions in particular increase the risks of service disruption and displace local program staff who in many cases have built up years of experience. They should be avoided. Now that the PEPFAR pivot is in full swing, it should be given time to complete its work before new strategies are considered.

Walk before you run on UTT: Given the high stakes involved with any rollout of UTT, it is important to move cautiously, ensure that budgets are robust, and that the necessary systems are in place. Particular care must be taken to maintain adherence rates, especially among patients who start ART at an earlier stage than they would have done under previous guidelines. These people may feel healthy and will need additional support and encouragement to ensure they continue taking their medicines.

Prioritize efforts to address South Africa’s health workforce deficit: The United States should explore and invest in creative solutions to the human resource gap in the way that the NIMART model transformed staffing of the HIV response. On a policy level, the United States should urge South Africa to produce a realistic, costed human resources plan to accompany the 2008 Human Resources for Health Strategy and formulate a clear policy on CHWs. The United States should suggest the South African government address other bottlenecks to recruitment by reforming the ineffective Health Professions Council of South Africa and removing hurdles to foreign medical staff working in the country.

Engage with NHI—but do it strategically. NHI is the single-most important reform of the health system yet the United States is standing on the sidelines. This is understandable given the political and economic uncertainties around the project. But the United States has a vested interest in the success of NHI and should seek to engage in efforts that most closely align with PEPFAR goals. One of these is investing in the effort to establish an NHI card. One of the biggest handicaps in tracking HIV patients and ensuring treatment adherence is the lack of a unique patient identifier. Under the NHI, this problem will be overcome by issuing every person an NHI card containing their essential data that will be used to access health
services. However, this plan remains several years away from being implemented. PEPFAR could help bring it a step closer by piloting a unique identifier for PLHIV. This would provide an important test of whether the system could be extended to all patients through the NHI card.

Strategy

Think regionally: Cracking HIV in South Africa depends upon cracking HIV in the southern Africa region, and vice versa. The flow of people throughout the region is considerable and South Africa is at the center of this movement because of its importance as a supplier of (mainly seasonal) jobs and a place of political refuge. One critical issue to address is to improve the ability to trace migrants who begin treatment for HIV and/or TB in South Africa, only to return to their country of origin. Adherence rates among this group are a particular problem. Stepping up efforts to follow the sex trade along regional trucking routes will also help disrupt a major vector of the HIV virus. South Africa and fellow members of the Southern African Development Community (SADC) should increase activities to harmonize policies and best practices and work together on procurement of ARVs and other essential health commodities. The private-sector constituency on health, which meets alongside meetings of SADC health ministers, is another potential vehicle for improving regional approaches to HIV.

Start thinking about the implications of success, and plan accordingly. It will be a tall order for PEPFAR to meet the ambitious goals of Focus for Impact but if it does so, what will come next? The HIV response will shift to a different track, centered on chronic disease management, predominantly in the community. This will place even more onus on South Africa’s PHC system to perform. Health planners should start thinking about the strategic implications of this and consider what role PEPFAR and the United States more broadly might play.

Conclusion

PEPFAR and South Africa are embarking upon an exciting phase in the HIV response. The CSIS delegation was struck by the high levels of energy and enthusiasm displayed by everyone involved in the process. The main actors are working well together and there is a palpable feeling that an opportunity has emerged to strike a serious blow against the epidemic. Yet the barriers to success are formidable. They range from the financial to the political, to the sheer scale of the disease burden and the difficulties of stemming the rate of new infections. The soaring ambition of Focus for Impact and the demanding targets involved mean that efforts could ultimately fall short, but the strategy is sound and the “reach for the stars” approach should be applauded and supported. The reality, however, is that success will depend upon the smooth functioning of a public health system that—absent major reform—is not capable of meeting the demands placed upon it. South Africa’s predicament explains why strengthening health systems must be a priority undertaking for the United States and other international partners if they want their global health investments to endure.
Appendix 1: HIV Data on South Africa

