



## **SUMMARY OF 2008 COUNTRY OPERATIONAL PLAN**

### **UNITED STATES PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)**

#### ***Prevention of Mother-to-Child Transmission (PMTCT)***

**Total Planned Funding for Program Area: \$33,000,270**

In PMTCT, PEPFAR supports the National Department of Health (NDOH) by supporting a range of PMTCT partners that work directly at the facility level to facilitate implementation of the PMTCT program. In addition, technical assistance in the areas of policy development and implementation, capacity-building, implementation of early infant diagnosis, and integration of PMTCT into existing Maternal Child and Women's Health services has been provided directly to the NDOH by two Centers for Disease Control and Prevention (CDC) technical advisors. The USG PMTCT strategy has also been heavily focused on capacity building. The NDOH, together with CDC and UNICEF is engaged in a stakeholder analysis that will map all PMTCT stakeholder activities, identify gaps and overlaps in technical assistance, and provide recommendations to ensure better coordination between stakeholders.

In FY 2008, the PEPFAR PMTCT program will continue to support the national PMTCT program by addressing some of the inherent programmatic gaps in service delivery. These include ongoing support and supervision for healthcare providers and community healthcare workers; the promotion of provider-initiated counseling and testing, providing follow-up for mother-baby pairs post delivery, quality improvement, ensuring integration of PMTCT into maternal, child and women's health services, community outreach and referral into wellness and treatment programs for HIV-infected mothers and exposed infants, and scale-up of early infant diagnosis services. All PMTCT PEPFAR partners will meet with the NDOH quarterly to ensure that these objectives are being met and to ensure greater coordination between partners and government.

The NDOH has recently announced the policy shift from the provision of single dose nevirapine to dual therapy for all HIV-infected pregnant women. To this end, the primary objective for FY 2008 will be to work with the NDOH on finalization of policy and guideline development, updating health care workers, and providing site specific support to ensure readiness and implementation of the new PMTCT policy. PEPFAR partners will play a key role in facilitating readiness for implementation by providing ongoing assistance to the provincial and local health structures to address operational challenges; ensuring all health care workers receive the necessary policy updates and training; and strengthening linkages between antenatal care and HIV service delivery as well as social services. Activities in FY 2008 will ensure better coordination with the NDOH, particularly around capacity building and training. At the community level, the program will create increased awareness and demand for quality PMTCT service delivery. Activities

targeting cultural attitudes to mixed feeding, male involvement in PMTCT and increasing uptake of services will also be supported.

PEPFAR support to the South Africa Government (SAG) includes:

- USG staff work closely with the NDOH to improve PMTCT uptake and service delivery. Staff have assisted with drafting the revised PMTCT protocol to include the introduction of dual therapy and PITC.
- PEPFAR support to the National PMTCT Program includes: training of facility nurses on PMTCT protocols that will provide sustainable benefits to all pregnant community members; implementation of PMTCT service quality assurance through thorough PMTCT facility service assessments and onsite mentoring of facility staff for improvement; and provision of a PMTCT quality assurance tool to the NDOH for continued use and of training on its use.
- Several partners will provide extensive training to healthcare workers, including pharmacy personnel and nurses, to support PMTCT services.
- Management Sciences for Health will conduct focused provincial assessments of the pharmaceutical component of PMTCT services, as well as assist with the review of National PMTCT standard treatment guidelines.

## ***Abstinence and Be Faithful (AB)***

### **Total Planned Funding for Program Area: \$37,463,363**

Consistent with the South African Government (SAG) strategy, the USG supports a comprehensive, multi-sectoral, “ABC” approach to prevention. The USG Five-Year Strategy emphasizes abstinence and faithfulness (AB) for youth; expansion of media and community outreach through Faith-Based Organizations (FBOs) and Community-Based Organizations (CBOs); links to other preventive services; and HIV testing and care. As of September 2007, outreach efforts had reached over 6.5 million people with AB messages. The FY 2008 COP increased funding for AB prevention to \$37,463,363 million.

