# South Africa

# Country Operational Plan

# FY 2014

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

# Operating Unit Overview

## OU Executive Summary

Country Context:

South Africa has four concurrent burdens that heavily impact the health sector – HIV/AIDS and tuberculosis (TB), poverty-related illnesses (perinatal, neonatal, childhood, and maternal diseases), non-communicable diseases, and violence and injury. In 2014, South Africa celebrates its 20th year as a free and democratic society; however, the country continues to grapple with the legacy of apartheid and inequality in the health sector evident by marked differences in rates of disease and mortality between races (National Planning Commission Report, 2011). Although South Africa is a middle income country and spends more on health than many other developing countries, health outcomes are worse than those in many lower income countries. HIV and its related diseases contribute significantly to maternal mortality (50%) and mortality under five years of age (35%). South Africa is finally starting to see decreases in child mortality after the peak of 82 deaths/1,000 live births in 2003 (HDACC 2012), to 47 deaths/1,000 live births in 2011 (UNICEF 2012). The maternal mortality ratio is an estimated 300 maternal deaths per 100,000 live births (2010).

UNAIDS modeling estimates that there are 6.1 million people living with HIV (PLHIV) in South Africa with a prevalence rate for adults between the ages of 15 and 49 reportedly of 17.9% (95% CI 17.3-18.4), and with an estimated HIV incidence rate of 1.37% (95% CI 1.28-1.49). However, recent results from the 2012 South African National HIV, Behaviour and Health Survey (a population-based household survey led by Human Science Research Council [HSRC]) estimate the number of PLHIV at 6.4 million with a prevalence rate among adults 15-49 at 18.8% (95% CI 17.5-20.3) and an incidence rate of 1.72% (95% CI 1.38-2.06). The UNAIDS model will be re-run with the updated survey results; however, both data points indicate that the number of new infections each year is declining over time and the prevalence rate is slightly increasing. With more than 2.5 million individuals receiving antiretroviral treatment (ART), the increasing prevalence rate reflects a success of the expanding ART program as PLHIV live longer. The HIV epidemic also affects many children with an estimated 369,000 (HSRC) to 410,000 (UNAIDS) children infected with HIV.

The epidemic is largely driven by heterosexual transmission, and there are a number of underlying behavioral, socio-cultural, economic, and structural factors that influence risk for HIV transmission. These include mobility and migration; race, economic and educational status; alcohol and drug use; early sexual debut; sexual violence; low prevalence of male circumcision; lack of knowledge of HIV status; intergenerational sex; multiple and concurrent sexual partners; discrimination and stigmatization; and inconsistent condom use, especially in longer-term relationships and in pregnancy/post-partum. In

particular, gender dynamics and unequal power relations between men and women play a significant role in heterosexual HIV transmission. Approximately 54% of HIV-infected adults are women; with black women aged 25-49 having a prevalence of 32% (HSRC 2012). A 2011 Desmond Tutu Foundation study estimates one third of young girls in South Africa have a forced first sexual experience, and nearly 75% have had at least one non-consensual sexual encounter. In addition, low and late marriage rates and unstable long-term relationships across all populations oftentimes lead to multiple concurrent partnerships, and potentially foster HIV transmission through complex, linked sexual networks. This is especially true in high mobility populations.

Key population (KP) groups shoulder a significant burden of HIV infections in South Africa. Prevalence and incidence vary significantly across geographic areas (54% of PLHIV are concentrated in the Gauteng and KwaZulu-Natal provinces), and migration and mobility are important risk factors that dramatically increase vulnerability to HIV. A study conducted by the International Organization for Migration on migrant farm workers found that, in 2010, 39.5% were HIV positive. Significant transmission also occurs among prisoners, commercial sex workers (CSW) and their clients, men who have sex with men (MSM), and people who inject drugs (PWID). According to the Sex Workers' Education and Advocacy Taskforce, over 90% of the 260,000 CSWs in South Africa are female and one fifth of all new infections are estimated to relate to sex work. Estimates of HIV prevalence among the approximately 1.2 million MSM range from 10.4% to 35.5%, and the NSP suggests that 9.2% of new HIV infections are related to MSM sexual activities. Among the KPs, high levels of stigma and discrimination create barriers to accessing health and HIV prevention services.

