

The Politics of Transition & the Economics of HIV

AIDS & PEPFAR in South Africa

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The Politics of Transition & the Economics of HIV: AIDS & PEPFAR in South Africa

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Photo: HIV treatment center at primary care clinic in Maryhill section of Durban

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The Politics of Transition & the Economics of HIV: AIDS & PEPFAR in South Africa

Executive Summary

AIDS poses a unique and unprecedented challenge to South Africa. The country has the largest HIV epidemic in the world—with 6.4 million people living with HIV—and one of the largest TB epidemics in the world as well.¹ *South Africa is home to one in six people in the world living with HIV.*² Yet breakthrough research and modeling make it clear that South Africa can reverse its epidemic—driving rapid decreases in mortality and new infections—if it quickly scales up anti-retroviral drug access and other core interventions.

The country's recent AIDS response has generated enormous optimism, both in South Africa and internationally. The biggest change, in many ways, has been political—dramatic shifts in ideology and motivation at the highest levels of government have moved the country from denialism and inaction to a bold national mobilization to bring anti-retroviral treatment (ART) to scale. Building on efforts begun under activist pressure, today's dramatically increased domestic funding and strong National Strategic Plan (NSP) have expanded uptake of science-based interventions, reshaping the role of the South African public health sector.

Meanwhile, the approach of the U.S. government (USG) has evolved along with the changing political context. Domestic U.S. politics and growing demands on a stagnant budget for the President's Emergency Plan for AIDS Relief (PEPFAR) have prompted shifts in U.S. AIDS policy in South Africa.

The PEPFAR program in South Africa has been among the most successful foreign aid efforts in the world—both for people living with HIV and in the politics of U.S. foreign relations. Since 2004 PEPFAR has invested nearly \$4 billion in the country through funding NGOs and both the

private and public sector to help take treatment, care, and support programs to scale.

Today PEPFAR in South Africa is managing perhaps the largest “transition” of a global health program in history—withdrawing direct staff and funding for the treatment of hundreds of thousands of HIV-positive patients as they move toward being fully provided for in the South African public sector. In many respects the political transformation imagined in the 2010 Partnership Framework has been positive, with the South African government (SAG) demonstrating considerable leadership and PEPFAR structuring a new relationship that shares decision-making power over the program.

However, in important ways, the politics outpaced smart policy-making and implementation: political transition was translated into a rapid, widespread pull out of U.S. support for “direct services” that likely resulted in care disruption for thousands of people. **A significant course correction is now needed if South Africa is to consolidate the gains that have been made and accelerate the response toward halting the epidemic.**

Beyond South Africa, findings from this report suggest an important reality: In most countries transitioning away from U.S. support for core direct services is incompatible with scaling up to reach an “AIDS Free Generation”—PEPFAR's agreed aim under its strategic blueprint. In the wealthiest country in Sub-Saharan Africa, with a comparatively strong public health system, the struggle to reach those in need with ART and other life-saving prevention and treatment interventions is placing intolerable strains on the health system.

PEPFAR's “transition” has encountered numerous challenges, including those detailed in this report, as a result of capacity limitations. The fact that such acute problems have arisen in

¹ Shisana 2013.

² UNAIDS 2013.

South Africa suggests that caution is in order with respect to PEPFAR plans for other African countries with considerably fewer resources. Even if Uganda or Malawi could scale up their growth rates to record-setting levels of 10% a year, it would still be more than a decade before they would qualify as middle-income;³ fast-growing Nigeria, meanwhile, has a health system that ranks among the worst performing the world.⁴ As such, talk of “transition” outside of South Africa, Botswana, and Namibia is premature and risks sacrificing the epidemiological impact that is within our grasp.

South Africa’s success in responding to HIV has important implications that extend far beyond the country. With the largest HIV treatment program in the world, South Africa is the model for the region—innovating rapidly with PEPFAR help by rolling out nurse-initiated ART nationwide in primary health centers, integrating HIV and TB programs, and decentralizing drug-resistant TB management. South Africa is not only a hub for HIV leadership, but also a central driver of the epidemic as a result of regional economic and migration patterns. If scale-up works in South Africa, long-term benefits will be felt throughout Southern Africa—but so too will failures. As such, success in the country is essential to achieving an “AIDS Free Generation.”

FINDINGS

This report draws on over 75 interviews with US and South African government officials, PEPFAR implementing organizations, front-line clinicians in the public sector, civil society groups, academic experts, and people living with HIV along with public documents.

Successes on which to build:

1. Political commitment has accelerated and reinforced progress in South Africa.

One of the most evident successes of the past two years has been the mutually re-enforcing political commitments by leaders at the highest levels of the South African and American governments that have cascaded throughout the AIDS response. While South African leaders (both government and civil society) deserve the lion’s share of credit, the PEPFAR-SAG relationship has also had an important role to play.

2. Increased capacity of public sector is a major priority that, previously neglected, is now receiving urgently needed attention.

The shift to local partners and, more importantly, to providing services within public sector settings is bearing fruit. The public nurse, working side by side with PEPFAR staff in the AIDS response, is also providing antenatal care and other health services, generating cascading health effects that benefit South Africa as a whole.

3. New models of PEPFAR governance demonstrate that host governments can co-“own” US-funded programs.

With much talk of “country ownership” in Washington, new governance structures created in the South Africa Partnership Framework are unique in PEPFAR and show shared decision-making is possible. High-level Steering and Management Committees are providing venues for essential coordination between governments.

³ World Bank, 2012.

⁴ Nigeria Health Sector Development Team 2009.

Strategic failures that should be addressed:

1. What happened to the patients? PEPFAR does not know if transitioned patients are successfully receiving care, although available evidence suggests that a significant number of patients—*tens of thousands*—may have fallen out of care as a result of the transition.

From both an ethical and public health standpoint, the biggest breakdown of the transition is perhaps the simplest: despite pledges to do so, PEPFAR failed to ensure that patients in ART and pre-ART care experienced no disruption in service access and were successfully transitioned to full support in the South African public sector.

From the more than 1 million people PEPFAR reported “directly” supporting at the start of the transition, PEPFAR today supports treatment and care services for only about 30,000 people and is in the process of transferring many of these to the South Africa public sector. In the transition process, however, PEPFAR undertook no systemic tracking or retention support to ensure that patients were actually successfully kept in care—and thus the precise size of any disruption is not known.

The most significant problems have occurred where patients were transferred out of NGO clinics, private medical practices, or public sector facilities because of the end of PEPFAR direct support. According to key informants interviewed in preparation of this report, and reports in the media, many patients experienced dauntingly long waits, intense stigma, and poorly-prepared staff. Clinics in many regions experienced stock-outs of ARV and TB drugs at the time of transition.⁵ Some patients were turned away from overwhelmed public sector clinics that largely did not receive increased staff to deal with the influx of patients. Marginalized populations and pediatric patients have been especially at risk.

⁵ South African HIV Clinicians’ Society et al. 2013; Doctors Without Borders (MSF), Treatment Action Campaign (TAC), and SECTION27 2013.

Where PEPFAR was supporting public-sector clinics that did not transfer patients out, withdrawal of PEPFAR support for direct services resulted in the removal of doctors, nurses, counselors, data capturers, and others paid for by PEPFAR. In at least some of these clinics, loss-to-follow-up rates have risen and disrupted care in ways that could have been avoided by a more step-wise, well-monitored transition. People in pre-ART care—a critical epidemiological group highly vulnerable to attrition⁶—have also not been systematically tracked to see if they stayed connected to care.

The only known public study of loss in this transition finds that 19% of patients in ART care from one of the most motivated and capacitated groups of PEPFAR SA patients did not make even a first visit in the public sector—a number that likely over-estimates actual retention, but is in line with other loss-to-follow up data in the country.⁷ Even assuming retention in public sector was many times more successful, we estimate *between 50,000 and 200,000 people may have fallen out of care in the transition*.⁸

2. Contractual provisions and arbitrary deadlines, rather than an evidence-based assessment of the readiness of the public sector, too often drove the transition process.

In Western Cape, a clear accounting of what was to be absorbed was made available to decision-makers before any major transition occurred, leading to an orderly transition in a province with a robust health system. In most of the country, however, this did not occur. Cooperative USG agreements were re-written and transition of patients was well under way before a full assessment of how many patients

⁶ Kranzer et al. 2010.

⁷ Bassett et al. 2013 a, b.

⁸ See the full report below at Table 3 for explanation of this estimate and methodology. Exact inference is difficult, but we assume at least the 1.1 million people reported in the PEPFAR Country Operational Plan as “directly supported” before transition were affected. Based on clinic visits and key informants we find reason to believe Bassett et. al.’s estimates hold for both NGO and public sector PEPFAR models, but include estimates for as much as 4-times less loss than Basset et al. find, which still suggests 50,000+ people “lost.”

Note: just before release a PEPFAR blog suggested 4-9% “loss,” which conforms with estimates below. Von Zinkenagel 2014.

and staff positioned needed to be absorbed by SAG. The failure to assess public sector readiness before the transition began undermined the ability of decision-makers to decide on the timing and pace of transition clinic by clinic. Only where NGO or government partners forcefully resisted a premature transition were more gradual, and seemingly successful, transitions achieved.

3. PEPFAR built remarkable human resource capacity, but at the very moment when scale-up is urgently important, the South African AIDS response is losing human capacity—especially community health workers—due to the failure to develop a coordinated plan.

A consistent sentiment echoed by informants is that the substantial expansion of health worker capacity represents one of PEPFAR's greatest successes; thousands of doctors, nurses, adherence counselors, data capturers, HIV testers, and community health workers were trained, paid, and retained in PEPFAR-funded positions. However, no comprehensive plan was put in place to retain these essential personnel in the national AIDS response: slow public sector systems and hiring freezes were prevalent throughout the country, and the first accounting of essential positions was not completed until late in 2012 when transition and staff changes were long under way inside implementing organizations. With PEPFAR's move from direct services to technical assistance, many of the best physicians and nurses stopped providing direct clinical care and instead transitioned to "mentoring" or training positions; others left the AIDS sector altogether. The most severe losses are occurring among community health workers, many of whom were laid off before the government had a viable human resources strategy in place. The result has been a net-loss to an already massively understaffed public sector, forcing authorities to scramble to hire new staff and increasing the risk that a substantial share of patients will be lost to follow-up.

4. At a moment when major gaps still exist in direct service, especially for key populations and patients with complex cases, PEPFAR's move to a primary focus on technical

assistance risks undermining PEPFAR's visionary mission to end the AIDS crisis.

PEPFAR determined to transition to a technical assistance role *before* having a clear sense of what that assistance was meant to accomplish within the AIDS response. Even more pressingly, in many clinics that lack sufficient human resources, technical assistance is dramatically less useful than direct services. Massive service gaps exist for underserved populations such as men who have sex with men and sex workers, and existing systems also have limited capacity to respond to complex clinical cases or to the needs of children living with HIV. Existing PEPFAR programs have played a crucial role in closing these gaps and could be further leveraged. Whereas a strategy that mixes direct services with technical assistance would enable PEPFAR to achieve multiple aims in South Africa, a line against direct service provision by PEPFAR-funded staff risks hobbling efforts to address the needs of people living with HIV.

5. The PEPFAR pull-out has decreased non-governmental capacity. Innovation and advocacy deficits are already being felt.

The development of robust non-governmental capacity on HIV represents one of the most useful side-effects of PEPFAR. Many interviewees suggested that one of the greatest contributions that PEPFAR brought was the ability to act fast and innovate—with not easily replicable effects across the AIDS response.

Governance issues:

1. Solidifying and expanding the innovative practice of shared governance will require joint planning and inclusion of civil society.

In practice, as expected, participants on all sides of the new PEPFAR governance report both successes and challenges. Trust has been built as regular working meetings begin to break down many of the old barriers that prevented collaboration and encouraged misinformation. The two governments have not yet achieved true joint planning, however—calendar misalignment and cultural difference have been challenges. In addition, Civil Society still does not figure in formal PEPFAR structures.

RECOMMENDATIONS

For PEPFAR South Africa

- A. Immediately initiate a project to track previously-PEPFAR supported people living with HIV and identify those who have fallen out of care.
- B. Build on PEPFAR's success in developing human resources and quickly work with the South Africa Department of Health to re-mobilize trained HIV-proficient staff for the AIDS response.
- C. Support a blend of direct services and technical assistance, with a focus on complex areas, including clinical services for key populations, 2nd and 3rd line ART, TB/HIV co-infection, and other areas the public sector struggles to serve.
- D. Commit to a long-term presence with sufficient resources to do the job.
- E. Craft a clear prevention strategy that focuses on key interventions from the PEPFAR Blue Print: HIV counseling & testing, antiretroviral therapy, condom distribution, medical male circumcision, prevention programs for populations most at risk, and prevention of mother-to-child transmission.
- F. Second more staff directly to the South Africa government and the South Africa National AIDS Council.
- G. Focus technical assistance on clear, achievable objectives instead of nebulous "health systems strengthening."
- H. Immediately engage civil society in the PEPFAR governance process.

For the Global PEPFAR Program

- A. Re-evaluate any further PEPFAR "transitions" or "sustainability plans" in *upper* middle-income countries in light of their impact on the ability to rapidly scale up interventions. Immediately clarify, publicly and specifically to U.S. government staff, that PEPFAR will remain focused on service delivery in all *low- and lower-middle income* countries and is not "transitioning."
- B. Focus the "country ownership" conversation on governance rather than service delivery; Build on the good work in South Africa that is showing how co-management with government breeds success, while decoupling this from questions of who pays for direct services.
- C. Given the move in South Africa away from direct support, establish a clear distinction in how PEPFAR counts people on treatment between indirect support and those directly supported through PEPFAR funding of essential core costs for drugs, salaries, and infrastructure.
- D. Make civil society a genuine, adequately-resourced partner in PEPFAR planning and accountability.

