South Africa’s Future at the Brink

Emergency in the World’s Largest HIV Epidemic

AUTHOR
Sara M. Allinder

A Report of the
CSIS GLOBAL HEALTH POLICY CENTER

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Executive Summary

Every day approximately 685 South Africans become infected with HIV; most are 15-49 years old—those of reproductive and working age who are the backbone of South Africa and the future of its economy. South Africa remains the largest HIV epidemic in the world, responsible for nearly 20 percent of all people living with HIV (PLHIV). It is one of only four countries with hyperendemic epidemics—entrenched HIV epidemics where more than 15 percent of adults are living with HIV. Fueled by syndemics of health conditions and of social conditions such as violence, especially against women, and other health conditions, HIV remains an emergency in the country and a threat to the country’s future.

Despite incredible progress over the last decade, control of South Africa’s HIV epidemic is unlikely in the near future without more aggressive action to push through barriers to effective and impactful program implementation. These barriers keep the country from achieving its targets for suppressing the virus in those who are already living with it and keeping others from becoming infected. The government has proven itself to be a committed leader, funding 70 percent of the national response. However, chronic issues hinder the implementation of well-planned policies, which has led the U.S. government, the country’s leading partner, to threaten funding cuts. Complacency has set in as the country has been challenged by political and economic crises, high rates of unemployment, and one of the largest economic disparities in the world.

As of September 2019, South Africa’s progress toward the 90-90-90 goals stood at 91-70-83 because of lingering issues with patients adhering to treatment.

The country is off track to meet its own target of 6.1 million on HIV treatment by the end of 2020, which would help put it on the path to controlling its epidemic. Only 30 percent of all PLHIV in South Africa were virally suppressed in 2018. In addition, the country also is off track to meet the 2020 Fast Track milestones set out by the United Nations Joint Programme on HIV/AIDS (UNAIDS) to end HIV as a public health threat by 2030. As of September 2019, South Africa’s progress toward the 90-90-90 goals stood at
91-70-83 because of lingering issues with patients adhering to treatment. South Africa’s success or lack thereof will factor greatly in whether this goal can be attained globally.³

What will it take to address the HIV emergency in South Africa and accelerate its path to controlling the epidemic? There are five immediate policy, program, and financial actions that the South African government and its partners, including the U.S. government, can take to help accelerate epidemic control.

1. The South African national government, with strong coordination and buy-in from provincial and local governments, should remove implementation barriers to the provision of health education and prevention and treatment services for adolescents and young adults, including correcting any policies that hinder its HIV response and opportunities to reach youth.

2. The South African government should make oral pre-exposure prophylaxis (PrEP) available at full scale across the country with mass messaging campaigns and easy access at distribution points in communities away from health centers.

3. The South African government should sustain and expand its financial investment as well as develop strong partnerships, especially with the business and corporate sector, to help extend its reach to ensure these policies and programs can be implemented.

4. As South Africa’s largest HIV partner, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) should consider whether its level of investment is rightsized to its goals—not only in South Africa but globally—and appropriately matched to the proportional need in South Africa.

5. The South African government, the U.S. government, and other partners should consider ways to scale up concurrent efforts to combat the social inequalities, toxic masculinity, unemployment, and chronic health system failures that help fuel the spread of HIV.
South Africa has made tremendous progress since 2000 when Nkosi Johnson stood on stage at the International AIDS Conference in Durban to call global attention to the HIV denialism happening in his home country. New infections have declined on average by 40 percent since 2010 nationally, with larger declines in some provinces including KwaZulu-Natal (KZN). Life expectancy has rebounded from 52.5 years in 2005 to nearly 63 years in 2018, driven by declines in deaths of 70 percent among adult women and 59 percent among men since 2005, which is attributed to the increases in antiretroviral treatment (ART) coverage up to 62 percent in 2018. Nearly 4.8 million people were on ART at the end of 2018, with approximately 680,000 newly initiated during that year. Still, an estimated 71,000 South Africans died of AIDS-related causes in 2018.

**Despite those gains, HIV remains an emergency issue in South Africa for four key reasons:**

1. The distance the country has to go to gain control of the virus as a public health threat to the nation,
2. The decades-long mortgage to treat increasing numbers of PLHIV with large numbers of South Africa’s youth becoming infected,
3. The relationship between HIV and other health and societal issues fueling new HIV cases and complicating the response to other diseases, and
4. South Africa’s status as the regional economic, transit, and migratory hub in Southern Africa.

**Distance to Epidemic Control**

The continuing large number of annual new infections, challenges in the initiation and retention of PLHIV on ART, and low achievement and sustainment of viral suppression
fuel the epidemic and add to the distance South Africa must go to control HIV as a public health threat. An estimated 240,000 South Africans were newly infected in 2018, which equates to 4,600 new infections every week. National models project continuing slow decline of infections, but well below the accelerated reduction to 88,000 per year needed by 2020 to meet the Fast track goals. Of particular concern is the burden of disease on women who represent 64 percent of new infections and 63 percent of all adults living with HIV. In some communities within KZN, an alarming 60 percent of adult women are living with HIV. Other key population groups have high rates of infection including sex workers (SWs) at 58 percent, people who inject drugs at 22 percent, and men who have sex with men (MSM) at 18 percent.

There also are significant gaps toward achieving the UNAIDS 90-90-90 Fast Track goals by the end of 2020. At the end of 2018, South Africa’s progress toward the goals sat at 90-68-87, meaning an estimated 90 percent of PLHIV knew their status but only 68 percent of those diagnosed were on ART and 87 percent of those on ART were virally suppressed. Overall, 62 percent of all PLHIV were on ART and only 54 percent of all PLHIV were virally suppressed. Viral suppression is critical to the health of the individual but also for prevention as someone with an undetectable viral load cannot pass on the virus. Only 30 percent of all PLHIV in South Africa were virally suppressed in 2018. In late 2019, the National Department of Health (NDoH) reported only a slight increase to 91-70-83. In addition, approximately 56 percent of patients presenting for care arrived very ill, which indicates they had not been properly diagnosed and treated or had not adhered to treatment if they had started.

In his 2018 State of the Nation address, President Cyril Ramaphosa called for initiating 2 million more South Africans on ART by the end of 2020. Despite action by the government, the U.S. government through PEPFAR, and other partners, South Africa lost more patients to follow up (meaning they left treatment or could not be tracked) than it initiated on ART, resulting in a net loss in 2018. Additional intensive action was taken through 2019 (detailed in the PEPFAR text box and below in the Service Delivery Barriers: Treatment section), but as of February 2020, the country remained
off track to reach the ambitious treatment targets. **An additional 296,000 new patients will need to be initiated and retained on ART per quarter to support the government’s targets of at least 6.1 million people on treatment in the public sector by the end of 2020.** These figures highlight continuing failures in the delivery of HIV services from diagnosis to treatment adherence and underline significant gaps toward achieving epidemic control.

**The Decades-Long Impact on South Africa’s Youth**

While South Africa is not experiencing the same sort of youth bulge as its neighbors, approximately 45 percent of the population is under the age of 25.17 Children under the age of 15 have an HIV prevalence rate of 1.7 percent. That rate jumps up to 3.8 percent for adolescent males and young men ages 15-25 and 10.8 percent for AGYW.18 Adolescent girls/young women (AGYW) ages 15-24 constitute one-third of new infections. Without a massive decline in the new HIV infection rate among those under 35 years old, the sheer numbers becoming infected will stay alarmingly high and providing decades-long treatment to ever-growing numbers of people will remain a financial burden for the government.