USG South Africa prevention program will enhance efforts to sharpen risk perception regarding multiple partners and concurrency, and to address important populations that are not being reached. Within the AB prevention program area, the USG will maintain a major focus on youth and will support the Department of Education and a diverse array of indigenous faith-based and other non-governmental partners to deliver intensive, curriculum-based messages. Use of interactive teaching methods will help youth personalize information and develop the skills they need to abstain. The Harvard School of Public Health and the GoLD Peer Education Agency will work to strengthen the quality of peer education implemented by other USG partners. Several partners are working in tertiary institutions; the USG will work with these partners to ensure that there is no overlap and that there is a strategy developed for addressing this population.

With FY 2008 funding, the USG will adapt “Families Matter,” an evidence-based intervention to engage adult family members in communicating with youth about prevention, and to create safer contexts for young women. Linkages between AB and OVC programs will ensure that orphans and other at-risk youth receive HIV prevention education. Soul City will target younger youth aged 8-12 through its Soul Buddyz mass media series, print materials and clubs.

At the same time, the USG will initiate new prevention activities targeting key adult populations. The lynchpin of these efforts will be a high visibility, multi-level, multi-media campaign to increase understanding of the risks associated with multiple and concurrent partners. This will be the thematic

focus of a new television drama series and a series highlighting real-life individual success stories in adopting abstinence and fidelity. The TV series will be supported by radio, outdoor media advertising, and a cellular phone text messaging campaign. Campaign messages will draw on recent qualitative research on the drivers underlying multiple partnerships. The campaign will give special emphasis to the role that male attitudes, norms, and behavior play in sustaining sexual networks, cross-generational sex, and high rates of concurrency and partner turnover. In the lead up to the 2010 World Cup in South Africa, the campaign will feature prominent South African soccer players delivering messages about male responsibility, personal risk perception, and community action to support healthy behaviors. The campaign will also engage in a parallel effort to target the young women who are at highest risk.

Media activities will be complemented by an expansion of outreach to adult populations, especially men. A new initiative will seek to promote partner reduction through high visibility advocacy by the leadership of national faith-based networks and non-governmental organizations (NGOs). This will be linked to grass-roots social mobilization to shape new community norms of responsible sexual behavior through local FBOs and CBOs. Other new activities will target migrants and mobile populations with comprehensive prevention education, as well as young women in their twenties in high transmission areas. In addition, new workplace programs will target small and medium enterprises and selected government departments. These new initiatives will deepen understanding of the risks associated with multiple overlapping partners and cross-generational sex, the potential for exposure to HIV through regular partners, and the benefits of mutual monogamy in the context of knowing both one's own and one's partner's HIV status. Women of reproductive age and their partners will also be educated about the risks of HIV in pregnancy. The role of alcohol and substance abuse in risky behavior will be integrated into prevention education for all audiences.

Ongoing prevention activities will reinforce normative change and responsible sexual behavior through networks of CBOs, FBOs, traditional leaders and healers. AB activities targeting adults will receive complementary funding for Condoms and Other Prevention activities, in order to provide comprehensive prevention education for individuals who continue to engage in risky behavior. Strong linkages will be established to counseling and testing, and for those who test positive, to positive prevention, PMTCT, care and treatment.

## ***Medical Transmission/Blood Safety***

### ***Total Planned Funding for Program Area: \$2,791,000***

In 2008, South African National Blood Service (SANBS) will utilize PEPFAR funds to expand and make its donor base more representative of the demographics of the country. This will be achieved by establishing four new donor clinics in geographical areas previously not serviced by SANBS. Recruitment and educational materials that are language and culture specific and appropriate for the target donor population will support the program. Through this effort, prevention messages will be developed focusing on the relationship between lifestyle and safe blood, the need for blood by patients and the importance of societal involvement in this "gift of life" relationship between donor and patient. PEPFAR resources, leveraged with existing SANBS infrastructure and collaborative funding, will continue to strengthen SANBS information technology systems and training of donor recruiters, HIV counselors, technicians, quality officers, and internal and external healthcare providers. In the future, SANBS plans to link with other PEPFAR partners specifically working in ARV services to improve the referral network for persons who test positive.