**The Politics of Transition & the Economics of HIV:
AIDS & PEPFAR in South Africa**

Full Report**The Politics of Transition & the Economics of HIV: AIDS & PEPFAR in South Africa****METHODOLOGY**

This report is based on information gathered in over 75 interviews and visits to public and NGO facilities in South Africa in June, July and December 2013. In addition, publicly and privately available documents from PEPFAR and the SAG informed the research and provided background for the report. Research was conducted largely in Gauteng Province, Western Cape, and Mpumalanga, with some phone interviews with key informants in Free State and KwaZulu Natal.

Interviews were conducted with:

- Major PEPFAR implementing organizations, including those with now-ended grants and those receiving current funding, as well as groups based both in the US and in South Africa.
- U.S. government officials from the State Department, Centers for Disease Control, and the US Agency for International Development.
- South African central government officials from the President's Office, Ministry of Health, and South African National AIDS Council (SANAC).
- Facility managers and front-line clinicians in Department of Health clinics.
- Patients previously receiving care in PEPFAR-supported clinics.
- Civil society and community groups representing people living with HIV/AIDS, sex workers, and lesbian, gay, bisexual, transgender and intersex (LGBTI) people.
- Independent experts from think tanks, universities, news outlets and advocacy groups.

All interviewees were informed about the nature of the research and that findings would be summarized in this report. In order to encourage subjects to speak freely on sensitive matters that

could affect their employment and/or their project's funding, all interviewees were told that perspectives would not be attributed to specifically identifiable individuals. As such, this report includes aggregated perspectives and quotes identified by the speaker's position rather than individual.

Thousands of people are engaged in the South African AIDS response and, as such, this report cannot claim to capture all perspectives or facets of the recent changes in the landscape as PEPFAR programs have transitioned. However, best efforts were made to ensure a diversity of interview subjects based on their position related to U.S.-funded programs—including recipients of current funding, activists documenting problems, and U.S. government officials. The report notes conflicting views from time to time, though one of the chief findings is the striking consensus that emerges from nearly a hundred hours of interviews. Nonetheless, the claims in this report are necessarily limited—they reflect the understanding of the author, based on information from various perspectives, at a single point in time.

INTRODUCTION

South Africa's AIDS response has generated undeniable optimism and excitement, both in South Africa and internationally. In the evolution from a meager to a robust and pioneering response, the biggest change, in many ways, has been political; South African and American government officials have displayed dramatic shifts in ideology and motivation, leading to a new direction on AIDS. Activist pressure played a critical role in enabling this new, more promising approach to AIDS, while new leadership in the South African government, notably from President Zuma and Health Minister Motsoaledi, has generated substantial infusions of domestic funding and strategic and policy shifts toward science-based interventions have reshaped the role of the South African public health sector. In addition to changes in the politics of AIDS in South Africa, new scientific developments have transformed the AIDS response globally, making it clear that South Africa has a chance to reverse its epidemic *if* it rapidly scales up antiretroviral drug access and other core interventions.

At the same time, and in parallel, the U.S. government's (USG's) approach to AIDS in South Africa has also changed, with a re-evaluation of U.S. support in the country driven by domestic U.S. politics and growing demands on PEPFAR budgets that have not grown. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) South Africa now is managing the largest "transition" of a global health program in history—withdrawing direct staff and funding for the treatment of hundreds of thousands of HIV-positive patients as the South African public sector takes over.

At each of these levels—South African, U.S., and international policy spaces—the politics of transition have had both positive and negative effects on the lives of people living with HIV in South Africa. On the one hand, the SAG has owned its leadership role on AIDS, while PEPFAR has worked with the SAG to form a

new, far more productive, relationship. Unfortunately, the politics of this transition were not fully matched by smart implementation. A significant course correction is now needed.

Whether South Africa succeeds or stumbles in responding to HIV will have an impact that extends far beyond South Africa. With the largest HIV treatment program in the world, South Africa is a model for Southern Africa. In bringing ART to scale, South Africa has innovated by rolling out nurse-initiated ART in local primary health centers, integrating HIV and TB programs, and decentralizing management of drug-resistant TB. South Africa is not only a hub for HIV leadership, but also a central driver of the epidemic as a result of its economic and migration patterns. If scale-up works in South Africa, the benefits will be felt throughout Southern Africa—but so too will failures. As such, success in the country is essential to achieving an "AIDS-Free Generation."

Background: The Politics & Epidemiology of the South African Epidemic

South Africa faces an enormous task in responding to AIDS. The country has the largest HIV epidemic in the world—with 6.4 million people living with HIV—and one of the largest TB epidemics as well.¹ *One in six people in the world living with HIV live in South Africa.*²

Among adults, 17% are living with HIV, with HIV prevalence 10 percentage points higher than the national average in some provinces such as Mpumalanga and KwaZulu Natal.³ At a sub-population level, the epidemic is having a disproportionate effect in certain populations.

¹ Shisana 2013.

² South African National AIDS Council (SANAC) 2011a.

³ Human Sciences Research Council (HSRC) 2013. And see districts have registered rates as high as 46.1% in Gert Sibande in Mpumalanga per Department of Health 2012b.

One study in Johannesburg found that 43.6% of men who have sex with men surveyed were living with HIV,⁴ with men who have sex with men estimated to account for 9.2% of new infections nationwide.⁵ There are approximately 153,000 sex workers in South Africa, according to the recently completed National Sex Worker Population Size Estimation study, with three localized studies finding HIV prevalence among

people are currently receiving ARVs. As shown in Figure 1.1, scale-up is significantly reducing both deaths and new infections. However, as Figure 1.1 also indicates, the country will need to more than double the number of people receiving ART to satisfy new WHO guidelines and to reach the 2016 goal of the National Strategic Plan of universal access.⁷

A recent campaign saw nearly 20 million South Africans tested for HIV, with more than 2 million people learning that they are HIV-positive.⁸ Applying the new WHO treatment guidelines and scaling up treatment as prevention will require continued increases in both first-time and regular repeat testing.

Similar scale-up will be needed for other core HIV services, such as male and female condom distribution; the government has pledged to increase the annual number of distributed condoms from 492 million last year to 1 billion by 2016. The country also aims to achieve a 10-fold increase in the number of men who receive medical male circumcision.⁹ Thirty million people will need to be tested for HIV and screened for TB—a herculean task that amounts to nearly a third of the total tests worldwide in recent years.¹⁰

Further scale-up will also need to address inequities. Under the older 2010 treatment guidelines, 80% of treatment-eligible women were receiving ART in 2012, compared to only 60% of men. Likewise, while 81% of treatment-eligible adults were receiving ART, only 63% of treatment-eligible children obtain therapy.¹¹ Meanwhile, a substantial, but not

Figure 1.1: South Africa Epidemiology & ART Scale Up 1990-2016

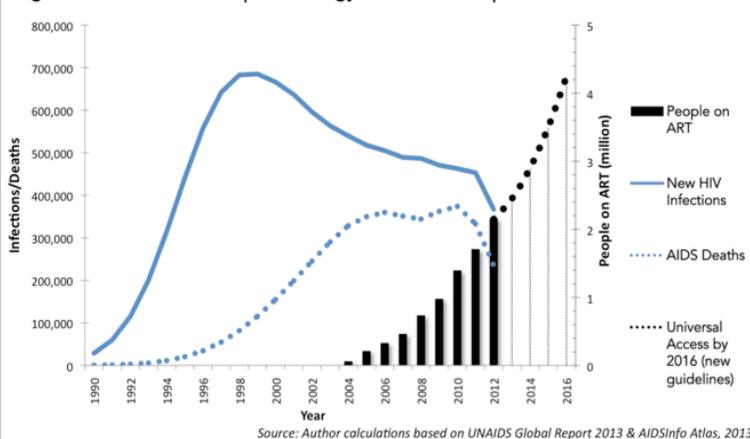
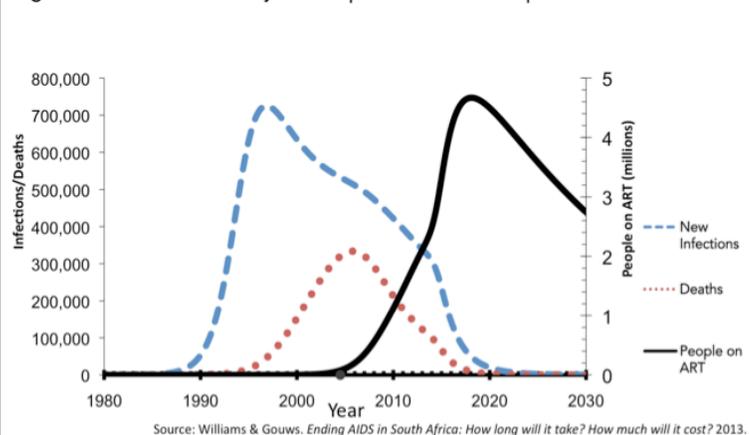


Figure 1.2: South Africa: Projected Impact of ART Scale Up 1980-2030



sex workers of approximately 60%.⁶ Young women ages 15-24 are four times as likely to have HIV than young men their own age.

The South African AIDS treatment program is a huge accomplishment—by far the largest ART program in the world. The most recent government survey finds that over 2.4 million

⁴ Rispel et al. 2011.

⁵ South African National AIDS Council (SANAC) 2011b, p 26.

⁶ Nogoduka 2013.

⁷ Graph is based on achieving 80% of the total 5.3 million people in need (UNAIDS 2013, A99) New WHO guidelines recommend treatment initiation at any CD4 cell count for children under five, pregnant women, patients co-infected with tuberculosis or hepatitis, or sero-positive persons in a serodiscordant relationship; all other patients testing positive should initiate treatment at CD4 counts <500.

⁸ Pillay 2012.

⁹ South African National AIDS Council (SANAC) 2011b, p 46.

¹⁰ World Health Organization, Global Health Observatory Data 2011, <http://www.who.int/gho/hiv/en/>.

¹¹ UNAIDS Global Report on the AIDS epidemic 2013.

fully understood, gap still exists for services for key affected populations who face crisis-level HIV rates.

The good news, however, is that the value proposition for the country has changed dramatically: Figure 1.2 displays findings by Williams and Guows, who note an enormous potential for rapid declines in mortality and incidence if services are rapidly brought to scale.¹² Especially promising is the evidence from a randomized clinical trial and confirmed in more real world observational studies that anti-retroviral therapy is among the most powerful tools available in preventing new infections¹³--alongside condoms, effective key populations programs, PMTCT, and medical male circumcision. Modeling in KwaZulu-Natal suggests that the risk of acquiring HIV declines by 1.4% for every 1% increase in ART coverage.¹⁴ These projected gains would be in addition to important advances already achieved as a result of the AIDS response, such as a major increase in life expectancy.¹⁵

Simultaneous scale-up of these potent strategies would have a transformative effect on the AIDS response. As these numerous studies underscore, the impact in South Africa from such a scale-up would be historic. To get there, however, South Africa will need to mount a disease response that surpasses most anything seen in recent history. The country will doubtlessly need help getting there.

PEPFAR & the Early Politics of AIDS Services in South Africa

South Africa is considered an upper-middle-income country economically and a rising geopolitical power as an official member of the increasingly influential BRICS group. Yet despite these enormous advances, the country has health outcomes worse than those in many lower-income countries. It is one of only a handful of countries where infant mortality rates

have *increased* since the mid 1990s, with rates that fall much closer to low-income Bangladesh than middle-income peers such as Brazil.¹⁶

It is important to also remember that South Africa is not yet twenty years from the end of Apartheid and continues to suffer from that era's devastating legacies. The health infrastructure inherited by the African National Congress (ANC) government in 1994 was geared toward the health of the white and wealthy portion of the population, with more than half of the financial and human resources allocated to the private sector.¹⁷ In 2002, infant mortality rates were nearly 10 times higher in the black population than among whites, while white women on average lived 50% longer than black women.¹⁸

South Africa is also still emerging from the years (1999-2008) in which former President Thabo Mbeki led the country. During the Mbeki years denialism, obfuscation, and inactivity characterized the national government stance toward AIDS.¹⁹ The Treatment Action Campaign (TAC) and its allies undertook a sustained activist effort, fighting tooth and nail for each incremental advance in treatment and care in the public sector. Due to the resistance of the national government, mother-to-child-transmission programs were launched in Khayelitsha as a pilot project, without the knowledge of the South African Ministry of Health, and were rolled out nationally only after TAC famously took the government to Constitutional Court.²⁰ It was over objections of the government that MSF/Doctors Without Borders' project launched ARVs in public-sector facilities in May 2001.²¹ Even as more people in South Africa needed treatment than in any other country on earth, billions of Rand allocated in the budget for drugs went unspent, and essential early funding from the Global Fund was obstructed.²² By one estimate, the Mbeki

¹² Williams and Guows 2013.

¹³ Cohen et al. 2011; Biraro et al. 2013.

¹⁴ Tanser et al. 2013.

¹⁵ Bor et al. 2013.

¹⁶ UNDP 2010; Lozano et al. 2011.

¹⁷ Coovadia et al. 2009.

¹⁸ Bradshaw and Nanna 2004.

¹⁹ Cullinan and Thom 2009.

²⁰ Heywood 2003.

²¹ Neuman 2011.

²² Nattrass 2007; Cullinan 2011.

government’s belligerence and antipathy to science cost over 3.8 million “person-years” that could have been saved by rolling out a feasible ART program.²³ Facing a crippling HIV pandemic without sufficient tools, many of South Africa’s best doctors and nurses fled the already overburdened public sector, compounding the problem. This crippling period was finally reversed after long campaigning by civil society and a shift of government leadership, though it leaves a great deficit from which leaders are working.

It was into this context that the PEPFAR program arrived in South Africa in 2004 to support a more rapid response to the HIV epidemic in the country. South Africa was one of PEPFAR’s initial 15 focus countries. To date, PEPFAR has provided more than \$3.2 billion in HIV assistance that, by any measure, has led to major success—funding over 120 primary partners, including the South African Government, parastatals (i.e., quasi-governmental entities), non-governmental organizations (NGOs), unions, private entities, and universities to tackle the AIDS crisis.²⁴ The treatment program grew quickly and, by 2011 the program reported “1.1 million [people] received direct support from PEPFAR SA implementing partners.”²⁵ It has not only benefitted people living with HIV, but was also a major foreign relations achievement for the US government, which benefitted in global leadership and opinion circles, across the region and among other donors, as a result of PEPFAR’s success in South Africa.