![HIV Prevalence by Province By Year Among Ages 15-49](image)

**HIV Prevalence by Province by Year Among Ages 15-49**

Driving high rates of HIV infection among young South Africans are low levels of HIV literacy, the young age of sexual debut, and high rates of adolescent pregnancy and STIs. The age of sexual debut for boys is 10-12 years old and 13-14 for girls but there are often signs of sexual grooming of kids as young as 9. The vast majority of young women do not use contraception until after their first pregnancy, by which time they are likely to already have HIV. More than 122,900 girls aged 10-19 gave birth in 2017, including 3,261 aged 10-14,19 which equated to approximately 12 percent of all births. The most recent national survey data from 2017 shows the same low level as the last survey in 2012 of condom use among those aged 15-24, an increase in sexual debut...
before the age of 15 for boys, and an increase in multiple sexual partnerships for women under 24 years old.\textsuperscript{20} HIV prevention knowledge among this age group is only at 45.8 percent.\textsuperscript{21}

For many young adults, HIV is often not seen as a crisis because they have bigger worries (e.g., extreme poverty, unemployment and lack of jobs, and crumbling school infrastructure). HIV is a concern but, given the availability of ART, it is not an urgent, imminent threat. When they live in a community with high HIV rates and the risk of infection is so high per sexual encounter, there is a fatalistic feeling that getting infected with HIV is inevitable. Girls and women also face an epidemic of rape and gender-based violence and many say getting raped or pregnant is their number one fear, not HIV. As a result, many young adults do not prioritize, may have difficulty procuring, or may not be able to demand the use of HIV prevention tools. Urgent action is needed to bring down infections in this group, including easy availability of oral PrEP and supportive prevention messaging.

\textbf{Syndemics/Comorbidities}

HIV does not exist in a vacuum. HIV acquisition risk and HIV care complications are increased by other diseases, health conditions, and societal challenges, and in turn, HIV can create vulnerabilities to different infections or the occurrence of other health conditions. South Africa faces syndemics of health conditions such as STIs and TB, as well as of social conditions such as violence and mental health, which are helping to fuel or are fueled by its HIV epidemic. Comorbidities\textsuperscript{22} can lead to worse health outcomes for the patient, as well as an additional burden on the health system with more complex clinical management and higher cost.

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STIs inflame and elicit an immune response that makes it easier for HIV to establish infection. There are high rates of human papillomavirus (HPV), bacterial vaginosis (BV), chlamydia, gonorrhea, and syphilis.\textsuperscript{23} South Africa relies on syndromic management but since many of these STIs are asymptomatic, they often go untreated, increasing HIV risk.

TB remains the leading cause of death in South Africa, which has the sixth-highest TB incidence globally.\textsuperscript{24} There is a 10 percent lifetime risk for TB acquisition for a South African who does not have HIV. For PLHIV, there is a 10 percent annual risk for every year of life regardless of CD4 (white blood cell) count. The risk reduces to 5 percent per year if a PLHIV is on ART. Getting sick with TB while on ART can lead to persistent illness, treatment failure, and death. Most concerning is the increase of multidrug-resistant TB (MDR-TB) cases over the last decade, including a doubling between 2007-2012.\textsuperscript{25} There are regional differences as well; for example, in what is described as a
“HIV and resistant TB belt” in northern KZN and Mpumalanga provinces, there is 45 percent HIV prevalence and 39 percent HIV/TB mortality.26 TB preventive treatment (TPT) is the recommended standard practice for PLHIV, but South Africa continues to struggle with low coverage and treatment completion rates.27

South Africa also has seen a growing incidence of diabetes with annual increases since 1997 linked to rising obesity. Ischemic heart disease, stroke, and diabetes were the second, fourth, and fifth greatest causes of death as of 2017.28 For every 100 PLHIV under the age of 40 on ART, two develop hypertension every year, which has resulted in more than 140,000 new hypertension patients in KZN alone. However, HIV clinics are not screening for hypertension or diabetes despite the increased risk for aging HIV patients.

Violence continues to be a driver of HIV infection. Boys typically experience physical violence while girls more often experience psychosocial or sexual violence. By some estimates, one-third of South Africans have already experienced some form of violence by the time they are 20 years old. South Africa has one of the highest rates of sexual violence in the world with rape leaving victims susceptible to HIV infection. More than 30 percent of women 15-49 years old are estimated to have experienced recent intimate partner violence.29

Mental health issues, including depression, can put young adults especially at risk for HIV. “Sexually active adolescents and adults with serious mental illness evidence higher risk sexual behavior, including inconsistent condom use, having multiple sexual partners, trading sex, and drinking alcohol before sex.”30 Mental health also affects one’s ability to adhere to prevention or treatment regimes, including oral PrEP and ART. South Africa has a high burden of mental health disorders and the sixth-highest suicide rate in Africa.31 Suicide is the second leading cause of death of young adults after HIV. However, there are insufficient mental health support systems in South Africa, and health services that stigmatize or discriminate against those seeking HIV prevention and treatment services continue to be barriers to access and health-seeking behavior, especially for adolescents.

**Southern African Hub**

South Africa’s role as the economic and transport hub for southern Africa also adds to the emergency nature of the HIV epidemic. High rates of internal and cross-border migration have resulted in rapid urbanization with an influx into peri-urban and urban centers. An estimated 1.1 million people are expected to immigrate to South Africa between 2016-2021.

Mobility has been associated with multiple sexual partners and a higher risk of HIV acquisition. Young adults under the age of 30 are urbanizing the fastest. Urban informal areas have the highest HIV prevalence rates (19.9 percent)32 and often have the fewest prevention and treatment services available. The migratory patterns are reflected in the HIV demographics. Approximately 80 percent of PLHIV live in 27 districts in 8 provinces33 largely in the northeastern, eastern, and southern parts of the country, with the exception of Cape Town on the west coast. KZN and Gauteng
provinces, which house the municipalities of Durban, Pietermaritzburg, Pretoria, and Johannesburg, together account for approximately 50 percent of the HIV burden. Natural disasters and economic crises in neighboring countries in recent years have resulted in an influx of migrants from Malawi, Zimbabwe, and Mozambique, with many settling in Gauteng and Western Cape provinces.34

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Barriers to Control of South Africa’s HIV Epidemic

The critical gap to reducing new infections and achieving epidemic control in South Africa is not between evidence and policy, but between policy and implementation. Governance, public health system capacity, adequate funding, coverage and scale of services across the country, and implementation gaps and failures for HIV programs and supporting interventions pose barriers that will need to be overcome for South Africa to achieve its epidemic control goals.

Policy, Governance, and Health System Capacity

The government of South Africa deserves tremendous credit for its leadership on HIV over the last decade. Today, the government funds more than 70 percent of the national response, with increases projected from $1.7 billion in 2018/2019 to $2.1 billion in 2020/2021. In addition to his 2018 State of the Nation address call to initiate 2 million more South Africans on ART, President Ramaphosa also has called for action against gender-based violence (GBV), opportunities to address youth unemployment, and improvements in education. However, there also have been complaints that more is not being done—that the national HIV response has become passive and does not match the scale of the epidemic. The government has been consumed with a financial crisis and corruption scandals in recent years, which has focused political attention elsewhere. Many feel that the national HIV response has become passive and does not match the scale of the epidemic. There is hope that Dr. Zweli Mkhize, who became the new Minister of Health following the president’s May 2019 re-election, will provide renewed action and accountability for the HIV response. Dr. Mkhize is a medical doctor and the former Premier of KwaZulu-Natal who has seen firsthand the toll HIV has taken in KZN.