In conjunction with the HIV/AIDS epidemic, South Africa ranks third in the world in TB burden. The 2012 TB prevalence in South Africa was 857/100,000 population (WHO Global TB Report), and the highly improved TB cure rate of 74% of new cases in 2011 (up from 54% in 2000) nonetheless remains below the global target of 85%. The TB epidemic is also intensified by high levels of multidrug-resistant tuberculosis (MDR-TB). An estimated 5,000 MDR-TB cases were confirmed among new pulmonary TB cases in 2011 (WHO Global TB Report). HIV has a 65% co-infection rate with TB and leads to further expansion of the epidemics while complicating treatment of patients.

National Response:
The South African National AIDS Council (SANAC) launched the National Strategic Plan for HIV, STIs, and TB (2012 – 2016) (NSP) on December 1, 2011. The NSP reflects strong South Africa Government (SAG) leadership, civil society engagement, and commitment to a robust multisectoral HIV response and outlines four strategic objectives that form the basis of the national response:

1. Address social and structural barriers to HIV, STI, and TB prevention, care, and impact;
2. Prevent new HIV, STI, and TB infections;

3. Sustain health and wellness; and
4. Increase the protection of human rights and improve access to justice.

In line with these objectives, the NSP sets five broad goals that also guide PEPFAR investment decisions:

- Reduce new HIV infections by at least 50%, using combination prevention approaches;
- Initiate at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation;
- Reduce the number of new TB infections, as well as the number of TB deaths, by 50%;
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP; and
- Reduce the self-reported stigma and discrimination related to HIV and TB by 50% by 2016.

The SAG currently funds approximately three-quarters of the national HIV/AIDS response. For SAG's FY 2014/15, the budget allocation for HIV through the conditional grant to provinces is ZAR 12.3 billion (US$1.2 billion) and it increases to ZAR 15.7 billion (US$1.5 billion) by 2016/17. SAG has spent ZAR 41 billion (US$4.1 billion) on HIV and AIDS programs over the past five years and has allocated a budget of ZAR 43.5 billion (US$4.35 billion) over the next three years. PEPFAR's current investment is approximately 15% to 20% of the national response, while other development partners, including the Global Fund to Fight AIDS, TB and Malaria (the Global Fund), contribute between 5% and 10%.

In August 2012, the Partnership Framework Implementation Plan (PFIP) was signed by the U.S. Ambassador and SAG Minister of Health. The PFIP outlines PEPFAR and SAG joint investments through 2017 to further reduce HIV infections and strengthen health systems through the provision of technical assistance (TA) and targeted service delivery. PEPFAR will continue to provide comprehensive TA for HIV/AIDS care and treatment services while also implementing targeted prevention programs, driving health systems innovation, supporting programs for orphans and vulnerable children (OVC) and building country capacity in data-driven decision making, laboratory diagnostics, human resource development and training, supply chain management and other areas critical to strengthen the national health system. PEPFAR will continue to support the SAG expansion of treatment services through capacity building that increases access, efficiency and quality in patient outcomes, while the SAG absorbs financial and implementation responsibility for clinical services currently provided by PEPFAR. Both governments are working together to communicate these shifts, emphasize the continual scale-up of the national HIV and TB response, maintain high quality continuum of care, and ensure that patients continue to receive care and treatment services.

South Africa has more than 3,500 Primary Health Care (PHC) clinics and community health centers that

form the foundation of the public health system effort to provide universal access to health care services. The SAG approach to strengthen the District Health System and re-engineer PHC is implemented through three streams: 1) providing integrated community-based services through ward-based PHC outreach teams; 2) strengthening clinical governance through district specialist teams; and 3) implementing a school-based health services program. The SAG projects adding 400,000 to 500,000 individuals to the ART program each year. The rapid expansion and decentralization of the ART program, accompanied by task shifting toward nurse initiated ART, has put tremendous strain on the health system. PEPFAR's investments in strengthening the capacity of health care workers (HCW) and health systems are critical to ensuring a long term sustainable HIV response that is integrated with the delivery of PHC services.

In addition to PHC re-engineering, the SAG launched the Aid Effectiveness Framework in 2011 to improve development partner coordination in health. PEPFAR coordinates closely with the Global Fund, UN agencies, European Union, United Kingdom, Germany, Sweden, Clinton Health Access Initiative, Gates Foundation, Elma Foundation, Johnson & Johnson, MAC AIDS Fund, Anglo American, Atlantic Philanthropies, and others through participation in the AIDS and Health Development Partners' Forum to discuss specific programs that may complement PEPFAR's work.