Initially created by the Bush Administration as an emergency response, PEPFAR paid for drugs and supported private sector doctors and largely-US-based NGOs to build and staff clinics throughout the country. During the Obama administration, the program gradually transitioned to a longer-term response, shifting 80% of funds to indigenous South-Africa-based NGOs and 10% to the South African

government; as part of this shift, PEPFAR deprioritized stand-alone clinics and instead supported services in public health facilities.²⁶ In recent years, through a combination of greatly expanded South African domestic funding and Global Fund grants, the South African Government has been responsible for purchase of a substantial share of ARVs distributed in PEPFAR sites, creating something of a division of labor in which PEPFAR often covered costs for laboratories and facilities, and for the training and employment of core clinical staff and community health workers. Interviewees suggested PEPFAR-supported partners are responsible for much of the innovation in the

Table 1
PEPFAR South Africa Results Before Transition (2010/2011)

People on ARVs ^a	1.1 million
People testing for HIV ^a	6.9 million
HIV+ pregnant women receiving ARV prophylaxis ^b	207,100
Orphans & vulnerable children supported ^b	386,400
PEPFAR Spending 2004-2011 ^a	\$3.2 billion

Sources: a. PEPFAR. *Seventh Annual Report to Congress on PEPFAR 2011* b. PEPFAR. *South Africa Operational Plan Report FY 2012*.

South African system, even as South African government financing for the AIDS response has grown to finance about 85% of the total AIDS funding.²⁷

Political Transitions in South Africa

Following Mbeki’s departure from the Presidency, successive health ministers Hogan and Motsoaledi moved quickly to shift the country’s AIDS policy towards a more evidence-based approach.²⁸ Policy changes included long-awaited action to drive down the price of ARVs to half that of previous tenders,²⁹ announcing revised guidelines for ART, moving to nurse-initiated ART as part of the devolution

²³ Chigwedere et al. 2008.

²⁴ Toledo 2012.

²⁵ President’s Emergency Plan for AIDS Relief (PEPFAR) 2013b.

²⁶ Toledo 2012.

²⁷ Pillay 2012.

²⁸ Joachim and Sinclair 2013; Biles 2008.

²⁹ Kahn 2012.

of treatment services to local health clinics, and launching perhaps the most ambitious HIV testing campaign in history.³⁰ These policy changes have garnered South Africa considerable international attention, positioning the country in the vanguard of HIV innovation and leadership.

The crowning achievement of this policy transformation was the release by President Zuma on World AIDS Day 2011 of the new National Strategic Plan (NSP) on HIV.³¹ The National Strategic Plan pledged leadership by the national government to reduce HIV-related mortality, incidence, and eventually prevalence. It also cemented a major change in the relationship between civil society and the South African government that had begun in the South African National AIDS Council (SANAC) under then Deputy President Phumzile Mlambo-Ngcuka and TAC/AIDS Law Project leader Mark Heywood following the government's embarrassment at international criticism leveled during the International AIDS Conference in 2006.³²

Under the chairmanship of the current Deputy President, Kgalema Motlanthe, SANAC created a bold new National Strategic Plan, with buy-in across the South African AIDS response. The National Strategic Plan set five core goals:

- Reduce new infections by at least 50% by using a combination of prevention approaches.
- Ensure that at least 80% of people who are eligible for treatment for HIV are receiving it, with at least 70% being alive and still on treatment after five years.
- Reduce new TB infections and deaths from TB by 50%.
- Ensure an enabling and accessible legal framework that protects and promotes human rights to support implementation of the plan.

- Reduce the self-reported stigma related to HIV and TB by at least 50%.

The National Strategic Plan reflected the new political stance of the national government and accompanied substantial increases in government funding for HIV. The budget increased from R4.8 billion in 2009 to R9.2 billion in 2012 and is set to hit R12.7 billion by the 2014 budget cycle—with the budget approximately divided by a third each for drugs, human resources, and labs capacity.³³ Although only 496 public health facilities in March 2010 were providing ART, the government committed to ensure that all 4,333 public health facilities would eventually deliver ART services. For the first time, the government prioritized a tender for simpler, easier-to-take, fixed dose combinations of ART, with the Minister of Health administering the first dose to a patient in April of 2013.³⁴

The results have been impressive. By 2013 over 2.4 million people were reportedly receiving ART in South Africa. In 2012, only an estimated 2.7% of babies born to HIV-positive mothers contracted the virus – a sharp decline from the 10% transmission rate reported in 2008 and an even more dramatic reduction from the 25-40% rate in the absence of preventive intervention.³⁵ As a result of expanded access to ART, life expectancy in South Africa has surged upward – by more than 11 years, according to one study in KwaZulu-Natal.³⁶

These historic changes have altered the course of South Africa's HIV epidemic, bending the long-term trajectory sharply downward. The task now is to accelerate this progress as rapidly as the political shifts that made these gains possible.

Achieving this will be no small task. South Africa now aims to reach 3 million people on ART by 2015, which will require substantial new capacity from a public sector currently

³⁰ See budget speech Motsoaledi 2010 and speech announcing the testing campaign Motsoaledi 2010b.

³¹ South African National AIDS Council (SANAC) 2011b.

³² Heywood 2012, p 9.

³³ Ndlovu 2012.

³⁴ Motsoaledi 2012.

³⁵ Barron et al. 2013. Note that 2.7% reflects a population-based survey. 2008 figures are based on report testing rates, for which the equivalent 2011 figure was 2.8%.

³⁶ Bor et al. 2013.

bursting at the seams and described as “crumbling” in some provinces. In December 2012, the advocacy organizations TAC and Section 27 noted that reports of drug shortages, vital medical equipment breakdowns, staff shortages, corruption and mismanagement have become almost a daily occurrence, especially in the Eastern Cape.³⁷ In addition, reducing HIV incidence by 50%, as envisioned in the National Strategic Plan, will demand substantially greater success in preventing new infections among key populations— young women, sex workers, MSM and others, with levels of prevention and clinical services that the public sector has so far proven unable to provide.

A New “Framework” for U.S. Engagement

In the United States, the early years of the Obama administration proved a tumultuous time for global AIDS programs. In the President’s electoral platform, HIV played a substantial role, with then-Senator Obama pledging \$50 billion to global AIDS programs in order to double the number of people on treatment and “allow the U.S. to meet its commitments that have been flat-funded by the Bush Administration.”³⁸ In his early years in office, however, budgets did not match the promised expansion, as some advisors openly questioned whether expanding PEPFAR, especially HIV treatment, was “cost effective”.³⁹ The early years of the Obama administration also coincided with the rise of the BRICS (Brazil, Russia, India, China, South Africa) alliance of emerging economies, which began challenging key elements of U.S. economic hegemony; for some members of Congress and Administration officials, South Africa’s membership in the BRICS alliance

called into question the appropriateness of continuing high levels of aid to the country.

Scientific evidence, including the NIH-funded HPTN052 study, eventually converged with politics by the end of 2011 to generate a new Obama administration vision of “creating an AIDS Free Generation.” Launched by Secretary of State Clinton, this initiative included a new goal of reaching 6 million people with HIV treatment by 2013.⁴⁰

As part of reauthorization legislation for PEPFAR, non-binding political documents called Partnership Frameworks were mandated to outline multi-year commitments between the U.S. and the governments in countries receiving PEPFAR support. South Africa’s partnership agreement was among the first and by far the most ambitious of these new agreements, signed by Secretary Clinton and South Africa Minister of International Relations Maite Nkoana-Mashabane in December of 2010 in a high-profile ceremony in the Treaty Room at the U.S. State Department. While striking important tones regarding a reorientation of the PEPFAR relationship with South Africa toward partnership, the policy architecture of the South African PEPFAR “transition” reflects a skepticism regarding direct support for HIV treatment programs, perhaps as a result of some of the debates occurring within the Obama Administration in 2010.

But it also reflects a major diplomatic challenge facing USG officials. South African officials were not themselves united in their understanding of the optimal role for PEPFAR, with some mid-level officials advocating for a quick takeover of PEPFAR clinical programs while those at a higher political level appear not to have contemplated quite so quick a move.

Most of the partnership agreement emphasizes ways the two countries might work together to expand HIV care, treatment, and prevention services, with the South African government increasingly playing the leadership role. The agreement created a new joint management

³⁷ Heywood 2012a.

³⁸ Obama for America 2008.

³⁹ See, for example Denny and Emanuel 2008; Baker 2010. And see Kaiser Family Foundation 2013 documenting a reduction of \$363 million in bilateral HIV research and program funding between FY2009 and FY2012. Note that funding to the Global Fund to Fight AIDS, TB, and Malaria increased, but this did not fully offset the reduction in total AIDS+Global Fund funding from \$6.487b in FY2009 and \$6.424b in FY2012.

⁴⁰ Clinton 2011, Obama 2011.

structure and emphasized broad goals toward improved outcomes. Both the agreement and the statements at signing stressed that PEPFAR provides a comparatively small portion of South Africa’s overall HIV budget—much smaller than in many countries—about a third of what the South African government was spending even at the time.⁴¹ It made clear that U.S. funding would decrease, without specifying the pace or degree of reduced funding.

The agreement also introduces the idea of “transition” toward the end of the narrative section. Specifically the agreement envisioned a “process of transitioning direct service delivery related responsibilities currently under PEPFAR (staffing, financing, monitoring and evaluations systems, and provision of services) to the SAG...”⁴²

would be exclusively responsible for the takeover of clinical services. The prominence of NGO- and general practitioner-delivered treatment services complicated planning and roll-out for the transition. Based on the government’s commitment to assume responsibility for HIV treatment, U.S. officials determined that PEPFAR should accede to the government’s decision by transitioning out of support for direct clinical services in the program’s next grant cycle. Others involved in these discussions see the path to PEPFAR’s termination of direct support for clinical services somewhat differently, believing the U.S. made the decision to exit clinical services in order to disentangle itself from direct obligation to provide treatment to hundreds of thousands of people in a rising economic power. Interviews with people involved in both governments

Table 2
PEPFAR & SAG Funding 2012-2017 (Million \$US)

	2012	2013	2014	2015	2016	2017
South African Government	1,197	1,422	1,641	1,723	1,810	1,900
PEPFAR	484	484	459	413	350	250
Subtotal	1,681	1,906	2,100	2,136	2,160	2,150
Total <i>all sources</i>	1,763	1,917	2,100	2,163	2,160	2,150
Total Need for NSP	2,285	2,929	3,329	3,709	4,031	4,434
Gap	-522	-1,012	-1,229	-1,546	-1,871	-2,284

Source: PEPFAR. *South Africa Partnership Framework Implementation Plan*. August 2012.

Opinions differ over how the decision to transition PEPFAR out of “direct services” evolved. It is clear the South African government made a commitment to fully assume the responsibility of providing basic health services to its people as a part of a revitalized Department of Health. This included a plan to place nurses at the center of the delivery of first-line ART program and to devolve basic ART initiation and maintenance to local clinics throughout the country. Early on, there was especially strong sentiment that the public sector

suggest that the reality is probably a combination of these conflicting perspectives.

Despite the complicated perspectives and conflicts that accompanied negotiation of the partnership agreement, relatively little fuss attended the launch of the PEPFAR transition process in South Africa, the biggest PEPFAR treatment program and the wealthiest of all PEPFAR countries. What was never clearly agreed, however, was what it meant to “transition” from providing direct treatment. While the SAG was indeed assuming responsibility for basic, first-line ART services, surprisingly little attention focused on how best to deliver more complex care, expand pediatric

⁴¹ Clinton and Nkoana-Mashabane 2010.

⁴² Partnership Framework 2010, p. 11.

treatment, and reach key populations with clinical services. Similarly, the meaning of this “transition” remained ill-defined for prevention efforts, as attention focused primarily on the ART program.

Nearly two years passed before the implementation plan called for in the Partnership Framework, meant to solidify the many unanswered questions from the PF, was signed. An important meeting in Washington, DC, coinciding with the 2012 International AIDS Conference, brought together leading State Department officials with the Deputy President and Minister of Health of South Africa. These negotiations led to agreement on the pace at which PEPFAR funding would be reduced; rather than a sharp withdrawal of funding, the reduction would be more gradual –from \$484 million in 2012 to \$250 million in 2017. The negotiations also resulted in an important commitment by the US government to provide ongoing support for South Africa’s AIDS response, but they also left a great deal undecided, including exactly what form U.S support would take on the ground.

With the transition of ART programs already well under way by the August 2012 signing of the Partnership Framework Implementation Plan, many of these specific decisions – about when specific programs would be transitioned, the process of patient transition, which staff to be retained or laid off, and the portion of funding and shape of technical assistance – were largely decided by technical staff or implementing organizations as major contracts came to an end.

In some respects, the bi-national political commitment cemented important progress. It formally recognized that the South African Government was truly in charge of the response to the South African epidemic and required people at all levels to pursue bold new goals driven by the national government. The flip side, however, was that nimble PEPFAR systems responded to the political mandate to withdraw from support for direct services with a speed that outstripped the capacity of the government-managed AIDS response. While attention focused on the logistics of transitioning clinical

programs to the South Africa public sector, less attention was paid to other key priorities of the AIDS response, such as ensuring scale up or a mechanism to ensure that no patient experienced disruption.

Today, the PEPFAR program looks dramatically different than it did just two years ago. The majority of direct funding to NGOs to deliver ART, pre-ART care, and other clinical services has ceased. Most PEPFAR-funded doctors, nurses, and community health workers have been pulled out of front-line clinics in both the public and private/NGO sectors. From this process there are some important successes to build on as well as urgent errors that require rectification. Some lessons should be cautionary for the PEPFAR program as a whole.