South Africa has a federal system of government with decentralized power and responsibility for public sector implementation at the provincial levels. Responsibility for setting national guidelines related to the HIV response sits primarily with the NDoH. Other key departments, such as the Department of Basic Education, are responsible for complementary policies and guidelines that affect HIV-related activities. South Africa has been an early adopter of WHO guidelines, such as universal test and treat to provide ART to any person who tests positive...
for HIV. It also has translated those guidelines into progressive national strategies, such as its National Strategic Plan (NSP) for HIV, TB, and STIs for 2017-22. In addition, there are national campaigns such as “Cheka Impilo” targeting improved wellness and accelerated screening and testing for HIV, TB, STIs, and NCDs and “She Conquers” aimed at reducing HIV incidence in AGYW. A National Adolescent and Youth Health Policy, issued in July 2017, aims to “improve the health status of young people [ages 10-24] through the prevention of illness, the promotion of healthy lifestyles, and the improvement of the health care delivery system by focusing on the accessibility, efficiency, quality, and sustainability of adolescent and youth friendly health services (AYFS).” The “National Policy on HIV, STIs and TB for Learners, Educators, School Support Staff and Officials in all Primary and Secondary Schools in the Basic Education Sector” was issued in August 2017.

The national government must rely on provinces and districts to implement policies and guidelines. Some provinces have created provincial HIV “war rooms” that bring together relevant departments to ensure comprehensive care at ward levels. For example, KZN implemented war rooms in all of its wards to help facilitate Operation Sukuma Sakhe, which is designed to enhance integrated service delivery to the communities and to have communities mobilize and intervene on identified challenges in fighting HIV, TB, and STIs, as well as alcohol and substance abuse, gender-based violence, sexual assaults, and general crime.

However, there can sometimes be a disconnect between the policy outlined in the national strategies and the implementation in communities with numerous barriers to policy implementation as intended and at scale. Sometimes barriers come from local gatekeepers who are philosophically opposed to implementing the policy, such as those for comprehensive sexual health education.

### NOTABLE MOMENTS IN THE SOUTH AFRICA HIV RESPONSE

**1992** The National AIDS Convention of South Africa is held

**1993** The first National AIDS Plan is published

**2000** The 13th International AIDS Conference is held in Durban

**2001** CAPRISA is created

**2002** Restrictions against ART use in PMTCT programs are removed; The Global Fund is created

**2003** PEPFAR is announced by President George W. Bush at the State of the Union

**2010** The national HIV Counseling and Testing campaign is launched

**2015** South Africa becomes the first country in sub-Saharan Africa to fully approve PrEP

**2016** South Africa implements ‘test and treat’, whereby everyone with a positive diagnosis is eligible to start treatment; The She Conquers campaign is launched

**2017** The Current National Strategic Plan for HIV, TB, and STIs begins (2017-2022)

**2019** Operation Phuthuma is launched

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(CSE) and programs in schools (see below). Often, it is financial. Provincial and district
governments largely rely on conditional grants from the central government to facilitate program
implementation. As a result, there is variation in the HIV response across the country.

Despite increased financial investments made by the South African government, as well as
contributions by partners such as PEPFAR and the Global Fund (see text boxes), there currently
are not enough resources to saturate every community in South Africa with comprehensive
HIV services. As a result, services have been targeted to “Focus for Impact” on 27 districts that
represent approximately 80 percent of all PLHIV. This approach was codified in the current
NSP following PEPFAR’s geographic pivot in its 2015 Country Operational Plan (COP), which
was intended to direct finite resources at the most heavily burdened areas for greatest impact.
The government also has utilized its Global Fund grants to target saturation in some of these
priority districts.

GLOBAL FUND

The Global Fund has cumulatively disbursed $553.5 million for HIV and nearly $392
million for TB/HIV. The Global Fund’s investments have been complementary to those of
the South African government and PEPFAR with a focus on prevention, key and vulnerable
populations, and ongoing consultation with government and others. In early 2019, South
African submitted new grant proposals for the next round of disbursements. Additional
Global Fund support would enable continued targeted complementary support to AGYW
programs under the HER Campaign and other key populations.

A major limiting factor in providing high-quality HIV services is the infrastructure and
human resources crisis within the public health system, which cares for approximately
80 percent of the population. Given the scale of the epidemic, some facilities in South
Africa care for more than 10,000 PLHIV—more in a single clinic than the total number
of PLHIV in other countries. Overtaxed health care workers must manage HIV care while
simultaneously addressing other health demands. A series of hiring and wage freezes due
to budgetary pressures over the last four years has further strained staff. In February 2017,
Malebona Precious Matsoso, NDoH director general, announced to Parliament that there
were more than 40,000 vacancies across the country.

These infrastructure and human resource limitations have ripple effects across the HIV
response. One prime example is the multitude of data management issues, highlighted by
PEPFAR during its 2019 COP process, which has affected tracking testing, ART initiation,
linkage to care, and adherence. Paper file management, data entry into electronic
reporting systems, insufficient numbers of data entry clerks and computers, and non-
networked computers not connected to the national Tier.net data collection system were
among issues highlighted. Anecdotal evidence suggests frustrated patients got tired of
waiting for hours at a clinic for their existing file to be pulled, and thus learned to report
as a new patient to see a provider more quickly, which resulted in a new record created.
In some clinics, file management had gotten so bad that rooms were full of files stacked
to the ceiling. In addition, the absence of a working unique identifier for each patient that
can be accessed nationwide meant many patients migrating to different locations across the country had files in different facilities and may have been recorded as “lost to follow up” (not returning for treatment), even though they were accessing care elsewhere.

In response to threats of funding reductions by PEPFAR due to ongoing issues at facilities and poor programmatic performance, on March 18, 2019, Aaron Motsoaledi, minister of health at the time, “issued a circular directing provincial health leaders in all provinces to undertake specific site-level actions to accelerate patient-centered HIV treatment results across the cascade.”

The actions included: fully implementing a welcome back campaign to assist defaulting patients to return to care; ensuring nurses are trained and have performance metrics in HIV treatment services; setting performance standards for HIV trained nurses and lay counselors, including a minimum number of HIV tests per day and a standard number of PLHIV initiated on ART per day; strengthening the directive for community health workers to track and trace defaulting patients; improving data systems including the use of unique patient identifiers; expanding external pick-up points for HIV medications; and extending clinic hours for HIV services. These interventions were summarized in a 10 Point Plan for Acceleration (see text box), and the government launched Operation Phuthuma (which means “hurry” to convey the urgent need to meet the 90-90-90 goals) on April 1, 2019, to manage implementation. The NDoH intends to use Operation Phuthuma as the umbrella for all HIV activities until March 2021, with a common set of interventions prioritized across all districts per quarter. The goal is for each facility, district, and province to have an implementation plan that will be monitored weekly and supported by ongoing technical support visits.

The 2020 People’s COP acknowledges that there have been quality improvements to the national response and at least some impact of the circular on performance at the facility level. However, according to PEPFAR’s 2020 COP planning letter, “bottlenecks and inadequate policy implementation for optimal client-centered services persist at the provincial, district and site levels,” despite “extensive collaboration with and Circular dissemination by the [government].”

**OPERATION PHUTHUMA**

Launched on April 1, 2019, Operation Phuthuma, which means “hurry” to convey the urgency of meeting the 90-90-90 goals, is the government of South Africa’s campaign to implement its 10 Point Plan for Acceleration, which includes:

1. Strengthening management (including quality patient centered-care);
2. Strengthening data systems; clean up data;
3. Initiating patients on ART the same day they are diagnosed and following up after the first missed appointment;
4. Using an unique ID (Health Patient Registry Number or HPRN) to track patients;

5. Training all NIMART (nurse initiation and management of antiretroviral therapy) nurses (23,000) to initiate patients on ART;

6. Setting performance targets for NIMART nurses, lay counselors, data clerks, and community health workers (CHWs);

7. Strengthening Centralized Chronic Medicines Dispensing and Distribution (CCMDD) and increasing pick up points;

8. Decreasing waiting times at health facilities by, for example, improving the filing system;

9. Providing services in extended working hours; and

10. Increasing accountability of facilities to district leadership and rewarding facilities that perform well against targets.