PEPFAR Focus in FY 2014:
In 2014, PEPFAR will continue to focus on programs that are aligned with national priorities; coordinate with SAG, Global Fund, and other development partners to ensure implementation contributes to the goals of fewer new infections and more lives saved; and work toward strengthening information systems that can collect quality data for improved decision making. Specific priorities for COP 2014 include: 1) managing transition of clinical services to SAG with district support partners focusing on priority areas including HIV/TB and pediatric and adolescent services; 2) supporting HIV prevention services including HIV counseling and testing (HCT), scale up of medical male circumcision (MMC), positive health, dignity and prevention (prevention with positives), condom promotion and prevention of mother to child transmission (PMTCT); 3) implementing a focused service delivery program for OVC with increased support to strengthen the health and social welfare system and workforce for OVC services; and 4) implementing cross-cutting activities for HIV/AIDS-related surveillance, laboratory systems strengthening, human resource capacity building, health information systems, and supply chain management.

In alignment with PFIP budget projections, the COP 2014 budget decreases to $459 million from $484 million in 2013. This decrease is primarily absorbed through a 15% reduction in the adult treatment and elimination of antiretroviral (ARV) drug budgets, although limited ARV drugs for second and third line regimens will continue to be procured with remaining prior year funds. These reductions are accompanied by a 3% increase in pediatric care and treatment, a 2% increase in TB/HIV programming and a 9%

increase in Health Systems Strengthening (HSS) that includes funding for strengthening supply chain management. Prevention budgets for HCT and MMC will remain level. These overall funding shifts are a result of analysis and planning with the SAG and other stakeholders to address current gaps in the national response and focus PEPFAR's investments for strategic impact.

Progress and Future:
During 2013, South Africa was announced as a Country Health Partnership (CHP) country. Although signed prior to the official launch of CHPs, the PFIP forms the basis for implementing governance structures and processes for transparency and joint planning. The PFIP Steering Committee, co-chaired by the SAG Minister of Health and U.S. Ambassador, functions as the CHP oversight board. The PFIP Management Committee, composed of senior SAG and PEPFAR leadership, functions as the CHP planning and management committee and guides PEPFAR planning, budgeting, and implementation. Through the CHP, the USG and SAG will institutionalize and strengthen the structures and processes initiated through the PFIP. At the beginning of 2014, four positions were advertised by the National Department of Health (NDOH) that will be dedicated to supporting the bilateral coordination and implementation structures.

The initial Steering Committee meeting held in June 2013 provided high level endorsement for PEPFAR's investments and direction for prioritizing PEPFAR's implementation. Since that meeting, the Management Committee and the four bilateral work streams, Prevention, Care and Treatment, Orphans and Vulnerable Populations, and HSS have met several times to deepen joint USG-SAG planning. Workshops were held in 2013 to broadly outline priorities, notional budgets, and timelines for PEPFAR's operations through 2017. In addition, the Care and Treatment bilateral workstream held consultation meetings with implementing partners (IPs) to review approaches and standardized priorities for support to the 52 districts. The four bilateral workstreams also conducted joint portfolio reviews of all PEPFAR funding agreements to ensure alignment with strategy and prepare for COP 2014 planning.

The 2014 COP has been reviewed and endorsed by the bilateral Management Committee, and the Steering Committee is scheduled to meet in early March to review progress since June 2013. Significant progress has been made in planning and managing the transition for clinical services over the next few years as well as outlining the consultation process at the national, provincial, district and partner levels. Key priorities for achieving sustainable health outcomes include: 1) ensuring continuation of patient services during transitions; 2) planning in close partnership with provincial and district leadership to transition PEPFAR-supported patients to the public sector; and 3) mapping PEPFAR-supported human resources in public sector health facilities and planning for the deliberate absorption of these posts into the government payroll and supervision systems. To further joint collaboration through the CHP, the Management Committee has agreed to support a national review and prioritization of surveillance and

survey activities and to develop priorities for operational research and implementation science. In addition, the USG and SAG have agreed the CHP offers an opportunity to develop a more formal process for evaluating innovative models implemented by PEPFAR in order to determine what approaches SAG can take to scale for a more effective and efficient HIV response.

Programmatic success includes the implementation of the Accelerated PMTCT Plan that has resulted in universal access to PMTCT services across the country and a decrease to 2.7% in early transmission; a rapid increase in access to ART with more than 2.5 million people currently on treatment; and improvement in the TB cure rate to 74% of new cases. The SAG will continue to expand HIV care and treatment and PEPFAR continues to support the rollout of revised (April 2013) treatment guidelines to make ART available to all pregnant women for PMTCT, all HIV infected children, and gradually expand the use of fixed dose combination triple ARV therapy for adult patients with a CD4 count at or less than 350.