FINDINGS

Successes to build on:

1. Political commitment has been a reinforcing process in South Africa

One of the most evident successes of the past two years has been the mutually re-enforcing political commitments that have cascaded throughout the South African AIDS response. While largely a success of the South African leaders (both government and civil society), the PEPFAR-SAG relationship has also played an important role. The commitment of President Zuma, Deputy President Motlanthe, and Minister of Health Motsoaledi inspired action and energy throughout the South African AIDS response. The political commitment at the highest levels of the US government to put the South African government in charge helped ensure that the 2011 National Strategic Plan had something that previous plans lacked – a demonstrably true claim to be the driving force behind the full AIDS response nationwide. The Partnership Framework Implementation Plan took the National Strategic Plan as the starting point for the first time, and respondents for this report across the PEPFAR program suggested the National Strategic Plan had become a living document that guided their response. Where previous PEPFAR efforts had largely bypassed the public system, funded projects quickly became responsive to South African government priorities and began working within its frameworks in important ways.

2. Increased capacity of public sector is a major and important priority that is now getting attention rather than being bypassed.

In part because of the new political priorities within the South African government and in part because of new marching orders from Washington, PEPFAR is now helping build the capacity of the South African public sector more fully than it previously had. This has been a gradual process beginning in the first phase of PEPFAR programming but accelerating in the

recent transition to partnership. In the first few years of “PEPFAR II,” the program gradually moved away from the practice, in the first phase of PEPFAR, of channeling its funding primarily through major international implementers (e.g., Columbia University’s ICAP, the AIDS Relief consortium of Catholic Relief Services, or the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)). In Phase II, these partners handed over programs in South Africa to local NGO partners who were able to maintain services while building greater indigenous capacity and ensuring that a greater share of PEPFAR funding left the U.S. for South Africa.

By the time the Partnership Framework was signed in 2010, much of the program had already shifted not only to local partners, but also to providing services in the public sector. Clinics in public hospitals or ART-specific efforts in local department of health clinics became the standard means for delivering ART. PEPFAR renovated spaces and provided staffing and equipment in a public setting, and by the time of transition most of these programs were already receiving most of their ARVs through the South African government, albeit not without some challenges (described below). This model proved an especially potent mechanism for building capacity, as government clinical staff worked side-by-side with PEPFAR-funded NGO staff. The “spillover” effects of PEPFAR-built infrastructure improved performance on core health indicators across the sector, such as delivery in health facilities and child mortality.⁴³

Since 2010, PEPFAR has further prioritized strengthening the public sector, improving partner coordination by designated 1-2 lead partners in each district. Partners collaborate with district health management teams on planning, monitoring and implementing programs and provide roving teams that support facility-level services. As discussed below, the effectiveness of this model, in the absence of support for direct services, depends substantially on the existing human resource capacity, which

⁴³ Kruk et al. 2012; Samb et al. 2009.

is generally weak and varies substantially across the country. Still, PEPFAR has energetically taken on board the important priority of supporting the public sector, a policy shift that is likely to benefit the national response moving forward.

3. New models of PEPFAR governance are showing that governments, at least, can co-“own” US-funded programs.

One piece of the political change described above has been the new governance structures created by the Partnership Framework for PEPFAR, which are truly unique in the history of the program and hold broader promise as models for truly cooperative development. The new Steering Committee provides high-level political oversight for PEPFAR South Africa. It is co-chaired by the U.S. Ambassador and the Minister of Health and also includes the PEPFAR Coordinator, SANAC CEO, senior delegates from various South African ministries, and provincial officials. It meets twice each year, and its authority appears to be recognized in the country.

A second structure, the Management Committee, is co-chaired by the PEPFAR coordinator and the Senior Advisor to the Deputy President, who also has a strong role in SANAC. This committee meets every few months in full and often in task teams to coordinate and manage the ongoing relationship. Interviews suggest that this process has not been without its challenges: PEPFAR and SAG planning cycles are still out of sync, the USG and SAG sometimes have different priorities for funding, an instinct toward confidentiality within the USG sometimes undermines collaboration, and limited capacity on both sides has made it difficult to accommodate this structure. However, the committee reflects the growing reality that decisions are now being made collaboratively. Assessment of programmatic performance and review of PEPFAR funding opportunities is now tasked to the management team, providing the SAG with meaningful oversight of PEPFAR. Requests for proposals from USAID or CDC are being vetted with SAG before they are published, and PEPFAR planners

are taking on board more substantial input from the SAG on the Country Operation Plan. For the first time South African officials are reporting back to South African constituencies about the uses of PEPFAR funding. When it comes to determining priorities for new programming, Washington is at times taking a back seat to Pretoria. All of these are excellent signs that in a few years South Africa may well have a global model of inter-governmental cooperation in implementing large-scale health and development programs.

Strategic failures:

1. What happened to the patients? PEPFAR does not know if transitioned patients are successfully receiving care, although available evidence suggests that a significant number of people—*tens of thousands at least*—were failed by the transition.

From both an ethical and public health standpoint, the biggest breakdown of the transition is perhaps the simplest: PEPFAR failed to ensure successful transition of patients in ART and pre-ART care from PEPFAR implementers to South African public sector providers. The PEPFAR Partnership Implementation Plan said, “Transition should not compromise the quality and continuum of care. Beneficiaries of current services (e.g. a patient on ART) should not be detrimentally affected by the transition of services.”⁴⁴ This was a chief agreement at the highest levels of the U.S. and South African governments.

However, when patients were transitioned out of PEPFAR-funded NGO clinics, general medical practices, or down-referred/transferred from PEPFAR-funded centralized public sector settings to local public health clinics, no systemic plan or effort was in place to track patients to ensure they *were* successfully retained on ART. Those who had been in pre-ART care—a critical epidemiological group, especially in light of new WHO guidelines that call for much earlier treatment initiation—were also not systematically monitored to ensure that they remained connected to care in transition.

The transition process varied by PEPFAR partner and the experience within various models (NGO, GP, and public sector setting) of PEPFAR support are described in detail below. Some gave patients paperwork and sent them on their way, others worked with the Department of Health to ensure that a “spot” in a clinic was waiting on the patient, and some called to make sure the first visit was scheduled. Staff who had

⁴⁴ Partnership Framework Implementation Plan 2012, p 21.

been dedicated to patient tracing and preventing default or “loss-to-program” under PEPFAR—provided programming generally did not follow patients into the public system for any period of time.

Where patients remained at the same public-sector clinics while PEPFAR-supported staff were withdrawn as PEPFAR support for direct services was phased out, including those responsible for patient-tracing, there is a similar lack of data available about whether patients continued in care.

This is a substantial ethical failure, especially with respect to patients who were transferred from existing services and facilities against their wishes. The failure to ensure continuity of care also undermines public health efforts: ensuring these tens of thousands of people known to be living with HIV had access to care and could report an undetectable viral load should be one of the most obvious and important HIV and public health priorities.

Estimating Patient “Loss”

An NIH-funded study by Harvard researchers on the treatment transition appears to be the only publicly-available empirical evidence to date on the public health impact of PEPFAR’s shift from direct services to technical assistance.⁴⁵ This study found that *at least 19%* of those enrolled in ART and previously in care never made their first planned public sector visit.⁴⁶ Retrospectively tracing patients from the closed HIV clinic at McCord Hospital in Durban, researchers were able to reach most by telephone and then validated with a random sample of clinics whether patients made their first visit. Some have suggested that McCord is exceptional and the study overestimates the problem. However, while McCord was among the more abrupt transfers, this population was

⁴⁵ *Note:* just before release PEPFAR released a blog suggesting 4-9% patient “loss,” which conform to estimates below. Von Zinkernagel 2014.

⁴⁶ Note the data discussed comes from Bassett et al. 2013b from updated data not yet published; For previously presented estimates with similar but not identical data see Bassett et al. 2013a.

also among the most motivated and capacitated of PEPFAR patients, already paying out of pocket for part of their treatment at McCord and frequently traveling great distances to obtain premier HIV care. This data also reflects only the first public sector visit, not retention in care beyond that point. Interviews conducted for our report suggest that some patients experienced significant problems *during* their first visit and did not return. Bassett et al.’s research also did not track people in pre-ART care—the group most vulnerable to being “lost.” As such, this research may well underestimate any transition problems for transferred patients. That nearly 1 in 5 of these highly motivated and comparatively well-resourced patients appear not to have made a successful transition is worrying with respect to the broader population.

Judging the size of the potential problem is difficult for three reasons. First, numbers are not publicly available for PEPFAR-supported patients in pre-ART care or their outcomes. Second, reporting definitions of the US Office of Global AIDS Coordinator complicate efforts to obtain a precise and reliable number of patients receiving care in PEPFAR-supported facilities when the transition started.⁴⁷ PEPFAR reported that, as of end of Fiscal Year 2010, a few months before the signing of the Partnership Framework, PEPFAR partners were providing “direct” treatment support to 917,700 people,⁴⁸ whereas the subsequent Country Operational Plan reported that 1.1 million were directly-supported on ART by PEPFAR South Africa.⁴⁹ In 2013, US officials report that PEPFAR is providing direct treatment support only for around 30,000 and is in the process of transferring many of these. Finally, PEPFAR-supported models of care included NGO clinics,

the general practitioner model of supporting ART in the private sector, NGO-supported public sector centralized clinics, and support in primary health clinics. It is likely that disruption differed across different settings—without data, though, it is hard to know the impact.

While it is not possible to say with certainty exactly how many patients may have experienced disruption at this time, estimates can be made and Bassett et al. show it is possible to follow up with these patients to find an accurate tally.

Table 3 summarizes a range of possible numbers of patients “lost” during the transition based on Bassett et al.’s findings. As discussed above, and recognized by the researchers,⁵⁰ the Bassett et al. estimates are likely conservative for those transferred out in the transition. A significant portion of PEPFAR-supported patients were already in primary-level public

Table 3
Estimated patient “loss” in transition, not including pre-ART care

People on treatment who were receiving “direct support from PEPFAR SA implementing partners” at start of transition ^a	1,100,000
Possible number of people “lost” from care based on Bassett et al. estimate applied to full population (19%) ^{b *}	203,300
People “lost” assuming Bassett et al.’s finding is double the average due to smaller disruption in public sector (9.5%)*	101,650
People “lost” assuming Bassett et al.’s finding is four-times the average (4.75%)*	50,825

Source:
a. PEPFAR, South Africa Operational Plan Report FY 2012, p 2.
b. Bassett, I.V., et al., 2013b. Success of transfer of HIV care from a PEPFAR site to community-based clinics in South Africa (unpublished abstract) Conference on Retroviruses and Opportunistic Infections 2014, Boston, MA. Following on data update from Bassett IV, et al. Large scale, rapid transfer of HIV-infected patients from hospital-based to primary health clinics in South Africa: an assessment of self-reported linkage to care. 8th International Conference on HIV Treatment and Prevention Adherence, Miami 2013.
*Note: Base affected population is total reported less 30,000 still in PEPFAR programs.

⁴⁷ Note that the definition of what was reported shifted from “individuals receiving downstream system site-specific support for treatment” in FY2008 to the similar but not identical count of “the number of individuals receiving treatment services through service delivery sites or providers directly supported by the US Government” in 2009 and beyond.

⁴⁸ President’s Emergency Plan for AIDS Relief (PEPFAR) 2011.

⁴⁹ President’s Emergency Plan for AIDS Relief (PEPFAR) 2013b.

sector clinics, but visits to clinics (documented in detail below) suggest that loss-to-follow-up in these cases increased substantially. To account for this, we estimate a total number “lost” if the McCord patients were twice as likely or four times as likely to fall out of care than the average PEPFAR patient. The result is an estimate ranging from over 200,000 to as few as 50,000 people who fell out of care during the transition.

Loss-to-follow-up data from South Africa supports the estimates above. Without strong program intervention, double-digit disruption rates in transition should be expected. Indeed, with each successive step in the South African ART “cascade”, there is a loss upwards of 30%.⁵¹ Among the most thorough studies in the world, conducted in the relatively well-resourced Cape Town, found that a third of those who received a CD4 test and were found eligible for ART never entered care.⁵² Deeply worrying for the PEPFAR transition, pre-ART care is an

especially high-loss period even without transition to a new clinic or loss of clinic follow-up staff—only about half of those in pre-ART care in the Cape Town study remained until ART initiation or other endpoint.⁵³ A regional meta-analysis suggested that *only 17% of patients successfully move through the multiple steps between testing and successful ART care.*⁵⁴

The most recent household survey offers encouraging news, offering confirmation that over 2 million people are on ART in South Africa.⁵⁵ This figure might suggest that many of the PEPFAR patients *did*, in fact, continue in care given government scale-up during the period. However, the inability to confirm continuity of care is troubling, especially in light of evidence regarding the worrying drop-off of patients at the first clinic appointment following the transition. Indeed, interviews with PLWH previously receiving PEPFAR-supported care and clinicians at both the closing/transferring clinics and receiving clinics suggest that many patients experience substantial continuity-of-care problems.

Challenges from NGO/Centralized Clinics & General Practitioner Care

The most dramatic patient loss appears to have occurred in NGO clinics or private-sector general practitioner medical practices that were forced to close down or stopped providing care when PEPFAR ended its support for direct services. In some public sector settings, as well, the removal of PEPFAR staff and funding required clinics to transfer some or all patients out. In a previous transition from “Track I” partners to local partners several years ago, a similar transition seems to have included a much clearer plan for tracking patients. In contrast, cooperative agreements with PEPFAR partners for the transition to a public sector takeover, it appears, largely failed to include specific

while only 6% of those with lower CD4 returned on time—41% did so within a year.

⁵³ Kranzer et al. 2010.

⁵⁴ Rosen and Fox 2011.

⁵⁵ Shisana 2013.