The government intends to use Operation Phuthuma as its framework through March 2021. “Each facility, district, and province will have an implementation plan for these interventions which will be monitored weekly as well as through supportive supervision visits.” Operation Phuthuma conducts weekly facility and subdistrict meetings, as well as monthly district meetings and provincial Nerve Centers in all provinces. In FY 2019, the NDoH prioritized 756 facilities to improve quality then expanded nationally.

PEPFAR

PEPFAR has played a catalytic role in providing HIV treatment in South Africa and continues to provide critical innovation, expertise, and financing. When ART first became available, the South African government was still in denial about the epidemic, and PEPFAR proved that a treatment program was possible and could help turn the tide of death and despair. Since then, the South African government has assumed financial and political commitments, including strategic policy direction, support for the public health sector through facility infrastructure and healthcare workers, and financing the treatment program. One U.S. official called this paradigm shift over 15 years, “a singular public health success.”

As the South African government has taken on more financial ownership of the national HIV response, PEPFAR has focused its efforts on filling critical gaps, bringing expertise, providing technical assistance, and improving data collection and management. Only recently has PEPFAR stepped in to assist with direct service delivery. This focus on expanding the reach and quality of the HIV program has been a significant contribution, as has the PEPFAR’s focus on data to guide programming. For many observers, PEPFAR in South Africa has brought innovation and global best practices to improve the
largest HIV program in the world and filled critical gaps in the health system, including strengthening information systems, supply chains, laboratories, training, and direct service delivery in the highest-burden areas. With a total bilateral investment of more than $6 billion from FY 2004-FY 2019, PEPFAR’s investments have had a multiplier effect and encouraged South Africa’s political and financial commitments.

Globally, PEPFAR is pushing the epidemic control agenda in all of its supported countries with a special focus on the 13 that it thinks can achieve epidemic control by 2020. South Africa is not one of those countries. However, PEPFAR has remained highly invested. The program moved to a smaller geographic focus as part of a larger PEPFAR approach shift in 2015, reducing from 50 districts to 27. It further refined the approach in 2018 to a district-facility-intensive focus that targets 350 clinics within the 27 districts and 220 smaller clinics for aggressive support.

As outlined initially in the 2018 South Africa COP, PEPFAR has focused on filling six strategic gaps: 1) placement of 20,000 facility-based human resources in nine cadres; 2) support for more than 8,000 community-based health workers; 3) antiretroviral drugs to ensure uninterrupted drug supply; 4) mobilizing non-health system multipliers (i.e., FBOs and traditional leaders); 5) engagement with private sector health providers to expand service reach; and 6) support for health information systems scale up to minimize, for example, facility file and data issues.

On top of its annual COP funding, in late 2017, PEPFAR proposed providing South Africa with an additional $500 million in what is known as “the surge” to support President Ramaphosa’s goal to accelerate treatment initiation. PEPFAR planned to work with the government to ensure the treatment scale-up would be successful through additional technical assistance from implementing partners to facilities and communities and through direct service delivery. In 2018, PEPFAR launched Operation 10-10 to improve treatment retention at the largest volume sites in the highest burden-districts.

However, PEPFAR became increasingly alarmed over South Africa’s deteriorating performance and its failure to meet its treatment targets in 2018. According to PEPFAR, its resources were supposed to be an addition to existing public health system investments, including health infrastructure and health care workers in public facilities.
Instead, some 80 percent of treatment initiation was being done by PEPFAR partners, not government health care workers. In early 2019, PEPFAR—frustrated with a range of issues, including the country’s rising complacency with the epidemic and insufficient national investments in the health system to support increased coverage and quality of HIV services—signaled its intention to drastically reduce its investment from $678 million in 2018 to $400 million in 2019. Such a reduction in PEPFAR support would have had dire consequences as the government was unlikely to fill the void.

The initial 2019 COP planning letter threatened to cut the budget if the issues could not be addressed and results demonstrated with improved treatment and adherence numbers. In partnership with the NDoH, provincial leaders, implementing organizations, and others, PEPFAR embarked on what was colloquially known as the “February frenzy”—a hands-on, intensive, facility-by-facility approach built on Operation 10-10 and introduced by the PEPFAR South Africa team in FY 2018 based on a model from Namibia. The original strategy targeted the 10 highest priority facilities in the 10 highest burden districts to address key barriers and ensure rapid course correction. For February, PEPFAR chose 220 facilities to target. The February-March 2019 intensive effort in partnership with the government to remedy critical issues at facilities resulted in positive results and PEPFAR signaled its intention to restore funding in the May 2019 COP approval letter.

According to PEPFAR, the circular reached more than 343 of the highest-HIV burden facilities and helped mobilize public health facility managers across 27 priority districts. In addition to the February frenzy, the PEPFAR team conducted more than 550 facility visits between March 1 and April 13, 2019. As a result of those efforts, PEPFAR reported an increase of almost 100,000 in the number of PLHIV on ART between March 1 and May 24, 2019, and reinstated funding to $733 million for COP 2019 implementation in FY 2020.

COP 2019 will work to achieve epidemic control by the end of FY 2020, across all ages and sexes, working toward the ultimate goal across the country that 6,710,000 (over 6,100,915 in the public sector) are on life-saving treatment by the end of FY 2020. The program for COP 2019 will focus intensely on the 27 highest burdened geographic areas and facilities by enrolling an additional 1,061,588 PLHIV on treatment in FY2020 building on the additional 1,003,833 enrolled during FY2019 (totaling 4,876,235 on treatment) and ensuring viral load suppression in 4,219,335 patients in these areas.

While many observers have credited PEPFAR’s innovation and accountability for keeping the South African HIV response focused, they lament PEPFAR’s relentless push toward numbers and targets in pursuit of epidemic control, which they claim fails to grasp the complexities and nuances of the health system or the broader context of poverty, violence, and migration. However, many feel any reduction or removal of PEPFAR support would be problematic, potentially creating a vacuum of services, particularly for members of key population groups. It is unclear what happens in FY 2021 once all of the surge resources have been spent and the budget returns to previous levels. The 2020 COP planning letter reduces overall funding to $523,440,000 pending final approval by Congress.
Service Delivery

The gaps between policy and implementation are evident in the execution of HIV treatment and prevention programs more broadly but also in the way those programs address the needs of specific groups of people. These barriers drive inefficiency and ineffectiveness and inhibit South Africa’s ability to meet its epidemic control goals.

Service Delivery Barriers: Treatment

While South Africa has adopted same-day treatment guidelines, treatment initiation and retention have remained obstacles even while treatment coverage has increased by 70 percent. Approximately 680,000 PLHIV were newly initiated on ART in 2018, but data indicated more people stopped treatment than started. The 2019 People’s COP also noted that “several priority districts saw 10% or more of their total people lost by end 2018”; some districts lost up to 61 percent. Only one of the four major metropolitan areas with the highest burden, Pietermaritzburg, was not included on this list. PEPFAR called out the implementation failures in its 2019 COP planning letter and put a temporary pause on its program at the beginning of 2019.

It is critical that we establish a sound treatment program before we move to add new patients into the program. In COP 2018 [FY 2019 implementation], PEPFAR/South Africa must hold on all testing and active case finding until the linkage and retention issues improve. . . . The PEPFAR program has demonstrated extremely poor performance in ensuring every person who is started on treatment is retained, particularly from [fiscal year] FY 2017 to FY 2018 where results have been relatively stagnant at 479,912 to 481,014 respectively, despite an increase in resources.