HIV/AIDS PREVENTION:
The prevention response in South Africa is complex, with interventions implemented through a multisectoral approach. PEPFAR SA developed a Prevention Framework in consultation with SAG to guide the program focus and inform resource allocation through epidemiological data-driven analysis gained through costing studies, research and innovation, rather than by historical program intervention areas. It is aligned with the SAG goal of rapidly reducing new infections while strengthening systems and building capacity for sustained impact. Costing studies are also being conducted to maximize impact of financial resources. Overall, prevention activities are planned, over the next two to three years, to strengthen linkages with care and treatment services and improve linkages between community services and clinical platforms. The PEPFAR SA HIV Prevention Framework consists of three components: a) geographically-focused programs to reduce transmission rapidly through 80% coverage of target populations with high-impact combination interventions; b) systems strengthening at national level to increase the capacity of government partners, such as those addressing MMC, PMTCT, health communication, condom management, and sexuality education; and, c) targeted projects to address specific needs, such as gender-based violence (GBV), male norms and behaviors, and services for KPs. Among the prevention objectives are the elimination of Mother to Child Transmission of HIV; scale up of MMC; study of early infant male circumcision (EIMC); targeted strategic communication to increase demand for services; and focus on cross-cutting issues, such as strengthening communities, and strengthening and integrating gender activities, male norms and behaviors, health communication, condom use, and developing a GBV strategy. PEPFAR prevention will increase collaboration with Global Fund and other local and international stakeholders to avoid duplication efforts, maximize available resources, and identify and address programming gaps.

To reduce HIV incidence, PEPFAR will employ a variety of models to implement community-based comprehensive HCT programs in focused geographic areas. IPs will provide TA for strengthening linkages and referrals related to intensive case findings in hospital and community settings. PEPFAR will also work with the national and provincial departments of health to review the national HCT guidelines and registers, and strengthen quality assurance (QA) and improvement systems. PEPFAR-funded district support providers (DSPs) will be tasked with providing TA to scale up provider-initiated HCT, especially for antenatal mothers and 18 month-old infants for PMTCT follow-up interventions.

In support of the SAG's strategy to eliminate MTCT of HIV by 2015, PEPFAR administers support through DSPs who operate in all 52 districts, helping to improve the coverage and quality of PMTCT programs. Additional technically focused partners work within government structures to assist in developing policy, operational plans, and training of trainer models for instructing, surveillance, and quality improvement.

The SAG has set a national target of one million MMC for FY 2014-2015 which includes PEPFAR's 2014 target of 436,000 MMCs. To reach this target, PEPFAR implements a national MMC program that, in addition to service delivery, includes training, kits, and targeted TA. PEPFAR-funded partners use models to optimize volume and efficiency, and also emphasize forceps-guided surgery in their service delivery and surgical training. PEPFAR has also planned activities to assess the potential role of EIMC on incidence reduction. The Prevention team will also conduct feasibility studies with the NDOH in FY 2014. Planned MMC modeling work is expected to provide basic data on key subgroups that should be targeted to yield the greatest impact. PEPFAR will partner with UNICEF to develop guidance on translating findings and outcomes into stakeholder discussions, policies, and protocols.

Prevention programs will use targeted strategic communication interventions to promote HIV prevention practices and behaviors and to increase demand for critical services such as HCT and MMC. Activities, which will include a specific focus on women and girls, will also aim to increase government capacity to design, implement, manage, and evaluate prevention programs. Additional efforts will focus on community mobilization in villages, townships, and schools, in collaboration with SAG, SANAC, and other civil society partners.

The Prevention team is also engaged in several cross-cutting program activities. PEPFAR partners will use community strengthening activities like strategic, evidence-informed communication to expand prevention services that optimize linkages to care, treatment and prevention. The team will also continue to integrate gender activities into HTC, PMTCT, MMC, and behavioral prevention interventions that address GBV—a key structural driver of the HIV epidemic in South Africa. To better reach MSM and transgender populations, PEPFAR will collaborate with local partners and U.S.-based foundations to leverage access to private sector resources.