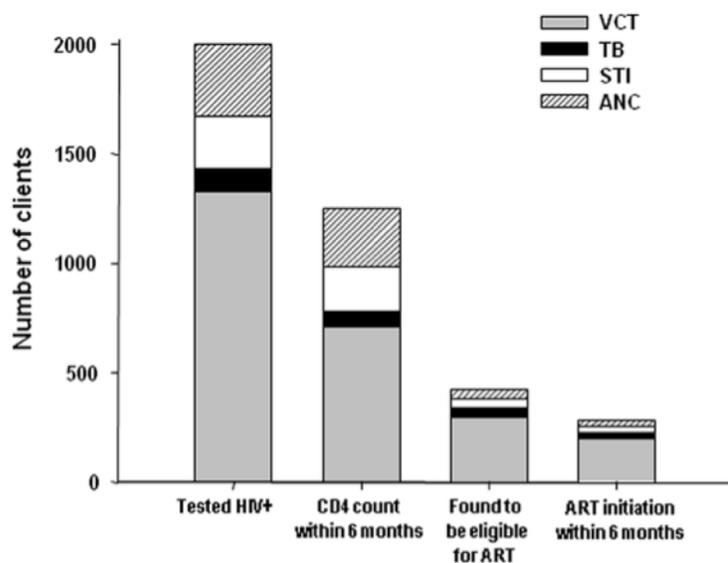


Figure 2: Treatment Cascade, Cape Town, South Africa

Source: Kranzer et al., 2010. Linkage to HIV care and antiretroviral therapy in Cape Town, South Africa. *PLoS One* 5 (11): e13801.

⁵⁰ Katz, Bassett, and Wright 2013.

⁵¹ Ahonkhai et al. 2012; Ingle et al. 2010; Bassett et al. 2010; Bassett et al. 2009.

⁵² Kranzer et al. 2010. And see a study in Johannesburg (Larson et al. 2010) that found nearly three quarters of patients with high CD4 counts did not return as scheduled,

provisions for the transition of patients. Thus, when funding for direct services ended, there was not a clear mandate for exactly what should happen to existing patients.

In some cases, this transition happened successfully: a minority of PEPFAR partners, it seems, produced clear (and confidential) patient lists for district health managers and followed up to ensure that patients had arrived at clinics. Most however, did not. Some PEPFAR-supported staff were able to spend several months in capacity-building efforts in well-prepared clinics as they referred large numbers of patients. Where local clinics were already strong and well-staffed and where number of in-referred patients numbers was relatively small—often true in the Western Cape, for example—patients were successfully welcomed into a new clinical home. PEPFAR-supported roving clinicians and data capturers in some clinics ameliorated potential problems.

But, in other cases, where local clinics were “ill prepared,” the transition was much less smooth. Patients who returned to referring PEPFAR sites reporting a host of issues associated with the transition provide perhaps the most striking anecdotal evidence. While these patients were a minority of patients, they were often the most capable and resourced patients. Based on these anecdotal reports, an unknown number of patients simply left care due to transition-of-care problems. Media reports were often the first public notice of such problems, and often provided PEPFAR with the first sign that problems were occurring. Several media reports documented problems in Durban, including the McCord Hospital’s shutdown of its renowned Sinik’ithemba clinic due to PEPFAR cuts, resulting in the transfer of 4,000 adults and 1,000 children into an overburdened and unprepared public sector.⁵⁶ As one patient, Faith ka-Manzi, who stopped treatment wrote, “I can never get up at 4am to stand in a queue behind almost 100 people, risking my life or possible rape by leaving for the clinic in the dark alone as a woman (every 26 seconds, a woman gets raped

in South Africa). No thank you!”⁵⁷ Meanwhile, media outlets reported issues specific in Tshwane,⁵⁸ Johannesburg,⁵⁹ Soshanguve,⁶⁰ Ekurhuleni⁶¹ and widespread issues in Mpumalanga, Limpopo and rural areas like North West. The Southern African Catholic Bishops’ Conference reported being unable to transition some of their 40,000 patients because the public sector was unprepared.⁶²

A variety of factors undermined continuity of care at different facilities. For the most part, local public health clinics were not provided any increased staff to deal with the influx of patients, and in some cases transfer coincided with staff lay-offs. As such, patients reported showing up to overflowing clinics, and some were reportedly turned away, told the facility was at capacity.

In other cases, public clinics clearly lacked the capacity to support the PLWH. Gauteng, Eastern Cape, Limpopo, Kwa-Zulu Natal and Mpumalanga clinics all faced stock-outs of medicines for substantial periods. In the Eastern Cape, for example, as PEPFAR was completing transition of many adult patients, a survey by MSF and Treatment Action Campaign found that 53% of facilities responding had experienced ARV and/or TB drug stock-outs, with 24% having to send patients home with no ARVs. A follow-up survey in May 2013 indicated that 40% still experienced stock-outs.⁶³ For our report, clinicians and patients reported that in both Mpumalanga and Gauteng patients have at times been given as little as a few days’ or a week’s supply of drugs, undermining adherence and encouraging some patients to fall out of care.

Some patients, educated in the type of care to expect, returned to referring clinics after having been prescribed the wrong medications or having gone 6 months or more without a CD4 or

⁵⁶ Patel 2013; Medley 2012.

⁵⁷ Ka-Manzi 2012.

⁵⁸ Mahlangu 2013a.

⁵⁹ Cullinan 2011.

⁶⁰ Mahlangu 2013b.

⁶¹ Ibid.

⁶² Catholic World News 2013; Radio Vaticana 2013.

⁶³ Doctors Without Borders (MSF), Treatment Action Campaign (TAC), and SECTION27 2013.

viral load test despite requests. One mother of a child living returned in tears to the referring clinic after five months during which her child had never actually been examined or had a diagnostic test despite being ill. Another PLWH reported that she was dismissed by nurses as a complainer when she reported side effects of stavudine, including lipodistrophy, shortly after being transferred. “The sister yelled at me in the middle of the waiting room,” she reported. “She said if I want to die then I should just stop treatment and that would not be hers to worry about me anymore.” Unable to tolerate the medication’s side effects, this patient stopped her medication and avoided the clinic for three months until a local activist from the Treatment Action Campaign informed her she could resolve her side effects by switching to tenofovir.

Ensuring continuity of care for pediatric treatment proved especially challenging. Nurses at local clinics often lacked expertise in pediatric HIV care and were reluctant to take on patients. While partners sought to address this deficit through short trainings, staff turnover meant some clinics remained completely unprepared for pediatric cases.

Stigma is also a major and underappreciated cause of problems in the transition process. Patients faced disclosure of their status in clinics where people gathered in a single room for an entire day to wait for care alongside family, neighbors, and co-workers. Patients reported that some public sector clinics used a “special line” for HIV-positive patients or simply had nurses assess and treat patients directly in the main waiting area. Clinicians at both referring and receiving clinics report knowing patients who simply stopped treatment due to fears that their confidentiality would be breached.

Key populations were especially at risk. Local groups reported that LGBTI and sex worker populations often refused to move to local clinics, where they had previously faced discrimination and stigma. Those who sought support from community-based groups often found alternative private or NGO options, but leaders suggested that only the most capable were likely to seek help, with most instead

opting to drop out of care. Without default tracing, however, there is no way to assess the size of this problem.

Some US government officials and PEPFAR partners have suggested this is simply an issue of preference—that patients continued to have meaningful access to care but preferred the high-quality NGO care to that of the public sector. Evidence suggests, however, that the quality was such a problem that it drove people out of the system. Many local clinics reported that they lacked staffing capacity and patient information systems to even know who had defaulted in care; one clinic lacked even a phone. Those who did know the numbers reported substantial rates of default, with numbers in the thousands in Gauteng and Mpumalanga alone.

Several PEPFAR partners have continued to provide direct care to patients who return for care, despite the mandate to transfer. Many partners reported continuing to treat some of the patients who returned through volunteer time or unofficial arrangements with clinics. Where implementers and patients pushed back, PEPFAR responded with bridge funding. A PEPFAR analysis conducted after much of the transition had already occurred, in November 2012, found that *55% of critical direct service positions still funded were at risk of ending without funding*. PEPFAR reprogrammed \$16 million (6% of treatment budget) to bridge the “service delivery gap.” This did not address already-transitioned programs, however, and research for this report suggests the true gap created by transition is far larger—though made invisible by the failure to track patients.⁶⁴

Integrated Public Sector Clinics: Loss to Follow Up Crisis?

Since 2010, PEPFAR has prioritized a service model whereby PEPFAR support is directed to existing public-sector clinics to support NGO staff working in clinics. For these situations, one could have assumed that the transition from direct services to technical assistance would

⁶⁴ President’s Emergency Plan for AIDS Relief (PEPFAR) 2013a.

prove to be less problematic, as patients often remained in the same clinic.

The staff provided by PEPFAR included doctors, nurses, counselors, data capturers, and others, and the approach provided a much better integrated model of care. During FY2011, PEPFAR began a “realignment of facility-based implementing partners to ensure comprehensive support at a district level”⁶⁵, with staff either laid off or moving from working side-by-side DOH as providers to being mentors and technical assistance providers. Few of these staff, especially critical community health workers such as adherence counselors, were retained at the facility following the withdrawal of PEPFAR support for direct services.

Evidence suggests that the withdrawal of such staff *did* have a substantially negative impact on patient care. At one clinic visited during preparation of this report in Gauteng province, for example, loss to follow-up rates increased from less than 1% to 14% after the withdrawal of key staff responsible for adherence, who were never replaced. Another clinic reported having 3,500 patients on the roster, but as many as 1,000 were recorded as defaulting (29%). They could not, however, tell how many of these patients might still be in care since they were months behind on patient information after PEPFAR-funded data capturers were pulled out of the clinic and not replaced by government.

Foreseeable Problems, Programmatic Lapses

Research for this report – conducted over six weeks – is necessarily limited and primarily provides anecdotal evidence. To date, however, no clear tracking mechanism exists to determine how substantial the problem is.

Each of the problems encountered during the transition was foreseeable and could have been dealt with. In most instances, the issue is *not* that withdrawal of PEPFAR funds was fully responsible for the problems at local clinics; weaknesses at the sites are long-standing, and

even where PEPFAR was supporting service delivery, SAG has been providing much of the medicine and staffing for the ART program for years. However, had PEPFAR ensured that a system was in place to track patients for at least the first year, it could have fulfilled a responsibility to ensure that patients received the care they need – the fundamental objective of a public health approach to ART scale-up. PEPFAR officials monitoring patients’ connection-to-care would have detected early on that a significant subset of clinics to which patients were being transferred were not, in reality, prepared for the transition. Indeed, such a monitoring system could have provided an ideal platform for identifying technical assistance needs. No such system is in place, however. PEPFAR partners transferring patients were not required or resourced to do the tracking themselves, and their systems for tracing patients were dismantled as patients moved out of their care.

Unfortunately, the Department of Health did not have an operational record system in place when the transition began. In December 2010, South African technical teams approved a plan for a three-tiered ART monitoring system composed of a paper-based register, a non-networked electronic register (TIER.net) and a networked ART system for patient monitoring. The task of consolidating 40+ non-standard monitoring systems took until March of 2011, at which point the government disseminated new standards and prepared for a roll-out of the TIER.net system in 2012.⁶⁶ It is only now – in 2013 – that final roll-out is reaching many district level facilities, well after nearly all PEPFAR patients have been transferred.

Addressing this issue, even at this late date, should be an overriding PEPFAR priority. PEPFAR, of course, cannot on its own fix problems that are endemic to a massively overtaxed public health system and PEPFAR, but given that hundreds of millions of dollars are still available in PEPFAR funding, identifying patients who have fallen out of care and

⁶⁵ President’s Emergency Plan for AIDS Relief (PEPFAR) 2012.

⁶⁶ Department of Health 2012a; McIntosh 2013.

rectifying these problems is eminently achievable.

Pull out of direct services?

Meanwhile, interviews across the country suggest that the premise of the move to terminate support for direct services should be re-considered. As discussed below, all players, including US government staff, recognize there are major gaps in the ART program that are unlikely to be filled quickly by government, with direct service staffing among the biggest crises.

2. Transition was too often driven by contracts and arbitrary dates, rather than by the documented readiness of public sector. Implementation of the political decision to pull out of direct service outpaced the ability of both the US and South African governments to prepare.⁶⁷

The PEPFAR Partnership Framework Implementation Plan promises to “ensure that the South African system is adequately prepared to absorb the programmatic elements that PEPFAR built up over the years, particularly the clinical services, without compromising patient access to care and treatment, quality of services and continuum of care.” This is an important guiding principle, but in practice the lesson taken from PEPFAR South Africa should be that programs built up over a decade simply cannot be transitioned in a matter of months.

The Partnership Framework, signed in December of 2010, was a high-level political agreement on the future relationship between the US and South Africa on AIDS. Following a decade of rocky relations between PEPFAR and the SA Ministry of Health and Presidency, it envisioned a shared governance model and a shift of clinical programs over the course of 5 years. The details were to be set after a “comprehensive assessment” of the direct services supported by PEPFAR and agreement on a way to transition services in an orderly

manner that would not disrupt the South African system or patient care. Much of the next year was taken up with that assessment at a macro level. At the time the Partnership Framework was signed, PEPFAR itself did not have a full accounting of how many staff positions the program was supporting, which critical services were being provided, and what parts of the country’s infrastructure would disappear without PEPFAR.

Unfortunately, contrary to the provisions of the Partnership Framework, it seems that much of the transition occurred *before* PEPFAR was able to gather this critical information and jointly plan with its South African counterparts. In perhaps the most striking example, many PEPFAR partners received notice in the June-August 2012 that they were to transition all patients to the public sector by September 30th of that year, yet it was not until November of 2012 that a full accounting was complete of the number of PEPFAR-supported staff who had been providing services to those very patients.

Throughout the assessment process, many involved in the AIDS response, including within the South African government, were taken aback by the magnitude and complexity of services to be absorbed by the public sector. The political agreement in principle was, as is often the case, seemingly less daunting than the task of actually assembling the resources, staffing, logistical systems and strategy needed for successful transition in a country as large as South Africa.

Implementers had been signaled that this transition away from direct services was coming by a meeting in early 2012. There had not been clarity, however, about how or when the transition would occur, or its extent. Some implementers began immediately to plan—beginning to re-train some staff for technical assistance efforts, laying off other staff, and putting together plans for the transition of patients. Others waited, unsure of exactly what it meant for them or how they would transfer patients into a public health system they viewed as unready.