The 2019 COP planning letter threatened to cut PEPFAR’s annual budget for FY 2020 to $400 million if these issues could not be addressed and results demonstrated with improved treatment and adherence numbers. In partnership with the NDoH, provincial leaders, implementing organizations, and others, PEPFAR embarked on what was colloquially known as the “February frenzy”—a hands-on, intensive, facility-by-facility approach built on Operation 10-10, which the PEPFAR South Africa team introduced in FY 2018 based on a model from Namibia. The original strategy targeted the 10 highest priority facilities in the
10 highest burden districts for intensive technical and administrative support and capacity building. For February, PEPFAR chose 220 facilities to target. The teams also conducted more than 550 additional facility visits between March 1 and April 13, 2019. The goal of these efforts was to address key barriers, such as data management and health worker capacity, and ensure rapid course correction. As part of the effort, patient files were reconciled and those who were truly lost to follow up were tracked and connected back to care. As a result, PEPFAR reported an increase of almost 100,000 PLHIV on ART between March 1 and May 24, 2019,\(^57\) and reinstated funding to $733 million for 2019 COP implementation.\(^58\)

However, despite progress over the course of 2019, PEPFAR once again called out issues in its 2020 COP planning letter stating, “Underperformance across the treatment clinical cascade persists.”\(^59\) Initiation and retention of PLHIV on HIV remain issues. “As a whole, PEPFAR South Africa put 636,253 new patients on treatment, reaching a total of 3,700,167 patients overall in the 27 highest burden districts and 4,719,473 across the whole country . . . [However,] the program only reached 81% of [the] COP18 [total PLHIV on treatment] target in the 27 districts.” As a result, the program, in partnership with the government, must support nearly 300,000 initiating on treatment per quarter in 2020 to meet the target 6.1 million on ART by the end of the year.\(^60\) In addition, PEPFAR has directed the South Africa team to ensure 95 percent patient retention at all PEPFAR-supported sites in FY 2021.

Complicating the efforts to initiate and retain patients on treatment is low knowledge of HIV itself, how it affects the body, and how ART attacks the virus and can lead to suppression. Low treatment literacy mirrors low levels of overall health knowledge noted in the most recent Human Sciences Research Council (HSRC) national survey. Given the public health facility and worker limitations mentioned above, there often is not enough time to provide adequate information to each patient. The HSRC recommended in 2018 that behavior change interventions be revitalized and strengthened with a special emphasis on risk perception given that everyone is at risk of HIV infection.\(^61\) It also recommended focus on treatment literacy to drive demand and adherence. The 2019 People’s COP called on PEPFAR to provide financial and other resources to increase treatment literacy, and PEPFAR stated it would “support PLHIV and community led treatment literacy interventions which will include trainings and health promotional campaigns.”\(^62\)

**VIRAL LOAD (VL) MONITORING**

The availability and access to VL monitoring is a critical issue for patient management and achieving suppression for individual and community impact. A previous review of patient case files from a mix of clinics in KZN revealed that only 40 percent of adults and 25 percent of children are getting VL monitoring every 12 months. Increasing viral load coverage has been a focus area for the PEPFAR program, which saw an increase from quarter one of FY 2019 (69 percent) to quarter four of FY 2019 (76 percent) across PEPFAR and centrally supported sites.\(^63\) However, PEPFAR cited numerous remaining gaps in reaching the required coverage rates at facilities.

CAPRISA’s Dr. Kogie Naidoo has introduced a five-point plan to make VL monitoring routine, with the first step being that patients take ownership and demand a new test on
their VL anniversary. Instilling a professional nurse as the clinic “VL champion” and having a pharmacist gatekeep by only dispensing new prescriptions to patients who have been monitored within the past 12 months are key. Accurate and up-to-date patient records also are important to ensure all interactions with a provider and the pharmacy are correct. Engaging KZN district leadership and clinic administrators and having them take ownership of the approach has resulted in an increase in VL monitoring from 40 percent to 73 percent, which has been sustained over time.

**Service Delivery Barriers: Oral PrEP**

Pre-exposure prophylaxis (PrEP) offers a tool to help break the transmission cycle. An oral PrEP pill taken daily can reduce vulnerability to infection by 99 percent. The World Health Organization (WHO) expanded its PrEP recommendations in September 2015 to include all population groups at substantial risk of HIV infection. “PrEP should be an additional prevention choice in a comprehensive package of services that also includes HIV testing, counselling, male and female condoms, lubricants, ARV treatment for partners with HIV infection, voluntary medical male circumcision and harm reduction interventions for people who use drugs.”

According to WHO, PrEP should be offered for populations with an HIV incidence of about 3 per 100 person-years or higher. The incidence rate in South Africa is 8.7 per 1,000 adults aged 15-49 years old. In areas where there is so much virus circulating due to high infection rates and low viral suppression, every sexual encounter is high risk, and widespread PrEP could be a prevention lynchpin.

Although PrEP was approved in national guidelines in 2016, implementation has been slow and inadequate. In the highest-burden province of KZN, in February 2019, provincial DoH officials reported that PrEP was only available in three districts and that they were still learning about implementation before a nationwide scale-up. There have been numerous challenges such as issues with messaging, health worker sensitization and training, and availability. South Africa’s initial implementation in 2016 targeted only female sex workers, which created an unnecessary and difficult to undo stigma around PrEP use—that it was only intended for people who sold sex. The NDoH guidance subsequently was expanded to include MSM, serodiscordant couples, and AGYW. However, the 2017-22 NSP only includes PrEP for young women 18 years of age and older—not adolescent girls or young men—even though all young women in South Africa up to the age of 24 and young men up to 29 should be eligible for PrEP under the WHO guidelines. The limited number of facilities offering PrEP with trained health care providers has further hampered roll-out.

Another challenge is that many donors have earmarked their PrEP support for very specific populations—primarily MSM, sex workers, and AGYW, which inhibits NDoH’s ability to design a comprehensive and inclusive demand-creation campaign that targets people based on their individual risk rather than their group affiliation, many of which are heavily stigmatized. As a result, PrEP may not be available for those who seek it outside of the donor-targeted groups (e.g., young men denied PrEP at university campus clinics targeting AGYW). Given the high rates of HIV incidence, limiting PrEP to specific groups instead of all who are at high risk is problematic.
Some of the initial barriers are being addressed, and the number of people enrolled has increased over the course of 2019. An estimated 35,000 people were on PrEP as of October 2019, up from 8,000-24,000 people at approximately 50 clinics nationwide as of August 2019. The national target is 18,000, but that equates to only 14.5 percent of the 240,000 presumed to be at risk based on the 2018 new infection rates. PEPFAR has committed to expanding PrEP services, especially for AGYW, with an FY 2020 target of 62,120 across 11 districts. In FY 2019, the program achieved a 2,198 percent increase in new PrEP users among AGYW and a 375 percent increase among KPs.

An estimated 35,000 people were on PrEP as of October 2019, but that equates to only 14.5 percent of the 240,000 presumed to be at risk based on the 2018 new infection rates.

PrEP scale-up will require extensive outreach to create demand, ensure adherence, and negate any stigma to ensure that all those at high risk can have access. Many young women, especially, are starting and stopping use, and more needs to be understood about why and how it relates to risk. One young man in KZN told us he was more likely than not to contract HIV so why take a pill now when he would have to take one later anyway. Other young adult PrEP campaigners highlighted potential obstacles such as perceived weight gain that might limit demand and uptake. A cultural predisposition against pill taking, which is associated with illness and disease, has also worked against uptake and may be mitigated when new technologies (i.e., injectable and implantable PrEP) come to market in the future.

**Service Delivery Barriers: Youth**

Insufficient or unfriendly information and services for youth remain a barrier to HIV prevention and treatment efforts. Some programs like MTV Shuga highlight themes around HIV, but young South Africans told us repeatedly that they wanted more leadership and information on HIV. They expressed frustration with the dearth of targeted outreach, media campaigns or HIV coverage, and high-profile champions, as well as insufficient investment to empower communities and civil society organizations to launch more effective and sustainable responses. More importantly, they want to see role models of healthy living that make HIV prevention and staying negative cool, as well as demonstrate how to live positively with HIV.

For school-age South Africans, there have been barriers to provision of basic health education and service delivery in schools, which are an important entry point because there is a high rate of school retention in South Africa. Unlike many African countries, secondary school is free in South Africa. Once out of school, it is difficult to reach young people. Despite the national policy on school-based health education, some provincial officials, school governing boards, and other gatekeepers often prevent services from being provided, even though the age of consent for health services is 12.