Many of the 2014 prevention priorities are related to foundational systems strengthening and capacity building. Technical staff and IPs will support the NDOH with rationalization of clinical registers used to monitor programs; help implement unique identifiers to track mothers and their infants for the first 1,000 days of life; ensure availability of health commodities; and implement a demand creation strategy for women living with HIV. The program will continue to prioritize operations research to highlight causes of key bottlenecks and identify solutions. PEPFAR, along with UNICEF and NDOH, will fund a PMTCT program evaluation led by the South Africa Medical Research Council (MRC). The six-week infant specimen from the MRC survey will be used in the nevirapine drug resistance surveillance activity. Partners will provide TA to AIDS councils on use of data collection tools, and will train partners and SAG on how to apply geographic information systems to map survey results and HIV trends. They will also help the SAG and SANAC finalize the monitoring and evaluation (M&E) framework for the National Sex Worker Strategic Plan, and collaborate with stakeholders to implement the framework that aligns with country-level M&E systems. A planned GBV surveillance system will track reported sexual assaults and domestic violence crimes, and a school-based sexuality and HIV prevention activity will be introduced in collaboration with the Department of Basic Education (DBE).

The prevention portfolio plans to start one new procurement mechanism to support work in FY 2014. This mechanism was included in COP 2013 and will support local communities in assuming ownership and scaling-up HIV prevention, especially related to sexual GBV.

CARE AND TREATMENT:
South Africa manages the largest ART program in the world. The number of individuals receiving treatment services increased from 500,000 in 2009 to more than 2.4 million in 2013. Since 2004, PEPFAR has collaborated with South Africa to increase access to ARVs by expanding the number of treatment sites, developing treatment policies, training health care providers, procuring and strengthening the delivery of treatment commodities, and monitoring and evaluating programs. The number of public health facilities providing ART has increased from 490 in 2010 to over 3,500 in 2013. This approach has also involved shifting toward a nurse-initiated service delivery model at primary health centers and away from services delivered mainly by doctors at hospitals. Greatly increased accessibility of ART at public sites has allowed for PEPFAR and SAG to partner in transitioning some patients to these public sites from PEPFAR-supported non-public sites. Of the more than 2.4 million people currently receiving ART in South Africa with PEPFAR support, only 35,000 individuals, or less than 2 percent, are receiving treatment in non-public sites supported by PEPFAR: the vast majority of patients are now accessing ART through public sites or other private facilities. In 2014, PEPFAR will continue to plan closely with SAG to ensure the remaining 35,000 patients are carefully transitioned to sustainable models of care managed by the SAG. In addition, PEPFAR and NDOH will continue to work with provinces to plan for and transition the

approximately 3,000 PEPFAR-funded human resource posts supporting the care and treatment program.

During October 2013, PEPFAR participated in a Joint National Review of the HIV, TB, and PMTCT programs conducted in collaboration with more than 160 international and local technical experts who visited health facilities in all provinces. The review found significant progress in implementation of the previous 2009 recommendations which included getting lay counselors to conduct HIV testing; having nurses initiate first line ARV treatment; integrating TB and HIV care; and decentralizing MDR-TB treatment. The Review also identified continuing challenges in the three thematic areas of quality; programmatic issues; and M&E and research. There are many challenges in quality of care, reflected in early defaulting in TB patients (gap between diagnosis and initiation on treatment) and most acute in the case of MDR-TB; the loss to follow-up of patients on ART and low number of children on ART; and poor treatment success with MDR-TB patients. With regard to programmatic issues, while there was overall improvement of HIV/TB integration, there were still examples of lack of integration, poor QA of HCT, sub-optimal use of registers, and lack of defaulter tracing systems. With respect to monitoring and evaluation, the key challenges are poor use of a unique identifier in health information systems, multiple registers, and sub-optimal use of community-based data for program management.

Other challenges faced in the care and treatment programs are the high level of internal migration that creates difficulty in patient follow- up; the lack of data related to MTCT rates at 18 months versus at six weeks; and the reluctance of some nurses in rural clinics to dispense treatment services to children. The TB burden in the pediatric population is not fully determined; however, as children with HIV age, it is expected that pharmacological long-term care needs will increase. TB-HIV co-infection will likely become a more pressing issue in pediatric treatment, and the number of MDR–TB patients will increase. Linkages to care and treatment for KPs like CSW, MSM, and PWID, are weak, having not kept pace with prevention programs and treatment expansion for the general population. These challenges, findings, and recommendations of the 2013 Joint National Review have guided NDOH and PEPFAR discussions on priorities for COP 2014 implementation.