Table 1: Key HIV Figures

<table>
<thead>
<tr>
<th>Year</th>
<th>Population Living with HIV</th>
<th>AIDS-Related Deaths</th>
<th>New Infections</th>
<th>Individuals Currently on ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>5,500,000</td>
<td>310,000</td>
<td>510,000</td>
<td>4,934</td>
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<tr>
<td>2005</td>
<td>5,700,000</td>
<td>320,000</td>
<td>490,000</td>
<td>40,181</td>
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<tr>
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<td>5,800,000</td>
<td>330,000</td>
<td>480,000</td>
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<tr>
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<td>6,000,000</td>
<td>320,000</td>
<td>480,000</td>
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<tr>
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<td>480,000</td>
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<td>6,200,000</td>
<td>330,000</td>
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<td>6,300,000</td>
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<td>420,000</td>
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<td>300,000</td>
<td>410,000</td>
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<td>2014</td>
<td>6,800,000</td>
<td>140,000</td>
<td>340,000</td>
<td>3,078,570</td>
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Table 2: Bilateral PEPFAR Funding to South Africa since 2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Dollars (millions)</th>
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</thead>
<tbody>
<tr>
<td>2004</td>
<td>93</td>
</tr>
<tr>
<td>2005</td>
<td>144</td>
</tr>
<tr>
<td>2006</td>
<td>222</td>
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<td>2007</td>
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<td>2013</td>
<td>484</td>
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<tr>
<td>2014</td>
<td>459</td>
</tr>
<tr>
<td>2015</td>
<td>413</td>
</tr>
<tr>
<td>2016</td>
<td>497*</td>
</tr>
</tbody>
</table>


* According to PEPFAR’s 2015 Country Operational Plan for South Africa, planned funding for FY2016 was $413 million. This number has since been boosted by $67 million under the DREAMS initiative (to be dispersed over two years) and an additional $17 million for voluntary medical male circumcision (VMMC) activities. See PEPFAR, “Country Operational Plan (COP) 2015: Strategic Direction Summary,” September 30, 2015, 111, http://www.pepfar.gov/documents/organization/250301.pdf.

Table 3: HIV Expenditures in South Africa, FY 2015

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Dollars (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEPFAR&lt;sup&gt;a&lt;/sup&gt;</td>
<td>413</td>
</tr>
<tr>
<td>Government of South Africa&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1,200</td>
</tr>
<tr>
<td>Global Fund to Fight AIDS, TB, and Malaria&lt;sup&gt;b&lt;/sup&gt;</td>
<td>99</td>
</tr>
</tbody>
</table>

<sup>a</sup> PEPFAR, “Country Operational Plan (COP) 2015.”
Appendix 2: South Africa Congressional Delegation Agenda

February 14–February 19, 2015

Delegation Members

Mary-Sumpter Lapinski, health policy director (majority), Senate Health, Education, Labor, and Pensions Committee

Nick Bath, health policy director (minority), Senate Health, Education, Labor, and Pensions Committee

Lesley Anne Warner, professional staff member, House Foreign Affairs Committee (minority)

Richard Downie, deputy director and fellow, CSIS Africa Program

Dr. Audrey Jackson, senior fellow, CSIS Global Health Policy Center

Sahil Angelo, program manager and research associate, CSIS Global Health Policy Center

Sunday, February 14: Johannesburg

Working dinner on political and economic trends in South Africa

Dr. Steven Friedman, director, Center for the Study of Democracy, University of Johannesburg

Mia Malan, health editor and director of Bhekisisa Health Journalism Center, Mail & Guardian Newspaper

Dr. Ralph Mathekga, managing director, Clear Content Research and Consulting

Monday, February 15: Johannesburg and Durban

Wits Reproductive Health and HIV Institute, Hillbrow, Johannesburg

Discussion about advances in HIV prevention research with Dr. Helen Rees, executive director of Wits RHI, and senior leadership team. Tour of the facility, including adolescent clinic, research center, and sex work project site. Accompanied by Christopher Rowan, U.S. consul general, Johannesburg.
Clinical Associates Twinning Program, Osindisweni Hospital, KwaZulu-Natal

Tour of Osindisweni Hospital to observe work of Clinical Associates, a cadre of mid-level health professionals supported by PEPFAR. Accompanied by Frances Chisholm, U.S. consul general, KwaZulu-Natal.