⁶⁷ On this point, see comment by Ambassador Goosby about the need to go “significantly slower” in Barton 2013.

Box 1: Mc Cord Hospital: Cautionary tale of aid

McCord Hospital in Durban provides a cautionary tale. It had been among the leading hospitals in South Africa—playing a key role as a training ground of black doctors throughout Apartheid—and its Sinik’ithemba HIV clinic was among the earliest to roll out ART. The clinic, part of the privately run Christian hospital, began receiving PEPFAR funding in 2004, which came to account for 50% of its budget. It was an early and prominent PEPFAR success story—initiating thousands of adults and children on ART and implementing a pioneering program to prevent mother-to-child transmission that reduced the transmission rate to less than 3% as early as 2005.⁶⁸ Indeed, McCord (and Sinik’ithemba) was a model for the region—the source of a substantial amount of our knowledge base on models of care in low-resource settings, pediatric ART, PMTCT, and HIV testing programs.⁶⁹

Unfortunately, it also became a model of the dangers of the politics of aid. Some suggest McCord prepared poorly for the transition, with administrators believing funding would not be withdrawn. Either way it is clear that when PEPFAR withdrew funding at the end of the cooperative agreement, in June 2012, it hobbled the clinic. McCord staff tried to persuade the government and PEPFAR to continue funding to Sinik’ithemba by designating it as a primary healthcare site for complex HIV cases, but when the government refused Sinik’ithemba was forced to shut down and transfer 5,000 patients into largely unprepared local clinics in just two months.⁷⁰ This turned out to be a huge blow— it “took the heart out of the hospital” as one official interviewed put it – and it set the stage for a financial crisis. This was exacerbated by contention with government (not of PEPFAR’s making) that resulted in withdrawal of the Department of Health subsidy to the hospital and its closure after 103 years.

Today, the Department of Health in KwaZulu-Natal is taking over McCord and is reopening it, with both government and hospital officials admitting missteps. But the Sinik’ithemba clinic has already been dismantled, its patients sent elsewhere. As a site of excellence in HIV care, Sinik’ithemba was exactly the kind of infrastructure national planners say is missing from the South African system to deal with treatment failure and pediatrics—a key piece PEPFAR could have helped fill in, if the politics of transition had not moved so much faster than the realities of the health system.

The high-level assessment in the Partnership Framework that was to be the basis for planning took many months, and the Implementation Plan was completed and signed only in August 2012. By that time, though, much of the transition was already under way, as many five-year PEPFAR funding agreements came to an end between June and October 2012, while many new agreements mandating only technical assistance activities began in September or October of 2012. New contracts had been signed, patients were being transitioned, and staff pulled out. By the time the Implementation Plan was signed, the endpoint for many programs was only *a few months away*.

In a number of cases, PEPFAR partners successfully resisted the original deadlines, receiving no-cost extensions for a few months into early 2013, meaning that the pace of the transition differed among partners. Among a few large partners who sought reprieve at high levels in the USG and SAG, the transition is still ongoing and appears to be occurring much more smoothly than in clinics where there was a swift transition.

***Implications of Limited Planning
for the Public***

The Implementation Plan contained none of the detail that would have been needed by the South African national government to work with provincial and local counterparts to plan for continuity of care, such as information about which exact services were being provided by

⁶⁸ Geddes et al. 2008.

⁶⁹ e.g. Reddi et al. 2007; Bassett et al. 2007; Uebel, Nash, and Avalos 2007.

⁷⁰ Bateman 2013.

which partners and how many staff were at issue in which region. As the PEPFAR planning process was not geared toward these questions but instead focused on achieving national targets, it is understandable that PEPFAR struggled to assemble this critical information. Since it is largely the provincial and district departments of health that actually had to absorb patients and staff, the absence of this level of detail has crippled their ability to respond effectively. Why the transition of patients had to happen *before* this information could be furnished remains an unanswered question.

There was one province—the Western Cape—where the principle of ensuring that the public sector could absorb the program clearly guided the process of assessment and planning. Led by strong USG staff in the province and a provincial government that demanded it, PEPFAR created a clear forward-looking, site-by-site strategy. PEPFAR partners assessed the staff who would have to be absorbed into public facilities, and detailed plans were made with provincial authorities to absorb this critical program staff.

For a variety of reasons, however, this level of planning did not happen in most of the country. The lack of planning, though, did not prevent the transition from occurring. Much of the problem described above can be attributed to a U.S. government process that moved efficiently to rewrite the mandates of partners, but then proceeded to transition patients at a speed that outstripped even its own ability to deal with the consequences.

The weak South African public sector health system, especially at the provincial level, was also unable to react quickly. The transition required hundreds of local clinics to receive a flood of new patients, but many had never dealt with ART and had no relationship with PEPFAR programs.

Provinces like Gauteng, Limpopo and the Eastern Cape clearly struggled. As one official put it, “There could not have been a worse time to transition to the public sector. At least 5 provinces showed major weaknesses that could

not be overcome quickly.” The focus, however, was on end dates of contracts rather than on the readiness of local clinics to absorb patients. As one interviewee reported, “It really became a mantra of ‘we need to get the patients off our books by X date’ rather than a careful process focused on patients.” That time period—18 months at the outside and as little as 3-4 months in some cases—was often too little.

Public clinics in Free State, Mpumalanga, and Gauteng all described receiving influxes of hundreds of patients across a three-month period. For much of the year, however, there was a freeze on hiring for various reasons from provincial departments of health, so the same staff now faced crushing patient loads. Three-month-long transitions, during which PEPFAR-funded staff visited public sector sites to provide assistance in the transition, ended without a true scale-up of capacity. One clinic visited for this report received nearly 2,000 new patients during the year, referred from several previously-PEPFAR-supported sites, but during that time actually lost one of the three nurses staffing the clinic. The clinic has no pharmacy staff, so the two existing nurses cover the patient load of 100+ per day while also dispensing all the medicine. According to one nurse, “Training and new information is welcome, but it does not help make the queues go any faster. What can I do? Should I send people home?” At another site, local clinic managers refused to send nurses to train at the PEPFAR-funded clinic because they said their staff learned only “bad habits,” like spending half an hour with each patient when queues required them to see at least 50 per day.

At a small number of sites where the government articulated a clear inability to deal with transition—primarily in geographically remote areas—PEPFAR extended contracts for 1-2 years to allow for a longer transition. Transition of many pediatric programs was extended for a few months, as well, and in a few rare cases year-long extensions or more were allowed. These exceptions were made for a minority of the program, with the rest expected to transition by the dates in their contracts.

USAID reportedly struggled the most. Several of those interviewed identified the culture of USAID, focused more on contracting processes than on implementing medical programs, as a stumbling block. Too much faith was put in simply writing contracts and assuming implementers could or would ensure that all involved would be ready. When local clinics were not ready, USAID had an especially difficult time understanding this lack of readiness as a problem it needed to address and identifying the tools to remedy the situation.

Within PEPFAR, however, USAID is hardly alone in experiencing difficulties associated with the transition. Across the program, similar date-driven transitions occurred. These problems are especially befuddling as there was no fiscal necessity to move so quickly. PEPFAR funding for treatment in South Africa remained robust across years—\$262.9 million in 2013 and \$263.8 million in 2012⁷¹—calling into question the urgency of transitioning struggling ART programs on a strict timetable of a few months.

PEPFAR's comparative strength, the ability to move quickly and nimbly, has proven a problem during the transition, as implementation has often *preceded* planning for the transition. The politics of transition shifted the programmatic imperative from “scale-up” to “hand over - yesterday.”

3. PEPFAR built remarkable human resource capacity, but without a coordinated plan the South African AIDS response today lost human capacity—especially community health workers—just as scale-up is increasingly imperative.

A consistent sentiment echoed among interviewees that building health worker capacity represents one of PEPFAR's greatest successes. With the move to indigenous organizations in 2010, capacity-building efforts only expanded; thousands of doctors and nurses were trained, paid, and retained in PEPFAR-funded positions. Less obviously, but

potentially even more importantly, thousands of lay-workers –adherence counselors, data capturers, HIV testers, and community health workers – were recruited to the PEPFAR program.

The South African government, however, had no revised human resources plan in place when PEPFAR transition began. PEPFAR, for its part, could furnish no national list of staff positions supported until the transition of patients was nearly complete.

By the end of 2011, an initial overall South African human resources plan was created by government but lacked any level of specificity or mention of PEPFAR-funded posts that would be absorbed. Indeed, the report documented a gap of 83,043 health workers that was not projected to be filled before 2025.⁷² At the time PEPFAR began to transition, an average of 42.5% of healthcare professional posts in the public sector were vacant, while in Limpopo over 80% of physician posts were vacant.⁷³ This is due to a combination of factors, including a shortage of qualified applicants, frozen posts due to budget shortfalls, and failures in public sector administration. Meanwhile, estimates suggest that over 25% of the work force trained each year never enters the South African health sector, but instead go abroad or find other jobs.⁷⁴

In this context, a not insignificant human resource loss occurred within the country's AIDS response under the PEPFAR transition. While no formal assessment exists, it is clear too few of the skilled PEPFAR-supported clinicians are still providing care directly to people living with HIV in South Africa today.

With the move to technical assistance, many of the best physicians and nurses were retained by the NGOs that received additional grants from USAID or CDC. However, these staff ceased providing direct services for PLWH and instead transitioned into “mentoring” or training positions. Others who lost PEPFAR funding

⁷¹ President's Emergency Plan for AIDS Relief (PEPFAR) 2013a. slide 14.

⁷² Department of Health 2011, p 12.

⁷³ Econex 2010, p 4.

⁷⁴ The Colleges of Medicine 2010.

moved their best staff to research grants. Where this was not possible, quite a few staff were laid off.

Clinics visited for this report illustrated the problem. At several sites, while staff struggled with large patient burdens, they were coping, in part due to the valuable technical support provided by PEPFAR-funded mentors. Clinicians reported regularly drawing upon roving teams of doctors, nurses, social workers, and data capturers for help with complex cases and to train new staff. In other clinics, however, key PEPFAR-funded staff were never replaced and/or public clinics are so understaffed that technical assistance is ineffective. Several clinics in Mpumalanga and Gauteng reported that important clinical providers moved to technical assistance instead of care, while PEPFAR data capturers, who had been critical to their capacity to order the right amount of drugs, were withdrawn and never replaced. As a result, reduced nursing staff had to be reassigned to the task. As one put it, *“why are you coming each month to teach me how to run the patient record system when I have a queue of patients and nobody to see them. One of us should be spending our time to take care of them, don’t you think?”* One Tshwane clinic visit illustrated the challenge seen throughout the system: under PEPFAR support the clinic had two nurses, three data capturers, two pharmacy assistants, and four counselors. With the transition, the clinic was able to retain both nurses but lost all their pharmacy assistants and all but one data capturer, while at the same time receiving an influx of new patients from centralized ART sites.

The November 2012 analysis – the first time PEPFAR furnished a national account – found that PEPFAR still supported 3,258 clinical staff positions overall, spending \$48.5 million per annum. Of the 2,796 staff providing direct services at the time, 55% were at risk of termination without PEPFAR funds, since they could not be immediately absorbed into government. It is worth recalling that this accounting in November emerged *while the transition in many programs was well under way and as many NGO partners were already shedding many staff in that process.* To

PEPFAR’s credit, once this was identified, the program committed funds for 1-2 years to ensure these critical positions would not be lost.

Fortunately, some were absorbed by government; clinics and managers within the Department of Health described efforts to retain staff they could, especially nurses. While no comprehensive assessment is available, anecdotal evidence suggests that many clinical staff moved into the private sector, others to non-governmental jobs outside HIV, or in a number of cases left the country. Formerly-PEPFAR-supported staff interviewed for this project reported that crushing patient loads and lack of support made them question moving to the public sector. The major factor cited by all respondents, however, was inefficiency in government. Even where budgets existed, many posts often take over a year to fill in the public sector, far too slow to make up for PEPFAR’s shedding of thousands of staff in a mere 18 months.

The biggest loss, however, has come outside the identified “critical” positions in the area of community health workers. By some informal but informed estimates, 15 – 20,000 community health workers are or will be without posts due to the PEPFAR pull-out – a number that, if accurate, represents *a quarter of all community health workers in South Africa.*⁷⁵ These are lay staff, who often received on-the-job training as adherence counselors, data capturers, and HIV testers, but have largely not been re-employed by Department of Health clinics. These community workers were the unsung heroes of PEPFAR programs’ ability to both expand access and keep patients in care, and their mass dismissal represents a major deficit to the AIDS response.

There are reports that some provincial health authorities are scrambling now – in the face of poor adherence rates and huge loss-to-follow up

⁷⁵ Department of Health 2011, p. 48. The estimate was provided in two independent interviews with people in a position to know. Despite requests to PEPFAR staff, no estimate of CHWs supported by PEPFAR were made available.

– to recruit new counselors and other staff. The tragic irony of the situation is that as PEPFAR was shedding community workers in 2011 and 2012, the Human Resources Strategy of the Department of Health envisioned *creating* formal posts for community health workers as a structured part of public health clinics beginning only in 2012 with major hiring by 2015.⁷⁶ South Africa has struggled for years to develop a viable community health workforce policy, relying often on volunteers, underfunded NGOs and CBOs who hire informal CHW labor, or delaying needed recruitment, training, and retention of adequately compensated community health workers.

Clearly the human resources crisis in South Africa is not of PEPFAR's making. However, a more formal and thoughtful strategic approach could have identified the full list of PEPFAR-supported personnel and created a gradual multi-tiered strategy to retain as many in the AIDS response as possible. For example, PEPFAR funding could have retained community health workers, especially low-cost employees, for a year or more in public sector clinics to allow the government time to develop a human resources strategy. In the absence of a formal plan to transition lay staff from PEPFAR-supported NGOs into public-sector roles, many have been laid off, their whereabouts unknown. Now, months later, having launched recruitment efforts for community workers, the government now ironically reports encountering trouble identifying qualified candidates, since formal qualifications are lacking in this sector.

4. At a moment when major gaps still exist in direct services, especially for key populations and for complex cases, the move to *primarily* technical assistance risks PEPFAR's focused mission to end the AIDS crisis.