The American Association of Blood Banks (AABB), a PEPFAR partner, provides technical assistance (TA) to SANBS. SANBS has reported that the TA provided by AABB has been of high quality and AABB has especially played an important role in the development of the new risk model in South Africa. In FY 2008, AABB will focus on establishing an accreditation program for SANBS, improving training activities, strengthening the IT system, and providing TA on policies and guidelines. No other major donors are working directly in blood safety at this time.

## ***Medical Transmission/Injection Safety***

### **Total Planned Funding for Program Area: \$2,272,232**

Statistics indicate that the average number of medical injections per person per year in South Africa is 1.5. In addition, all South African facilities that use syringes for patient care use single use and sterile syringes, that is, those observed to come from a new and unopened package. The PEPFAR program in South Africa aims to address issues of medical transmission of HIV through the Making Medical Injections Safer (MMIS) project led by the John Snow Research and Training Institute, Inc. The goals of this project are to:

- (1) Improve injection safety practices through training and capacity building;
- (2) Ensure the safe management of sharps and waste; and
- (3) Reduce unnecessary injections through the development and implementation of targeted advocacy and behavior change strategies.

The project's three main programmatic areas are logistics, waste management, and behavior change communication. Training on these issues, its core activity, is provided to professional and non-professional staff. The project works at national, provincial and district government levels and is present in all nine provinces of South Africa. A multi-pronged approach is used in training and consists of providing in-service and on-the-job training to three different levels of workers: senior management, middle managers and clinical personnel, as well as waste handlers, as a short-term approach. JSI/MMIS is planning to conduct pre-service training with the incorporation of injection safety content in the curricula for nurses, doctors and other professionals.

The National Department of Health (NDOH) with input from MMIS has developed national policy guidelines on Infection Control and Prevention. In addition, the project is working with the NDOH on an agreed set of norms and standards for injection safety. An accreditation process to assess compliance to these has been planned with the Council for Health Service Accreditation of Southern Africa. These processes will comply with evaluation activities conducted by the first national injection safety survey.

The NDOH Quality Assurance and Environmental Health units will institutionalize the adapted version of the "DO NO HARM" manual as the country's primary reference manual for training in injection safety. Sustainability is achieved by leveraging support from local partners. To date, MMIS has garnered support from the Democratic Nurses Organization of South Africa; Khomanani (the South African Government's HIV and AIDS Information, Education and Communication (IEC) Campaign); Excellence Trends (a private firm consulting in waste management); and the Basel Convention for the completion of a number of deliverables such as training, and printing and disseminating of IEC material. In addition, MMIS works with South African provinces and municipalities to plan allocations for current JSI-related costs through the SAG Medium-Term Expenditure Framework.

The MMIS South Africa team has made significant progress since its inception. The team provided input to the National Policy on Infection Control, specifically the chapters on Injection Safety and Waste

Management. Secondly, systems are being implemented to procure personal protective equipment for waste handlers in two provinces, the Eastern Cape and Western Cape. Thirdly, MMIS South Africa and MINDSET Health Channel have collaborated to relay injection safety information to over 200 facilities (public hospitals and clinics) across South Africa, using a computer-based multi-media platform. An external evaluation has established that this technology significantly increases knowledge levels among users. Lastly, MMIS has recently conducted a national baseline assessment of injection safety in hospitals.

## ***Condoms and Other Prevention (OP)***

### **Total Planned Funding for Program Area: \$23,773,720 .**

The USG Five-Year Strategy mirrors the South African Government (SAG) strategy in calling for expansion of prevention programs focusing on high-transmission areas, most-at-risk populations, and workplace efforts. Consistent with the SAG, the USG supports a comprehensive ABC approach, with linkages to HIV testing and care.