PEPFAR SA’s primary objective is to support scale up of the national HIV treatment and care program, including pediatrics, TB/HIV, PMTCT and care components, through partnerships covering all districts (52) and all public facilities offering HIV services. While transitioning service delivery aspects of the care and treatment portfolio to the SAG, PEPFAR SA will bridge key gaps in direct service delivery and capacity building to ensure that this transition does not result in disruptions in patient care. The PEPFAR SA care and treatment portfolio is divided into two categories. Comprehensive district-based partnerships represent approximately two-thirds of the PEPFAR SA care and treatment funding and support all 52 districts. These partnerships are designed to improve HIV-related patient outcomes by strengthening health and patient management systems at facility, sub-district and district levels while building capacity in

coordination, management and planning to strengthen HIV services. Focal care and treatment partnerships (one-third of funding) support advanced clinical care services or target specific clinics and populations. Populations targeted include prisoners, military personnel, migrants, residents of informal settlements, adolescents, CSW and MSM. In addition, focal support is provided at the national and provincial levels for capacity building in monitoring and evaluation, TB/HIV, PMTCT, pediatric HIV, and nutrition, care and support.

PEPFAR is supporting NDOH efforts to finalize a National Framework for Linkage, Retention, and Treatment Adherence for HIV, TB, and other Chronic Diseases, and PEPFAR will provide training, mentoring, and monitoring to assist health care providers and facilities in implementing interventions contained in the framework. PEPFAR will also work with the NDOH to revise the cervical cancer policy that incorporates current data and knowledge. Although PEPFAR does not support cervical cancer treatment, PEPFAR will support cervical cancer screening as part of comprehensive HIV care. In addition, more than 1,000 HCWs have been trained in best practices to diagnose and treat both early and symptomatic cryptococcal disease. To increase adherence to care, PEPFAR will also explore the development and integration of a mental health screening protocol that would improve health outcomes.

PEPFAR is participating in the development of national Positive Health, Dignity and Prevention guidelines which address behavioral and biomedical prevention interventions for PLHIV, and is also developing materials to train HCWs on prevention interventions that are fully integrated into care and treatment services for PLHIV. PEPFAR will continue to invest the national rollout of the Integrated Access to Care and Treatment program which assists newly diagnosed PLHIV in understanding and coming to terms with their diagnosis, building a personal support network, and taking ownership and management of their disease. PEPFAR will also support integration of HIV programs with SAG's national family planning campaign aimed at increasing the availability and uptake of contraceptives and support effective communications to increase the involvement of KPs.

In 2013, the SAG revised the national treatment guidelines to include treatment for all HIV-infected children under five years of age, regardless of CD4 count. However, the coverage of children receiving ART (63%) is low relative to treatment coverage for adults (81%). A rapid pediatric assessment conducted in April 2012 highlighted gaps in the pediatric program. Pediatric services continue to lag behind adult services because clinics offering pediatric services like immunizations and Integrated Management of Childhood Illness do not necessarily offer ART. To address treatment disparities, a Blueprint for Action was developed to increase the number of sites providing age and developmentally-appropriate services, and identify the best models for providing services to both perinatally and behaviorally infected adolescents. PEPFAR district support partners will train and assist site personnel to improve and increase the number of sites providing pediatric services. In June 2014, the

SAG will conduct a MCH program review to evaluate progress made.

The bilateral Care and Treatment workstream has identified the following priority areas for strengthening the HIV response in all districts:

1. Strengthen testing to treatment cascade, including TB;
2. Improve patient retention and quality outcomes through continuum of care;
3. Support quality improvement of care and treatment (QI/QA);
4. Focus on pediatrics and adolescent program support;
5. Follow mothers and babies through first 1,000 days;
6. Assist with roll out of the Integrated Chronic Disease Model;
7. Build program management capacity at district level;
8. Strengthen data and data management at facilities and district level; and,
9. Support supervision, M&E, planning, and supply chain.

A new care and support cooperative agreement will continue PEPFAR's programs for HIV care to improve the effectiveness and quality of HIV/AIDS programs and decrease the burden of HIV, AIDS and TB, through integrated services including pediatric, PMTCT and TB services.

New procurement mechanisms to support PEPFAR's work in treatment in 2014 include: a program evaluation cooperative agreement to assess the effectiveness of adult and pediatric treatment programs and document valuable lessons learned during the transition of patients from private to public clinics.