The weaknesses described above will clearly require a bold and strategic effort to strengthen the public health sector. Department of Health human resource systems in many provinces take

months to hire staff and are unable to effectively plan for staffing needs. The pharmaceutical supply chain is collapsing under the pressure of scale-up. And the training and clinical capacity of Department of Health staff is often lackluster. In this context, PEPFAR has identified an important role in helping address these issues.

PEPFAR is responding to these realities by shifting funding into technical assistance efforts in treatment and clinical care. PEPFAR provides support care and treatment across all 52 districts of South Africa—with CDC leading in 14 districts, USAID in 28, and shared efforts in 10 districts. The program has shifted to working at two levels: At the district level the program is providing technical assistance to the broad-based district health management teams to help with planning, monitoring, and implementing quality programs. In addition, PEPFAR partners are supporting roving teams of clinicians and administrators that provide facility-level support ranging from consultations on hard cases to implementing new record systems. PEPFAR has largely centralized efforts so that one partner is responsible for each district or one partner at each level per district.

Visits to clinics suggest that this model can be helpful in cases where clinics are sufficiently staffed and where patient loads are reasonable. Visits to clinics suggest that under these circumstances, technical assistance, particularly clinical consultations and management help, is having a beneficial effect.

Two major issues cause concern:

First, the move to technical assistance preceded a clear understanding of what technical assistance was meant to accomplish within the AIDS response. Important and useful work is now under way within PEPFAR, with support from outside contractors, to define indicators and measurements for technical assistance. However, PEPFAR is currently moving the vast majority of its care and treatment budget out of direct service into “health systems strengthening” *before* critical goals, objectives, protocols and indicators are in place. Interviews with USG staff, PEPFAR partners, South African

⁷⁶ Ibid. p. 49 & table p. 134 showing gap-filling strategy.

government officials, and public sector recipients repeatedly surfaced the same problem: a lack of clarity on the purpose of technical assistance. Instead of the number of people on treatment, are PEPFAR partners responsible for the overall viral load of patients? The loss-to-follow-up rates in the public sector? How will PEPFAR ensure it is building durable capacity? How will PEPFAR ensure that the capacity it builds is relevant to South Africa's needs? How will PEPFAR avoid building redundant capacity? Worryingly, interviews for this report suggest that some technical assistance providers are measuring success based on the number of workshops held or number of visits to clinics. This is the style of development assistance that PEPFAR has avoided, and this avoidance is the reason for much of its success, many suggest. As one interviewee said, "Decades of technical assistance has failed miserably to fix the South African health system. PEPFAR now proposes to do so using HIV NGOs, but has yet to describe how it will not be the same black hole that leaves little to show at the end."

Second, and even more pressingly, in many clinics the above-noted shortage of human resources makes technical assistance dramatically less effective than direct services. In clinics where nurses are each seeing 75-150 patients per day, consultations on complex cases are nearly impossible and frustration abounds. With some of these same, busy clinics having a half-time clerical staff or less for the entire public health spectrum, training in record-keeping was reported by both recipients, and providers, as not constructive. Here, a bright line prohibiting PEPFAR-funded staff from providing direct services appears far less effective than an a strategy that mixes direct service with technical assistance.

The need for at least limited continued support of direct clinical services is nowhere clearer than when it comes to clinical services beyond care for adults receiving first-line ART care. Despite extraordinarily high HIV burden, MSM have been underserved for decades in the South African AIDS response, facing stigma in public facilities and failure of both treatment and prevention programs to adequately meet their

needs.⁷⁷ In 2008, Anova Health Institute leveraged PEPFAR support to launch the first clinic dedicated to MSM, with a further six sites becoming operational across several provinces.⁷⁸ This has begun to fill some of the important needs in the country that interviewees agreed are unlikely to be filled independently by the public sector for many years.

Sex workers face similarly limited services, with only a handful of NGO-driven health clinics largely funded by PEPFAR, such as the *Wits* Reproductive Health and HIV Institute programs. A recent study found that where no sex work-specific clinic and mobile outreach clinical services for sex workers existed sex workers were significantly more likely to engage in unprotected sex.⁷⁹ Meanwhile, services for the comparatively small population of people who inject drugs are nearly non-existent.

Interviewees for this report universally credited PEPFAR as the primary funder of medical/clinical services for key populations, with Global Fund financing available for some prevention activities. South Africa has been awarded up to \$307.3 in renewal and interim applicant funding from the Global Fund, a portion of which is set to target key populations, but little of this funding will support medical services. As such, there remains a key opportunity for PEPFAR to work with the SAG to expand key population services with major epidemiological potential.

Meanwhile, public sector has a limited ability to respond to complex cases, including those failing second-line therapy and pediatric cases. Parents interviewed reported that public sector nurses had insufficient training and time to deal with complex pediatric cases – a reality recognized by both USG and SAG officials. Similarly, while the South African government has secured the largest fixed-dose combination tender in history, both the drugs and the capacity to provide clinical care for third-line and salvage

⁷⁷ Cloete, Kalichman, and Simbayi 2013; Imrie et al. 2012; IRIN Africa 2011; Parry et al. 2008.

⁷⁸ Rebe et al. 2013.

⁷⁹ Richter 2012.

cases remains lacking. In both of these areas, there is a core opportunity not yet realized for PEPFAR to support game-changing direct services that would take pressure off the public sector as it tries to both absorb PEPFAR transfers and drive expansion.

5. The PEPFAR pull-out has been decreasing the non-governmental capacity. Innovation and advocacy deficits are already being felt.

One of the most valuable side-effects of PEPFAR is its contribution to a robust civil society capacity on HIV in South Africa. In addition to saving lives and improving the public health in South Africa, PEPFAR has also strengthened South Africa's still-young democracy. Actors across the AIDS response, and PEPFAR reports, recognized that the PEPFAR transition has resulted in a decrease in both NGO's implementation capacity and in civil society's engagement in health sector governance.⁸⁰ Ironically, the very capacity that helped make it possible for PEPFAR to transition out of direct services and hope to be replaced by government is now being, in the words of one interviewee, "decapitated."

Many interviewees suggested that one of the greatest contributions that PEPFAR brought was the ability to act fast and innovate. NGO partners recruited top talent and worked with a sense of urgency absent from almost any nation's government systems. Many of the most important innovations in South Africa – regimes to prevent mother-to-child transmission, earlier ART initiation, better medicines, medical male circumcision – were pioneered in the NGO sector and made their way slowly in to the public system. Drives are underway to expand HIV testing through innovation – for example, community-based, home, and even self-testing – and to keep people in care – for example, through default tracing and treatment literacy and support groups. Indeed, while ownership by the South African government of ART scale-up

has inspired stakeholders worldwide, it is worth remembering that forces outside the government were responsible for the nation's decision to introduce ART in the first place. A variety of NGO actors were involved in early service provision and treatment preparedness, including perhaps most publicly MSF and the TAC, but a great many others were supported by PEPFAR. Some of the most innovative and successful programs have now shut down due to a loss of funding, which is a major loss.

In addition, while the USG has not largely funded civil society accountability efforts until recently, some key PEPFAR partners have been leading voices in raising alarm about breakdowns in the public sector as they received patients unable to obtain care elsewhere, often behind the scenes. In other cases, PEPFAR clinics have employed leading members of civil society groups and PLWH leaders, enabling them to build movements for health equity outside government. With the PEPFAR transition, some of the most vocal clinicians have lost funding. The Department of Health has been deeply hesitant to finance a contentious NGO sector, seeking instead to consolidate control directly in the public sector.

⁸⁰ President's Emergency Plan for AIDS Relief (PEPFAR) 2013b, p 2.

Governance Issues

The practice of shared governance has been an essential positive innovation. Solidifying and expanding it will require true joint planning and inclusion of civil society.

The Partnership Framework envisions a new relationship based on the new politics of AIDS in South Africa. The recognition that it is no longer best for PEPFAR to plan and implement programs independent of the national AIDS governance structures is a major success of PEPFAR's leadership. In addition to important new structures such as the Steering Committee and the Management Committee, the South African Aid Effectiveness Framework launched by the Minister of Health outlined a framework overseen by the Department of Health to coordinate all development assistance.

In practice, participants on all sides report both successes and challenges to this joint management model. Substantial trust has been built and regular meetings and sharing of information are beginning to break down many of the old barriers that impeded collaboration and encouraged misinformation. The two governments have not yet achieved true joint planning, however. There are important cultural

and style differences that provide challenges. More importantly, however, the planning timelines for the two sides do not match up. By the time the South African planning process for the year begins, PEPFAR's process has largely concluded, meaning that true joint planning is difficult. Observers suggest that PEPFAR plans are still largely created by US government staff and vetted by experts and only then passed by the South African side for opinions. While this is a substantial improvement, both sides could learn more from a more collaborative joint-planning process.

Civil society, meanwhile, still does not figure in PEPFAR's formal structures. Despite the presence of a strong, well-capacitated civil society sector representing PLWH, LGBTI people, sex workers, faith communities, and academics, no substantial effort has been undertaken to enable their expertise to inform PEPFAR's strategy. This is not only a huge missed opportunity, but it breeds mistrust among civil society groups, where the belief that PEPFAR is fully "pulling out" is widespread. A new Diplomatic Cable, issued this year, instructs PEPFAR teams to rectify this situation, though planning for its implementation has seemingly not yet begun.

Recommendations for PEPFAR South Africa

A. Immediately initiate a project to track previously-PEPFAR supported PLWH and identify those who have fallen out of care.

The failure of PEPFAR to ensure that patients were tracked as they transitioned patients out of PEPFAR-support services and PEPFAR staff out of public sites is both an ethical lapse and an enormous missed public health opportunity. As HPTN052 conclusively demonstrated, ensuring that PLWH are connected to care and achieve and maintain an undetectable viral load may be the most important prevention intervention available. By the time of transition, PEPFAR reported directly supporting over a million people on ART and it may well be difficult to track them all. However, research conducted for this report, including discussions with clinics and PEPFAR partners, suggests that many PLWH could be found through simple and routine processes. At many public-sector clinics this would mean tracing patients from the point at which PEPFAR-supported staff pulled out. Clinics visited for this report all expressed that the major barrier to this task was the lack of resources to hire staff to do so. Where patients were transferred out of previous sites it will be harder, but most referring partners have records of each patient including contact information and where they were referred.

Prior to transition, PEPFAR programs regularly tracked defaulters and returned very low rates of loss to follow-up. Although PEPFAR staff are aware that substantial disruption and loss-to-follow up occurred during the transition, the scope of this problem is simply unknown due to the absence of systematized monitoring by PEPFAR. In this context, even a one-time effort to simply ensure that, in transition, PLWH were able to stay on effective treatment and identify ways to bring lost patients back is an imperative.

Effective monitoring will also strengthen the technical assistance provided. For this report, PLWH and clinicians reported some clinics to

which PEPFAR transferred patients to be functioning quite effectively within resource-constraints, while others were identified with regular stock-outs of key drugs, major gaps in staffing, substantial training deficits, and other gaps. It is hard to imagine a better metric to target technical assistance than identifying where patients have fallen out of care and why.

B. Build on PEPFAR's major success in developing human resources and quickly work with the Department of Health to re-capture trained HIV-proficient staff for the AIDS response.

The ability to attract top talent, quickly staff-up, and provide top-notch training to staff throughout the care spectrum – from physicians and nurses to lay counselors and data capturers – has been a hallmark of success within PEPFAR partners. Indeed, it is envied by their public-sector counterparts. By any measure, the South African public sector faces an acute human resource shortage. Hiring for most direct-care public sector posts is done by district- or provincial-level systems that are reputedly slow and inefficient.

In order to address the loss and potential further loss of trained clinicians and community workers, PEPFAR should begin an immediate plan to help partners in the South African government identify quality PEPFAR staff who could be brought into the system. This might include providing government agencies with lists of trained and previously employed staff, especially of the large number of lay counselors and data capturers, as a starting point for recruitment. Among the few clear, critical areas for technical assistance is in this area.

Before any further lay-offs occur, PEPFAR should require partners (as it has begun to do) to identify whether the post will be absorbed by government. Every effort should be made to retain trained staff in clinical posts, even if it

means continuing a position for a few months in provinces like Gauteng where hiring freezes are in place.

Finally, PEPFAR must address the deficit in clinical capacity that results from moving many of the most talented clinicians in the South African AIDS response into technical assistance positions. Some models seem more effective than others. For example, having “mentors” work side-by-side with partner clinics providing direct service while teaching others builds capacity at the same it addresses patient needs. But PEPFAR should strongly question models in which large numbers of skilled doctors, nurses, and administrators cease direct service provision in order to facilitate workshops or provide occasional stop-in visits, even as the clinic queues for patients persist or increase. Where staffing is extremely limited, this can exacerbate the human resources problem.

C. Support of a blend of direct services and technical assistance, and focus on complex areas, including key populations, which the public sector struggles to serve.

The decision at the political level to end support for first line ART was, debatably, a rational decision given the revitalized commitment to HIV services within the South African public sector. With the change in the SAG and a public sector invested in ART roll-out, a parallel system of AIDS clinics focused on broad initiation of ART was no longer a compelling necessity. The government was clearly able (with many bumps) to take over commodity purchase. And routine ART care will be needed in coming years at a scale that only an increasingly capacitated public sector will be able to achieve.

But these factors do not suggest that a full pull-out of PEPFAR funds from direct service is necessarily the best choice. The success of the overall South African AIDS response will depend upon driving effective scale-up of ART and substantially increasing the proportion of PLWH with an undetectable viral load.

Today, PEPFAR continues to provide direct clinical services in some regions where hand-over was not immediately possible and for some of the more complex cases. Rather than rush to “finish up” the transition, PEPFAR should adopt a more strategic approach that identifies the areas of direct service that the public sector is unlikely to be able to provide effectively for some years to come. Especially where success in these services is critical to the epidemic’s future – such as ensuring quality services for most-at-risk populations – PEPFAR continues to have a vital role. Regionally, too, there may be period of several years where some areas of the country may need direct services support from PEPFAR far more than any technical assistance.