United States' Government (USG) funding complements assistance from other donors. The USG and many donors co-fund Soul City's mass media and outreach activities. The Global Fund also co-funds several USG community outreach partners, and supports condom distribution and workplace programs through several NGOs.

A review of the USG South Africa prevention program in 2007 highlighted the need for a more comprehensive and strategic approach, together with increased coverage and intensity of interventions for key at-risk populations. In particular, the review highlighted unmet needs for prevention among MARPs, young women in their twenties—especially those engaged in informal transactional sex, migrants and other mobile populations.

The FY 2008 COP budgets \$24.7 million for 39 activities in the Condoms and Other Prevention program area. This includes significant resources, including additional FY 2008 funding, to expand existing programs and initiate new activities in response to the recommendations discussed above. With FY 2008 funding, the USG will significantly expand coverage of key MARPs, with an emphasis on formal and informal sex work and MSM. The USG will significantly increase support to NGO consortia in three major cities that provide linked drug treatment and comprehensive prevention and other HIV services for drug-using MARPs, and will broaden this activity to include non-drug using MARPs. In addition, a new activity will support development of a systematic framework for MARPS programming, and expand such programming to other "hot spots" utilizing formative research, mapping, and size estimation for different MARPs. These activities will emphasize targeted outreach and prevention education, linked to MARP-friendly STI, HIV counseling and testing, care and treatment services. The USG will continue to support ongoing prevention efforts in correctional facilities, and with sex workers and clients in inner city Johannesburg and selected mining communities. The USG will also continue to assist the South African Department of Defence in providing comprehensive coverage of the armed forces, with special attention to the role of alcohol in sexual risk-taking.

The USG will also expand programming for alcohol abuse. The new MARPs activity will include development of interventions to promote responsible drinking and adoption of HIV preventive behaviors, with a focus on bars, taverns and shebeens that are venues for meeting casual sex partners. Education on the role of alcohol in risky behavior will also be integrated into many of the initiatives described below.

A second major new activity will intensify prevention for migrant and mobile populations. The design of this initiative will be based on an assessment of priority needs in informal settlements, commercial farms, mining, transportation and border areas, recognizing that each of these localities and populations involve sector-specific risks and vulnerabilities and require distinct approaches. The USG will also seek opportunities to partner with the private mining, farming, and trucking sectors.

Another major new initiative will target the 11 “high transmission” districts, with a focus on adult male behaviors and the vulnerability of young women. Intervention design will draw on recent qualitative research on the drivers underlying multiple partnerships. Behavioral messages will emphasize partner limitation and consistent and correct use of condoms as key strategies for risk reduction. The USG will explore economic empowerment approaches to address the contextual factors that make it difficult for young women to adopt safer behaviors. Parallel activities will target the male attitudes, norms and behaviors that sustain sexual networks and drive concurrency and high partner turnover.

The USG’s overall approach to prevention with positives will be to integrate behavior change counseling into a comprehensive preventive package provided to all HIV-infected individuals through facility, community, and home-based care and treatment programs. To advance positive prevention, FY 2008 Other Prevention funds will support formulation of policy and guidelines by the SAG, and piloting of various community and facility-based intervention models.

PEPFAR will continue to scale up and improve PEP services for rape survivors through the network of Thuthuzela Care Centres and other appropriate networks, in partnership with the Presidential Women’s Justice and Empowerment Initiative. The USG will build on a previously developed best practice model that provides multi-sectoral, comprehensive care by linking the health, social service, police and justice departments, and expanding community education about PEP.

FY 2008 funds are budgeted for a male circumcision technical advisor at the National Department of Health, development of policies and guidelines, provision of safe clinical male circumcision, and creating and disseminating prevention messages in the context of MC. Training and service delivery activities will not be launched unless the SAG provides official approval.