"[U.S.] engagement in Africa is driven largely by four guiding principles: ... [the] Second [is to] harness the potential of Africa’s tremendous youth population to drive Africa’s economic growth and create real prosperity." - Assistant Secretary for Africa Tibor Nagy during his visit to South Africa in June 2019.
In addition, youth seeking prevention and treatment services often encounter stigma and discrimination at health facilities. “Adolescents seeking both contraceptives and counseling and testing for HIV in general clinic settings, are often turned away due to the personal views of health workers (that that adolescents should not be sexually active).”

Programs that reach youth outside health facilities have shown success mitigating barriers such as transportation challenges and concerns about stigma, as well as ensuring youth-friendly messaging. Sometimes these are youth groups offered in brick-and-mortar structures that provide other benefits such as career training. Mobile clinics also have been shown to be an effective way to reach adolescents, out-of-school youth, and men. By traveling to places where adolescents and young adults congregate, such as schools, workplaces, and social areas, these mobile units are able to reach those who will not come to a traditional health facility and are particularly useful in rural areas where the distance between clinics is greater. Among the many examples nationwide are the Desmond Tutu HIV Foundation’s Tutu Teen Trucks in Cape Town and Eastern Cape and Wits RHI’s mobile clinics in Gauteng, which provide multiple services including HIV testing and treatment, condom and PrEP distribution, STI screening and treatment, pap smears and cervical cancer screening, contraception distribution, and NCD screening such as blood pressure checks. Mobile units can be more efficient in terms of reach and finding those who are not accessing those facilities, but they are more expensive and thus seen as not as cost-effective as investments in traditional health facilities. As a result, there are not enough mobile clinics to meet the need.

**HEAIDS**

The Higher Education and Training Health, Wellness and Development Center (Heaids) is a nonprofit aligned with the Department of Higher Education and Training, which aims to support the health and wellness of tertiary students at 427 campuses across South Africa. Only approximately 50 percent of those who enter tertiary education graduate due to many factors including HIV, nutrition, pregnancy, poverty, or being orphaned, which limits the economic viability of South Africa’s youth. Heaids has found high rates of multiple sex partnerships (41 percent), transactional sex (14 percent), pregnancy (32 percent) of which 75 percent was unplanned, drug and alcohol abuse (up to 65 percent at the TVET level), and poverty and food insecurity (28.6 percent).

Heaids aims to mitigate these issues to give students a better chance at graduation. The First Things First (FTF) Program “encourages health seeking behavior and enhancement of quality of life in young people, through regular testing and/or screening for major ailments such as HIV/TB/STI, cancer and cardio-vascular risk factors, among others.”

Through wellness fairs offering a range of services, nurses who visit campus several times a month, use of peer educators, campus radio programs, and self-defense classes, Heaids reported more than 300,000 students were tested for HIV or received HIV, TB, or STI services in 2018—up 10 times since 2001. Only 100 of the campuses (universities) have a clinic, but nurses provide services in a special room and the integrated services offered have attracted student use by mitigating stigma. Heaids also has seen a carryover effect with information brought home by students and peer educators and/or shared on social media. The approach is now being replicated in other countries.
Service Delivery Barriers: Men

Across the board, South Africa is doing a much better job reaching women with HIV services, and the impact is evident in the variation in testing, treatment, and viral suppression rates. In 2018, 62 percent of women 15 years or older were on ART, compared to only 56 percent of men in the same age group.76

The percentage of males 15+ years on treatment in PEPFAR South Africa decreased by 15% [in the 12 months between the fourth quarter of FY 2018 and the fourth quarter of FY 2019]. In FY19, the greatest percentage increase in men on treatment (19%) was found in the 45-49 year-old age band with fewer men being put on treatment in the 25-29 and 30-34 year-old age bands. In addition, in the first three quarters of FY19, the program put less than half the number of men than women on treatment ages 15+ years, and 70% fewer males than females on treatment 25-34 years old.77

Part of the challenge is reaching the men. While women come to clinics when they are pregnant or for their children, young men rarely interact with the health system unless they have suffered a major injury. In general, men are less likely to know their HIV status than women or to seek care and treatment if they test positive. Health services seen as not “male friendly” and gender norms around masculinity that equate seeking health care with weakness are two factors. As a result, men 25-34 years old have the lowest viral suppression rates (41.5 percent) of any gender/age band in South Africa.

Preventing men from acquiring HIV is key and one important tool is voluntary medical male circumcision (VMMC), which reduces a man's risk of female-to-male HIV transmission by 60 percent.78 However, South Africa has struggled with increasing its VMMC numbers, although numbers have been increasing over time. Approximately 4 million men have undergone VMMC in South Africa, including 572,442 in 2018.79,80 In addition, many South African men receive traditional circumcisions as part of cultural practice.

Getting men diagnosed and virally suppressed as quickly as possible is also critical. Data has shown that the time from infection to transmission is short for men, whereas it is long for women.81 The Africa Health Research Institute (AHRI) has reported results from its population cohort in northern KZN that young men tend to have much higher comparative viral loads (VLs), which is likely driving women's incidence, as more copies of the virus make it easier to transmit. Rapid ART scale-up has led to decreases in population-level male incidence but has not done the same for women.

Programs targeting prevention and treatment initiation and adherence in men have been challenged by the need to reach men where they live and work with information and services. There have been notable examples of success, such as the work by Prince Nhlanganiso Zulu who has made it his mission to get Zulu men more engaged in their health care and accessing services. In December 2009, Zulu King Goodwill Zwelithini reinstated circumcision as a cultural ritual for Zulu men given the heavy toll HIV is taking on his people.82 The Prince has called on Zulu men to be circumcised83 and created the Isibaya Samadoda initiative, with the provincial KZN DoH, to mass mobilize men for health services including VMMC, provide HIV prevention support, change behaviors and cultural values that affect health outcomes, and address violence. The initiative has a special focus on out-of-school youth aged 19-34
and older men who are harder to access. As of April 2018, more than 1 million circumcisions had been conducted.\textsuperscript{84} In addition to provision of non-HIV health screening, the initiative holds behavior change camps to provide special prevention support and HIV screening for circumcised men. Prince Zulu also engages in community dialogues to engage men on health and social issues, including drug and alcohol consumption.

There is a need for more projects such as these across the country that reach men with comprehensive health and wellness. As of our February 2019 visit, PEPFAR’s new MenStar partnership with the Elton John Foundation had yet to start activities in South Africa. However, MenStar partners PEPFAR, Johnson & Johnson, and Gilead Sciences “are working together to develop a branded service delivery experience platform for men at clinics.”

[The new partnership will include] 1) An extensive review of new and existing insights and previous branding efforts to understand gaps and opportunities to reach men through a new branded experience platform; 2) Development of a strategic brand platform to address current barriers to bring men into treatment; 3) A communications campaign to drive men into the clinic; 4) A communication campaign to educate on the benefits of new and improved drug regimens; and 5) An improved service delivery experience, including empathy/compassion training for providers.\textsuperscript{85}

\textbf{Service Delivery Barriers: Young Women}

The Centre for the Aids Program of Research in South Africa (Caprisa) has shown that a particularly complicated cycle of transmission involves men aged 25-34 infecting adolescent girls/young women aged 15-24, who then go on to infect their longer-term male partners aged 24-35, and the cycle continues. The prevalence among 20- to 24-year-old women is three times higher than in men their age.