ORPHANS & VULNERABLE CHILDREN:

Nearly one third of South Africa's population is under 15 years of age, and approximately 22% of the country's 18.6 million children are affected by HIV/AIDS, with more than 2 million children orphaned by AIDS. The 2010 General Household Survey suggests that the overall number of orphans could be as high as 3.7 million, while the UNICEF 2010 South Africa Annual Report indicates that 3.9 million children have lost one or both parents. The impact of HIV and AIDS on children and their families is complex and multi-faceted. The National Action Plan for OVC and Other Children Made Vulnerable by HIV and AIDS (NAP) reflects strong SAG leadership and commitment to a robust multisectoral national HIV response. The plan recognizes OVC as a KP for whom specific interventions will be implemented as a primary prevention strategy for HIV and to mitigate impact and break the cycle of ongoing vulnerability. The Department of Social Development (DoSD) has been tasked with leading HIV prevention in the areas of social and individual behavior change, including changes in gender norms that are necessary for the prevention of new HIV infections, especially among OVC and youth.

Over the next two years the PEPFAR OVC program will maintain its three-pronged strategy – targeted

service delivery, system strengthening, and operations research– to support children and households affected by HIV/AIDS. The focus on targeted service delivery will provide comprehensive, evidence-based interventions in high-prevalence areas that are sustainable and support community capacity building. Overall, PEPFAR OVC programs will support the DoSD to:

1) Strengthen coordination (including with NDOH and DBE) and build the capacity of local structures, including families and communities to protect and care for OVC;

2) Build M&E capacity at all levels;

3) Strengthen linkage and referrals for Nutrition, Assessment counseling and Support, and encourage early pediatric testing and HIV testing for those sexually active under 18 years old;

4) Support family and community-based response mechanisms to protect vulnerable and at-risk children (with a specific focus on the 0-5 age group, child survivors of abuse and gender based violence, HIV-positive children and children living with sick or elderly caregivers);

5) Strengthen the social service professional workforce, including strengthening supportive supervision models and practices tied to improved programmatic performance and child well-being and household outcomes; and,

6) Continue to build the knowledge base through the introduction of outcome-level indicators for routine monitoring of OVC and youth programs, support evaluations and provide TA for roll-out of a DoSD community-based information management system.

GOVERNANCE AND SYSTEMS:

Priorities for Governance and Systems group are structured around five of the six WHO HSS building blocks: Human Resources for Health (HRH); governance and leadership; medical supplies; finance; and, strategic Information (SI). The sixth WHO building block, service delivery, is primarily addressed by Care and Treatment. Because each of these building blocks addresses system-level issues that are necessary for HIV prevention, care and treatment, the governance and systems work group works closely with other groups to coordinate activities. Most of the governance and systems activities occur at the national level and impact the entire population of PLHIV.

The HIV response in South Africa is directed by multiple national departments and largely implemented by corresponding provincial and district offices. Although South Africa's NDOH is responsible for establishing broad health policies that ensure that the health system is appropriately capacitated and resourced, provincial departments generally determine how staff and resources are allocated. South Africa is in the early stages of implementing PHC reengineering and focused on primary health clinics, community health clinics, ward-based outreach teams, and integrated school health programs. This district-based model aims to improve access to basic health services at the lower levels of the delivery system in preparation for implementation of National Health Insurance. These service delivery points are managed through two management teams, one with an administrative focus (the District Health

Management Teams), and the other with a clinical mentorship focus (the District Clinical Specialist Teams). The impact of these structures, as determined by NDOH evaluation, will also guide PEPFAR's ongoing support.

The SAG, in recognizing the need for appropriately capacitated human resources in effectively implementing PHC, has included the HRH Strategy: 2012-2017 in its annual performance plan. The HRH Strategy seeks to address skill gaps at all levels, including clinical and hospital management, and aims to produce high quality leaders and managers capable of assuming greater responsibility and accountability. The USG will continue to play a substantial role in the rollout of this HRH strategy through the provision of TA. The critical role PEPFAR plays in supporting HRH requires IPs to work closely with NDOH to develop district HRH plans and strengthen the use of information systems, such as SkillSmart. Under the guidance of district management, PEPFAR-funded district support partners will identify skills gaps and provide leadership and management training and mentorship.

PEPFAR supports provincial, district, and facility health team efforts to improve laboratory operations and services to safeguard the integrity of diagnostic, surveillance and other laboratory operations. Laboratory support will be expanded in 2014 to include implementation of electronic gate keeping that decreases costs by reducing unnecessary test orders. PEPFAR provides resources for training auditors to evaluate laboratory facilities' readiness for accreditation, and is also working with NDOH and National Health Laboratory Service (NHLS) to expand the national laboratory policy to include private sector laboratories. Efforts to roll out internal quality control processes help ensure that HIV rapid kits meet the required quality standards. The introduction of GeneXpert testing machines has also had a significant impact on South Africa laboratory quality and efficiency.