TB/HIV Care Association, Durban

Discussion about peer-led HIV prevention and treatment program for female sex workers and visit in mobile clinic to sex worker sites in Durban area.

Tuesday February 16: KwaZulu-Natal and Mpumalanga provinces

Murchison Hospital, KwaZulu-Natal

Visit to Murchison District Hospital, Port Shepstone, to learn about the scale of the MDR-TB challenge in South Africa and hear about nurse-initiated efforts to decentralize and deinstitutionalize MDR-TB screening and treatment services.

Childline, Ehlanzeni District, Mpumalanga

Discussion about HIV prevention and treatment services for orphans and vulnerable children; and broader child protection services, psychological support and family-oriented interventions. Accompanied community care worker on visit to vulnerable family.

Working dinner on rural healthcare challenges and HIV

Dr. Hugo Tempelman, founder and CEO of Ndlovu Care Group

Catherine Brokenshire-Scott, team lead for HIV/AIDS care and treatment, USAID Southern Africa

Wednesday February 18: Mpumalanga Province

Dr. Khosa-Dakei Center, Medical Male Circumcision clinic, Hazyview

Discussion about the effectiveness of MMC as an HIV-prevention tool and efforts to create demand for the procedure at clinic operated by Right to Care through a private general practitioner.

Visit to Bhubezi Community Health Center, Bushbuckridge, and surrounding clinics

Meeting with Dr. Hugo Tempelman, CEO of Ndlovu Care Group, and tour of its Bhubezi clinic, a public-private partnership where funding of HIV and TB services has transitioned from PEPFAR to the provincial government. Discussion about
Bhubezi clinic’s provision of technical assistance to 20 government clinics in the surrounding area and visit to one of the facilities, Kildare clinic.

**Medical Research Council/Wits Rural Public Health and Health Transitions Unit, Agincourt**

Visit to rural research center where health and sociodemographic data has tracked public health trends in the local community—including the evolution of the HIV epidemic—since 1992, demonstrating the positive impact of investments in HIV treatment and prevention.

**Thursday, February 18: Pretoria and Johannesburg**

**South Africa National Department of Health, Pretoria**

Dr. Yogan Pillay, deputy director-general, HIV/AIDS, TB, and Maternal, Child and Women’s Health, National Department of Health

**Meeting with HIV care provider on navigating PEPFAR transitions, Pretoria**

Conversation about the challenges of navigating PEPFAR transitions with Kevin Dowling, bishop of Rustenburg and founder of Tapologo Program, Rustenburg, North West Province

**Meeting with South African National AIDS Council (SANAC), Pretoria**

Dr. Fareed Abdullah, CEO, SANAC

**Working dinner on South Africa’s National Health Insurance (NHI) plan, Johannesburg**

Dr. Brian Brink, former chief medical officer, Anglo American plc

Professor Alex van den Heever, chair of social security systems administration and management studies, University of Witwatersrand

Dr. Mark Blecher, chief director for health and social development, National Treasury, South Africa

Vishal Brijlal, country director, Clinton Health Access Initiative

**Friday, February 19: Pretoria and Johannesburg**

**Meetings with United States Embassy Officials, U.S. Embassy, Pretoria**

Catherine Hill-Herndon, deputy chief of mission

Alonzo Wind, deputy mission director, USAID Southern Africa
Paul Mahanna, USAID health director (acting)

Charles Pill, PEPFAR coordinator, South Africa

Nancy Nay, deputy director, CDC South Africa

**Working lunch on private-sector health provision in South Africa, Discovery Health, Johannesburg**

Dr. Jonathan Broomberg, CEO, Discovery Health

Shaun Matisonn, deputy CEO, Discovery Partner Markets
A health care worker in Kildare Clinic providing HIV prevention services to a patient.

Energizing the Fight against HIV/AIDS in South Africa

Trip Report of the CSIS Delegation to South Africa, February 2016

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A Report of the CSIS GLOBAL HEALTH POLICY CENTER