Results reported in 2019 from an impact evaluation of the DREAMS—Determined, Resilient, Empowered, Aids-Free, Mentored, and Safe—partnership conducted by Epicentre in KZN and Gauteng provinces highlight how important it is to reach young women in age-disparate relationships with their partner more than five years older.\textsuperscript{86} The study found a significant increase in HIV prevalence in AGYW in such relationships as well as higher rates of STIs, lower condom use, and more episodes of physical and intimate partner violence. These relationships do not always reflect the “besser” phenomenon in which a man provides money or commodities as part of a relationship or are viewed by the AGYW as transactional. In some cases, it may be an exchange of sex with a taxi driver for a ride. The relationship dynamics also work in the opposite direction. The Wits Reproductive Health and HIV Institute (Wits RHI) noted that an estimated 20 percent of boys 10-16 years old are having relationships with partners more than 10 years older.

PEPFAR’s DREAMS program, launched in 2015, includes a core package of interventions to be “layered” to address the broader range of social, economic, and health issues that make young women vulnerable to HIV infection. In addition, both the Global Fund and the South African government have launched comprehensive AGYW programs to build upon DREAMS in South Africa. The government’s She Conquers program serves as an umbrella for PEPFAR and the Global Fund but has not been funded adequately to serve
its coordination role. The bigger issue though, as with other programs, is that there are insufficient funds to implement the program at a national scale. Activities are targeted to a limited number of districts.

PEPFAR’s DREAMS activities have been limited to four high burden districts (City of Johannesburg, Ekurhuleni, uMgungundlovu, and eThekwini) out of the 11 total districts prioritized for PEPFAR prevention support. There have been challenges with DREAMS implementation across the country, including completion of the primary package. In KZN, tracking whether individual AGYW received the desired layered services has been problematic. In FY 2019, the program reached 75.6 percent of its target, but only 115,000 active DREAMS beneficiaries AGYW were reached. Incidence remains highest in 20-24-year-old young women, of whom only 36 percent were reached with the full primary package of services.

For its 2020 COPs, PEPFAR is making additional resources available for DREAMS in FY 2021, including in South Africa, with instructions that they be used to saturate activities in urban areas and expand beyond their current geographic areas to any highest burden districts not currently covered. PEPFAR will expand to 14 additional districts in South Africa that have high incidence rates among AGYW and are not currently covered by DREAMS or the Global Fund’s HER Campaign. PEPFAR has several requirements for South Africa to access the additional funds, including ensuring “a fully operable layering database with unique IDs” across implementing partners and districts, “a full geographic footprint in all districts,” and a focus on areas with the highest need in large urban areas. Given that these funds are for use from October 1, 2020, to September 30, 2021, it will take time for these actions to have an effect.

**Service Delivery Barriers: Syndemics**

HIV prevention and treatment efforts are hindered by barriers to addressing the syndemic issues that fuel infection and complicate ART retention. For example, universal TB screening is not happening despite national guidelines. The 2019 People’s COP noted a 2018 TB infection control survey that found that 57 percent of surveyed facilities (119 out of 207) did not screen people for TB symptoms. PEPFAR instructed all of its care and treatment partners to offer TPT as a routine part of HIV care in the 2019 COP, but the overall TPT completion rate as of September 30, 2019, was “sub-optimal” at 58 percent. Revised national TPT guidelines were expected early in 2020.

Changing South Africa’s current medical guidelines to ensure that any sexually active individual is screened for STIs as well as HIV and given appropriate counseling and access to PrEP would maximize that individual’s touchpoint with a health provider. Leigh Johnson of the University of Cape Town, who is South Africa’s leading modeler, told us that “STI screening in HIV care would have the greatest population-level benefit.” In addition, offering HPV screening and pap smears along with HIV services would yield high dividends for the 4.7 million women living with HIV in South Africa. An estimated one in 26 South African women develops cervical cancer during their lifetime and women living with HIV are four to five times more likely to develop invasive cervical cancer. As part of increased funding made available for DREAMS in FY 2021, PEPFAR is requiring that $148,000 be dedicated to STI testing and treatment.
The president declared war on gender-based violence in his 2019 State of the Nation address and reiterated his commitment during his 2020 address. He aims to tighten bail and sentencing for those accused and convicted of GBV and amend the Domestic Violence Act to protect victims. However, there continues to be insufficient post-violence care to meet the epidemic of interpersonal, criminal, and sexual violence in South Africa. For example, there are only three care centers known as Tutuzelas in all of Durban, and the criminal justice system has failed to hold perpetrators accountable. Programs such as Stepping Stones and Creating Futures have been utilized by PEPFAR's DREAMS program and others, but they have not been implemented at a sufficient scale to have a significant impact. There are also concerns about whether providers are adequately trained and supported to deal with the variety of psychosocial issues that they will encounter.

**WITS GAP YEAR**

Programs such as the Girls Achieve Power (GAP) Year program run by Wits RHI in Gauteng province are working to address issues of self-worth and violence among 10- to 17-year-olds while retaining them in school and providing access to healthcare. Speaking to GAP Year participants during our visit, they found the self-defense segment of the program most useful and empowering. Overall, they got a boost of self-confidence from participating but requested more social support in their community, including outreach to their teachers and community leaders and provision of more practical and life skills.
Recommendations to Change the Tide

What will it take to address the HIV emergency in South Africa and accelerate its path to controlling the epidemic? There are five immediate policy, program, and financial actions that the South African government and its partners, including the U.S. government, can take to help accelerate epidemic control.

1

The central government, with strong coordination and buy-in from provincial and local governments, **should remove implementation barriers to provision of health education and prevention and treatment services for adolescents and young adults.** This is life or death for the South African people and every day that is lost to crisis action means 685 more people are infected. The scale of the impact on South Africa’s youth threatens the literal future of this country. Non-stigmatizing health information, preventative tools, and treatment services should be made available without reservation at all education levels, including primary schools. South Africa also should correct any policies that hinder its HIV response and opportunities to reach youth, including the screening protocols for STIs.

While the NDoH is to be commended for launching Operation Phuthuma to bring greater organization and focus to the HIV response as well as accountability by the district and local governments, the ongoing litany of issues highlighted through the PEPFAR COP process in early 2020—in the planning letters from the Office of the U.S. Global AIDS Coordinator and the 2020 People’s COP from local civil society—show that, despite progress, significant hurdles remain and are not being corrected at the speed necessary. There is no time for complacency. During our visit, we heard repeatedly that it would take a brave, strong, and empowered minister to “put the public health foot down” and push through the obstacles at schools and clinics to ensure education, prevention tools, and therapeutic services are provided. An urgency will have to match the commitment embodied in Operation Phuthuma.
South Africa should look to where it has already had success in bringing mass public health campaigns to schools. The HPV school-based vaccination program that began in April 2014 resulted in more than 350,000 Grade 4 girls (at least 9 years old) vaccinated in more than 16,000 public schools across South Africa. Social mobilization efforts involved the development of school-specific informed consent packages and a teachers’ guide. Informed consent forms were distributed in all 11 official languages of South Africa to some 18,000 public schools. High-level political attention and central coordination were found to be key determinants of success along with coordination in all provinces and districts and positive media attention. As a result of the efforts, 94.6 percent of schools were reached and 86.6 percent of age-eligible students were vaccinated. The Higher Education and Training Health, Wellness and Development Centre (Heaids) that provides health and wellness services for tertiary students at 427 campuses across South Africa is another model (see text box). South Africa’s high rates of not only HIV infection but also adolescent pregnancy speak to a need for CSE and multipurpose prevention messages and tools at primary, secondary, and tertiary levels. Another option would be to test all children for HIV with an opt-out option. Not only will this help older children who are already sexually active and may have been exposed to HIV get needed services, but it will have a secondary benefit of helping to find the estimated 400,000 children living with HIV who are lost in the system. Replicating some version of the HPV or Heaids approach for CSE and service delivery in primary and secondary schools could yield dividends for South Africa now and in the future.