Key activities for the SI portfolio over the next two years include working with the SAG on surveillance and surveys directed towards the general population, high risk populations, gender-based violence, TB and PMTCT. In addition, the SI team will work with the SAG to improve data quality and assurance through increased capacity and improved collection, management and maintenance practices. Other activities include the implementation of PEPFAR's monitoring, evaluation and reporting strategy (MER) and strengthening quality and interoperability of routine data management systems, including Tier.net, ETR.net, DHIS/DHIS 2, Rx Solutions, and SmARTer (Tier 3). In order to allow improved care and tracking over time, PEPFAR will support the NDOH's implementation of a unique patient identifier that can facilitate tracking and follow-up of patients across clinical sites.

PEPFAR will work with national and provincial governments, South Africa's Medicines Control Council, clinicians, pharmacists, and other key stakeholders to promote adherence to rational drug use, improve clinical efficiencies, enhance the procurement process and strengthen the supply chain. Supply chain

assessments, including those by PEPFAR partners, have served to identify structural and management weaknesses in the supply chain system, and provided the basis for developing new models for delivering medical products. The new direct-delivery system depends on a universal pharmaceutical management system and is based on a direct-delivery concept to reduce the country's dependency on provincial and lower-level depots. PEPFAR is supporting the NDOH in the development of a roll-out strategy of Rx Solutions and the software to meet the needs of all levels of the drug supply chain.

Six new procurement mechanisms will support PEPFAR's work in governance and systems in 2014. These mechanisms include: a CDC-NIH capacity building grant which provides several research training sub-grants to South Africa universities to develop fellowships for South Africa health professionals to develop expertise in implementation science; continuation of a contract to develop an M&E system that measures PEPFAR partner TA contributions and its impact on the South Africa health system; an information system development mechanism to track and store TB/HIV surveillance data and prevent unnecessary delays in detection and treatment; a NHLS cooperative agreement to strengthen the quantity and quality of laboratory services offered in the public sector and improve the capacity to conduct laboratory based surveillance; a twinning partnership to support the development of mid-level HCWs and strengthen pre-service training institutions and regulatory councils; and a continuation award with HSRC, a parastatal, to support the national population based HIV survey and other priority survey and surveillance activities.

GHI and Program Integration:

The PEPFAR SA program is working actively to promote country ownership and sustainability to support the SAG's broader health development agenda through systems strengthening. Building the capacity of facility, district, and provincial managers will impact the health system beyond HIV and TB, similar to the way that investments in supply chain for pharmaceuticals and other medical products benefitted the broader health system. The SAG has agreed to fund and manage the continued scale-up of care and treatment services, and the PEPFAR program will focus investments that build capacity for the national system to manage an expanding treatment program and maintain high quality services.

Through joint planning led by the SAG, the PEPFAR team actively collaborates with the SAG and other development partners to avoid duplication and maximize impact. The portfolio specifically addresses the vulnerability of women and girls and gender-based violence. The USG is represented on the Global Fund Country Coordinating Mechanism and participates substantively in Global Fund grant oversight, grant development and implementation via principal recipients. The PEPFAR SA program is engaged in numerous public-private partnerships. Systems are in place for robust M&E to ensure accountability for U.S. taxpayer funds. PEPFAR is also actively participating with UNAIDS and other stakeholders in the NDOH-led process to develop an investment case to direct and prioritize allocation of future national and

donor resources in order to maximize impact by reducing the number of new HIV infections and saving more lives.

PEPFAR SA has also worked to leverage COP 2014 programs with centrally funded initiatives including MMC plus up funding, McCann PPP for MMC, PPP Incentive Fund, SI Initiative, GF collaboration, MEPI, NEPI, and PopART. Brief updates on these centrally funded initiatives are included in a supplemental document.

In August 2014, PEPFAR SA revised its COP 14 submission to reflect a new funding request that is $200 million lower than the original request. Applied pipeline funds equalling $200 million were programmed to supplement this change. Total outlays were reduced by USAID and CDC, so that the total spend for the COP will does not exceed $459 million. Although efforts were made to mitigate the impact of this decreased spend plan, the programmatic impact will effect care and treatment, OVC, and prevention technical areas. Targets are expected to decrease by 20% on average, with the exception of VMMC and HSS targets. In addition, the PEPFAR SA transition of responsability to the South African government for treatment services in public health sites, will be expedited.