As such, PEPFAR should look at especially at three areas:

- Complex cases including third-line and salvage therapy, as well as pediatrics, where innovation and the cutting-edge knowledge base that PEPFAR has built could be expanded through strategically-located centers of excellence, that might also support complex TB-HIV and multi-drug resistant TB cases.
- Clinical services for sex workers and men who have sex with men, which PEPFAR has recently funded, need to be built out and taken to scale. A new Global Fund grant is likely to expand capacity of key populations in prevention, but effective and appropriate clinical services will still be neglected.
- Hard-to-reach populations for which continued PEPFAR support is needed include men and adolescents who are not coming into the public sector system for care and are falling out of the system at much higher rates.

What is needed is not demonstration or pilot projects, but substantial investments to take clinical services to scale in some of the most important sectors of the response that all in South Africa agree are neglected in the current efforts.

D. Commit to a long-term presence with sufficient resources to do the job.

There is much discussion in South Africa, at various levels of the response, about “when PEPFAR leaves.” PEPFAR should clarify what it envisions will happen after the Partnership Framework expires and should commit to a long-term presence in the country. Current efforts to create a detailed 5-year plan are an important step in the right direction.

The rumors of PEPFAR’s departure come, not from leadership within the program, but instead from the way in which the exit has been communicated, with a focus on “transition” but not on a long-term vision for impact.

PEPFAR should re-evaluate the current downward trajectory in funding in South Africa. The current plan is to reduce PEPFAR funding to US\$250 million in the country by 2017 according to the current Partnership Framework Implementation Plans⁸¹—which is a not insubstantial amount of funding. The projected funding reduction was planned, however, before the full promise of treatment as prevention was fully appreciated. The US risks squandering the promise of treatment-as-prevention and prolonging the pandemic if it fails to make appropriate short-term and mid-term financing commitments to HIV treatment programs that save lives and prevent new infections. Indeed, these modest investments will yield returns many times greater, as HIV incidence falls and the long-term queue for treatment is shortened. The case for continuing scale-up is even clearer under the WHO’s new 2013 Guidelines whereby 5.3 million of those currently infected in South Africa should be receiving treatment. The South African National Strategic Plan, launched prior to WHO’s change in its treatment guidelines, projects a total spending needs of just over \$4 billion by 2016 for a scaled-up response.⁸² According to South Africa’s calculations, the

AIDS resource gap is massive, reaching \$2.28 billion in 2017 according to the PFIP.⁸³

While the AIDS portfolio is the focus here, South Africa is facing additional challenges in financing health across the board, including efforts to roll out new TB drugs and GeneXpert diagnostic technology,⁸⁴ expanding vaccinations, revitalizing the contraception program, and rolling out cervical cancer vaccines to 400,000 9- and 10-year-olds. Moreover, there is a growing crisis of chronic, non-communicable disease in South Africa that must also be managed.

The Obama Administration should actively reject the notion that health assistance should bypass South Africa because it is a “rising power.” While a middle-income country, South Africa faces the largest HIV epidemic in the world, a public health system that remains weak in many provinces, an AIDS response digging out from so many years of denialist damage, and a health workforce crisis that puts it a decade behind its middle-income counterparts. Given its regional importance and the role of migration in facilitating the spread of HIV in Southern Africa, the South African epidemic has to be mastered for the global effort to succeed. Leaving South Africa underfunded would be profoundly irresponsible for a U.S. government that has pledged to ensure an AIDS-Free Generation.

It is important to note, too, that PEPFAR’s success stems directly from its decision *not* to do “demonstration” projects at small scale. This was a wise and visionary approach, as the South African health sector is replete with examples of donors big and small that adopted this approach with hardly any evidence of long-term impact remaining today. PEPFAR should take steps to avoid this failed model of development assistance – a genuine risk, according to some accounts of PEPFAR’s strategy moving forward.

⁸¹ Partnership Framework Implementation Plan 2012, p 35.

⁸² South African National AIDS Council (SANAC) 2011b, p 78.

⁸³ Partnership Framework Implementation Plan 2012, p 35.

⁸⁴ See, e.g. Stevens 2012, for a discussions of the challenges and successes of rolling out the new automated DNA test—especially helpful in high HIV-burden countries with substantial smear-negative TB.

Taking important interventions to scale rapidly and smartly is PEPFAR's fundamental legacy that must be maintained; it is precisely what has distinguished PEPFAR from other development models and a critical reason why PEPFAR has generated such historic results.

E. Craft a clear prevention strategy with focus on key interventions from the PEPFAR Blue Print: HIV Counseling & Testing, Condom Distribution, Medical Male Circumcision, Key Populations, Prevention of Mother-to-Child Transmission, and Treatment as Prevention.

It is not yet clear what kind of "transition" PEPFAR has in mind for HIV prevention. The South African government is largely underfunding prevention programs, and some critics contend that the National Strategic Plan under-prioritizes certain key prevention strategies, such as medical male circumcision. Unfortunately, by focusing on quickly transitioning treatment programs, an opportunity was missed for PEPFAR to perhaps encourage the SAG to first take on increased prevention role. In the provinces, especially, prevention funding is lacking, with none of the provinces spending more than \$10-20 million on prevention activities.⁸⁵ PEPFAR has demonstrated its potentially important role in strengthening HIV prevention efforts. Infusions by PEPFAR in recent years of \$40 million for additional medical male circumcision is an important first step, but reductions in funding for HTC are worrisome. A clear prevention strategy is needed for PEPFAR, focusing resources on high-impact interventions and strategies that the government and the Global Fund are unlikely to cover.

⁸⁵ Abdullah 2013.

F. Second more staff directly to the South African government and SANAC.

Although the increase in joint planning is one of the most positive features of the transition, its feasibility is undermined by substantial understaffing in important technical areas in the Ministry of Health and SANAC. The US government should consider an increased effort, if desired by the SAG, to second USG-funded staff to assist at the national level. Epidemiologists, modelers, and others could be very helpful and, in the process, would build relationships between the two governments that will help smooth efforts going forward.

G. Focus technical assistance on clear, fixable objectives instead of nebulous "health systems strengthening"

Implementing partners, clinic managers, patients, civil society, and officials from both the South African and U.S. government nearly universally expressed concern about the lack of clarity on what "health systems strengthening" means. The PEPFAR program has succeeded – and secured major bipartisan support in the U.S. political space – because it has eschewed vague mandates in favor of specific, input-focused and results-driven service delivery, for which partners were held accountable. The move to focus on outcomes over inputs (community viral load, for example, versus patients initiated on ART) could arguably complement existing measures, but there is a risk that PEPFAR accountability could suffer, as it difficult to attribute programmatic changes to any particular episode or stream of technical support. By contrast, given South Africa's urgent service delivery challenge, PEPFAR support for direct services is easily quantified and its impact can be clearly measured. To ensure the accountability of technical assistance providers and partners, PEPFAR should identify clear metrics to measure the impact of technical assistance, focusing primarily on technical assistance for specific treatment and prevention outcomes. "Hours of training" or "visits to clinics" – a typical means of "measuring" technical assistance – are the kind of indicators that fail to

speak to actual health outcomes. Whether the provincial depot delivers medicines to each clinic, on the other hand, or the number of patients at a *specific clinic* who are in care and virally suppressed are the kinds of accountability measures PEPFAR has shown can work. PEPFAR's model has proven more effective because it focuses on what U.S. funding can do well and that must continue.

H. Immediately engage Civil Society in the PEPFAR governance process.

In June, Secretary of State Kerry issued a diplomatic cable directing all PEPFAR country teams to directly solicit input from civil society on the development of Country Operational Plans – to take specific input on USG plans, report that input to headquarters, and respond to both headquarters and directly to civil society about how each request or suggestion was or was not included in the annual plan. There are

meaningful ways to do this and ways in which this could become a useless box-ticking exercise. PEPFAR should share the full set of Country Operational Plan targets, including geographic focus and expenditures planned, with civil society and have a similar conversation with leading civil society groups as they have with government about what the highest priorities are for PEPFAR funds the coming year. Country ownership must not only mean government ownership. For this to be effective it must be meaningful and should be focused on groups like TAC, Section27, and others that do not receive U.S. funding but are nonetheless deeply knowledgeable about the AIDS response. Consideration should also be given to including independent civil society representing PLWH in the formal governance structure for the Implementation Plan, which currently involves only government-to-government interaction.

Recommendations for the Global Program

A. Re-evaluate any further PEPFAR “transitions” or “sustainability plans” in upper middle-income countries in light of their impact on the ability to rapidly scale up interventions. Immediately clarify, publicly and specifically to U.S. government staff, that PEPFAR will remain focused on service delivery in all low- and lower-middle income countries and is not “transitioning.”

Whether intentional or not, both the language and the mindset of “transition” has seeped across the PEPFAR program. Increasingly, Botswana and Namibia are managing direct service scale-up, but beyond these two there is little case for losing focus on direct service delivery. USG staff in some countries are increasingly turning to technical assistance over direct service provision in both longstanding and newer PEPFAR-engaged countries.

Outside South Africa, findings from this report suggest an important reality: scaling up to reach an “AIDS-Free Generation” is not broadly compatible with transition away from direct services. Even in the wealthiest country in Sub-Saharan Africa with a comparatively strong public health system, the struggle to reach those in need of ART and other core epidemic-changing interventions is straining the health system nearly to its breaking point. “Transition” has encountered many challenges detailed in this report due to these capacity challenges. Most other PEPFAR countries, meanwhile, have nowhere near the resources and capacity of South Africa. Even if Uganda or Malawi enjoyed record-setting economic growth of 10% a year for the foreseeable future, it would still be more than a decade before they would qualify as middle-income,⁸⁶ while fast-growing Nigeria has a health system that ranks among the worst

performing the world.⁸⁷ As such, talk of “transition” outside of South Africa, Botswana, and Namibia is premature and risks sacrificing the epidemiological impact that is within our grasp.

In sub-Saharan Africa, PEPFAR needs to reaffirm the clarity of its mission: pills into bodies, condoms into people’s hands, paid and trained staff to shut down the pandemic. Paying salaries, buying commodities, and constructing facilities to drastically scale up will need to be prioritized over technical assistance in the vast majority of countries and circumstances. Where USG staff have suggested moving from front-line staff to municipal, district or regional support, this should be re-examined and often reversed. Where less established PEPFAR country programs are reluctant to invest in direct services and instead are funding training programs, this too should change.

- **In Vietnam**, for example, direct service support is essential; as PEPFAR is likely the only option for human-rights based clinical programs for IDUs, sex workers, and MSM.
- **In Nigeria**, scale-up continues to be far too slow, notwithstanding promises by the government to accelerate service expansion.
- **In Malawi**, where PEPFAR does not invest significantly in the treatment budget but instead focuses relatively small funds on training and technical work, direct investment would return substantial returns epidemiologically. PEPFAR is reportedly working on a “sustainability” strategy that should be shelved in favor of a strategy for rapid scale-up strategy, grounded in the realization that the epidemic will only become sustainable if we focus on speed, value for money, and quality in services for PLWH and their communities. In particular, PEPFAR must continue to invest the upfront resources and deliver the treatment-as-prevention programming that will sharply lower the rate

⁸⁶ World Bank, 2012.

⁸⁷ Nigeria Health Sector Development Team 2009.

of new infections and dramatically reduce costs in the long run.

B. Focus the “country ownership” conversation on governance rather than service delivery; Build on the good work in South Africa that is showing how co-management with government breeds success, while decoupling this from questions of who pays for direct services.

The important idea of “country ownership” has unfortunately become confused with the question of service delivery in some policy dialogues. The South Africa example shows clearly that a model in which key decisions are taken in collaboration with government – including core decisions about how a USAID or CDC request-for-proposals is shaped and which geographic areas PEPFAR funding should prioritize –can maximize impact and synergies with government and Global Fund programming. All PEPFAR countries should create steering and management committees or similar structures tailored to fit the PEPFAR/host-country needs. These can become key opportunities for virtuous cycles of mutual challenge and accountability to fuel scale-up. To work, however, these discussions must be divorced the question of who pays for services. PEPFAR must continue to invest in direct services at the patient level in most countries, but the need for co-governance of core programmatic decisions is no less real where PEPFAR plays a large role than where it plays a smaller one.

C. Given the move in South Africa away from direct support, establish a clear distinction in how PEPFAR counts people on treatment between indirect support and those directly supported through PEPFAR funding of essential core costs for drugs, salaries, and infrastructure.

PEPFAR has always provided essential above-clinic support to countries—supply chain

management, information and laboratory systems, human resource training, management, etc. Yet that support has been most effective when judged by the service-delivery-level outputs of the number of people on receiving treatment and prevention services. PEPFAR service figures, however, continue to attribute increases in scale-up in South Africa as a PEPFAR achievement, even though the number of people on treatment “directly supported” by PEPFAR has slipped toward meaninglessness. This risks fundamentally undermining PEPFAR’s credibility. Technical assistance and other indirect support are meaningful – and PEPFAR needs to develop metrics to reflect its indirect support – but the USG should not count patients on treatment in its “direct” totals if it does not pay the bulk of the clinical staff providing care or for the medicines the patients take.

According to the WHO, we now need to figure out how to get 26 million people access to ART from a current level of 9.7 million. This is a huge task, and it will require significant direct support from PEPFAR in the form of salaries and commodities.

D. Civil society need to be true, resourced partners in planning and accountability.

In South Africa, the PEPFAR team met at most a few times with civil society. This was a mistake. Research for this report turned up serious problems for patients in just a few days through discussions with civil society. Civil society could instead be a strong partner for PEPFAR coordinators and leadership teams from CDC and USAID, helping provide important insights that government lacks. Where this partnership has developed, it has been a mutually beneficial relationship: providing updates and improving oversight for the USG while increasing capacity of activists to hold their own governments as well as PEPFAR implementers accountable. Projects to monitor stock outs, watchdog government budgets, and improve treatment literacy among PLWH would complement PEPFAR’s programming and should be a priority for future funding.

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