2

The government should make oral PrEP available at full scale across the country with mass messaging campaigns and easy access at distribution points in communities away from health centers. Education campaigns are needed to overcome the stigma barriers erected when oral PrEP was originally introduced, ensure health workers are trained and educated to provide non-discriminatory care, and educate young adults on the benefits. Providing oral PrEP in schools or communities away from health centers should be a key component of the government’s approach. Additional financial support for community health workers, mobile vans, and mechanisms, like the automated pharmacy dispensing machines created by Right to Care, can enable more efficient and community-based distribution of oral PrEP.

3

The South African government will need to sustain and expand its financial investment, as well as develop strong partnerships to help extend its reach, to ensure these policies and programs can be implemented. Credit is due to the government for its commitment to fighting HIV over the last decade. Continuously increasing its annual expenditure toward HIV, despite a decade of little to no economic growth, is commendable. However, the financial demands of the HIV response outpace those increases. Additional support from partners such as PEPFAR and the Global Fund has enabled South Africa’s process, but it is unclear what the levels of support from either program will be in the future. The looming loss of PEPFAR’s surge money indicates a need for South Africa to increase its HIV
investments at a more rapid pace. Upcoming implementation of its long-awaited National Health Insurance (NHI) may enable the government to expand the financing for the HIV response. However, it is unclear how quickly the benefits will be felt within the national HIV response, and NHI implementation will be watched closely to ensure equitable, quality service access for PLHIV.

In the meantime, until the full impact of NHI implementation is known, the government should encourage greater participation in the HIV response by its business and private sector, including local South African companies and the multinational companies who are increasingly expanding their outfits into the continent’s southern hub. As a result of recent economic crises, many companies have been sitting on cash reserves and have limited corporate social responsibility (CSR) activities. Yet there are many ways companies could engage in HIV, including bringing in health services for their staff and family members whether at dedicated clinics or using mobile vans. Sponsoring a health clinic, school, or mobile van could support the community and bring brand recognition. Ensuring mobile services are available and marketed to the 10,000 people who apply for work every month at special economic zones could help reach difficult-to-access men. Trade unions could mobilize to create dedicated testing days in formal workplaces and share prevention and service information with members.

As South Africa’s largest HIV partner, the U.S. government has an important role to play as a financial supporter of the HIV response as well as a program implementer. PEPFAR should consider whether its level of investment is rightsized to its goals—not only in South Africa but globally—and appropriately matched to the scale and need in South Africa.

PEPFAR has shown itself to be a tough-minded partner. Beyond continuing to push the South African government to be aggressive and threatening to cut support, what more can the U.S. government do to move the needle? It will be important for the U.S. government to consider whether its political and financial investment matches South Africa’s epidemic and the role it plays in driving the number of new infections globally (i.e., 19 percent of all global HIV cases and 14 percent of new infections). Overall total funding for PEPFAR was $6.78 billion in FY 2019 with a planned spend of $752 million in South Africa—just shy of 11 percent of annual appropriations. However, that spend included part of the surge resources. PEPFAR’s reduction to $523 million for FY 2020 from surge levels would reduce South Africa down to less than 8 percent within PEPFAR’s flat funding. The government of South Africa’s planned increases in spending merely offset the U.S. reduction.

PEPFAR has repeatedly expressed concerns about the implementation issues plaguing the country. Many of these issues are out of PEPFAR’s direct control as its programmatic and technical support primarily go to shore up HIV services at public health facilities where the infrastructure and human capital is provided by the government. In 2019, PEPFAR’s threats to cut funding did succeed in getting the circular sent to the provinces and increased the numbers of patients initiated on ART and on PrEP. However, the country still struggles with scale and coverage. While the focus is on 27 districts, all of South Africa’s districts have prevalence levels above 4 percent and given increased mobility and
shifting demographics within the country, greater investment could increase coverage across the nation and ensure rapid scale up of critical interventions such as PrEP for all who need it. Consideration should be paid to increasing DREAMS beyond its planned increase in FY 2021. Even with the increase up, only 43 of South Africa’s districts will have DREAMS activities, and most will not have full coverage of activities. Given the burden of new infections in 15-24-year-old AGYW, PEPFAR should consider increasing even further to cover more of the country.

A new Ambassador, Lana Marks, started her tenure in November 2019, filling a post that had been vacant since the end of the Obama administration. Her appointment offers an opportunity to redefine the engagement with the government and build stronger relationships with the president and minister of health. High-level political and diplomatic engagement should keep HIV front and center as a critical issue. The United States can also use its good offices and engage U.S. companies doing business in South Africa to become active partners in addressing HIV for their employees and the broader community.

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The South African government, the U.S. government, and other partners should consider ways to scale up concurrent efforts to combat the social inequalities, toxic masculinity, unemployment, and chronic health system failures that help fuel the spread of HIV. Efforts to target HIV singularly will not be as successful as comprehensive, multisectoral approaches that address risk to infection. Responsibility for these actions lies primarily with the government of South Africa at national, provincial, and local levels. The president’s commitment to address syndemics affecting HIV risk, including gender-based violence and youth unemployment, is noteworthy and may have important spillover effects against HIV if they can be funded and implemented fully. The U.S. government should consider other foreign assistance tools at its disposal that might assist South Africa in tackling these issues, including re-establishing or expanding family planning, education, and economic strengthening programs led by USAID.
About the Author

Sara M. Allinder is senior associate with the CSIS Global Health Policy Center. She was executive director and senior fellow of the CSIS Global Health Policy Center from April 2016 to April 2020. Ms. Allinder has extensive experience with the U.S. government in global health, foreign policy, international development, human rights, and program management. For 10 years, she worked on the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in Washington and in Uganda, where she served as country coordinator of the $353 million PEPFAR program (2013–2015). She led a staff of more than 200 in preparing the 2013–2015 Country Operational Plan (COPs), served as senior adviser to the ambassador, contributed to the response to the Anti-Homosexuality Act, led development of Uganda’s DREAMS strategy targeting adolescent girls and young women, and revitalized engagement with civil society organizations. In four stints at the Office of the U.S. Global AIDS Coordinator (2003–2016), Ms. Allinder was a senior adviser on PEPFAR management and operations issues, including field-based staffing.

Ms. Allinder previously served as policy adviser in the Office of International Health Affairs at the U.S. Department of State, where she led the policy response to the SARS and Avian Flu outbreaks and served on the Steering Committee for the PMTCT Initiative, which preceded PEPFAR. She served as senior editor for Africa of the Human Rights and International Religious Freedom reports in the Bureau of Democracy, Human Rights, and Labor at the State Department and as writer/editor for the U.S. Department of Health and Human Services’ Office of Inspector General. Ms. Allinder also has worked for a member of Congress, the Department of the Navy, and a public relations firm. She was a Class of 2000 Presidential Management Fellow. Ms. Allinder holds a MPP, with a concentration in international development and health, and a BA, magna cum laude, in political science and sociology, both from the American University in Washington, D.C.
Endnotes

1 Only four countries meet the hyperepidemics definition at the national level: South Africa, Botswana, eSwatini, and Lesotho.

2 The simultaneous occurrence of epidemics of different health or social conditions in the same geographical area that enhances the transmission, frequency, and/or virulence of each other.

3 To understand the total number of PLHIV virally suppressed, you multiply the proportion of PLHIV who know their status (91 percent) times the proportion accessing treatment (70 percent) by those virally suppressed (83 percent). As of September 2019, the total of all PLHIV virally suppressed remained only 53 percent (91 x 70 x 83).


7 Ibid.

8 UNAIDS, Fact Sheet on HIV among men in South Africa, 5.

9 “2018 South Africa Country Fact Sheet,” UNAIDS.


11 “2018 South Africa Country Fact Sheet,” UNAIDS.


13 “2018 South Africa Country Fact Sheet,” UNAIDS.


15 “2018 South Africa Country Fact Sheet,” UNAIDS.


21 “2018 South Africa Country Fact Sheet,” UNAIDS.

22 When a patient has two or more health conditions.

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