Several partners are working in tertiary institutions; the USG will work with these partners to ensure that there is no overlap and that there is a strategy developed for addressing this population. The USG will continue to complement abstinence and faithfulness-focused prevention efforts with education about consistent and correct condom use, delivered through both community outreach and mass media programs. USG-supported HIV and AIDS workplace and community-based programs will adopt this comprehensive approach to address risk-taking by adults and older adolescents in the general population. The USG will also continue to build SAG capacity to better manage condom procurement and distribution.

## ***Palliative Care: Basic Health Care and Support***

### ***Total Planned Funding for Program Area: \$45,132,830***

Working in all nine provinces, the USG will support the SAG to increase the number of people living with HIV (PLHIV) and their family members receiving quality care services in communities through NGOs, CBOs, FBOs, and at public and private health facilities.

In FY 2008, PEPFAR will continue to focus on improved direct service delivery of quality palliative care. At the end of September FY 2009, USG support will result in the delivery of quality HIV and AIDS care

services for 1,235,086 PLHIV and their families at 2,662 service outlets which include hospitals, clinics, workplaces, hospices and home-based programs in communities.

The USG supports a holistic, family-centered approach to HIV and AIDS care which begins from the onset of HIV diagnosis, throughout the course of chronic illness, and end-of-life care. In order to ensure that all HIV-infected clients have access to basic care services and to minimize loss to follow-up (currently at about 70%), PEPFAR partners will provide a basic package of services for all HIV-infected individuals. This package will include: acceptance of status, disclosure, partner counseling and testing, prevention with positives (PwP), psychosocial support, nutrition counseling, pain assessment and referral, treatment literacy and adherence counseling, and outreach services to trace clients who have defaulted from the program. Emphasis will be placed on ensuring that HIV-infected individuals receive cotrimoxazole for those who are eligible as per national guidelines.

This package of services will be offered at community level through support groups. These support groups (primarily run by PLHIV) will serve as a link between the health facilities and the community to ensure a continuum of care. Counseling and testing sites will refer all clients testing positive for HIV to the support group in their area. Human capacity in the health care system is under strain, and coordination between public and private sectors, and facility and community-based care remains fragmented. FY 2008 investments will result in an improved continuum of clinical, psychological, spiritual and social care and prevention services for PLHIV. Partnering with the NDOH at all levels, PEPFAR partners will continue to support the integration of standardized quality palliative care services into primary healthcare and build HIV-related care services into CT, TB, ART, PMTCT, and prevention programs and reproductive health services, STI sites, workplaces and community and home-based care (CHBC) sites, including for OVC. This will build on previous investments in supportive care to improve access to preventive care and basic clinical care services for PLHIV at the community level. The average cost per beneficiary is \$87.66.

In FY 2008, PEPFAR partners will direct greater attention to strengthening quality HIV and AIDS palliative care service delivery and implementing standards of care. PEPFAR will support this effort by: (1) strengthening the integration of the basic care package and family-centered services across all care and treatment programs for adults and children living with HIV; (2) increasing the number of trained formal and informal healthcare providers, building multidisciplinary teams to deliver quality care with pain and symptom control and improving human resource strategies; (3) building active referral systems between CHBC and facility services; (4) developing quality assurance mechanisms, including integration of supervision systems and standardization of services and training; and, (5) translating national policy, quality standards and guidelines into action, particularly national adoption of the basic care package. For example, previous USG support to the Hospice Palliative Care Association of South Africa and its 143 member hospices and affiliates resulted in the development of national palliative care standards, quality improvement and accreditation programs, hospice management programs; and the development of national training centers for palliative learning across South Africa. In collaboration with National and provincial Departments of Health, FY 2008 funds will scale up direct delivery of quality palliative care services.

For FY 2008 reporting, the USG will continue to use a minimum requirement for someone having received palliative care which reflects a minimum standard of HIV-related services, aligning the program more closely to the definition of palliative as holistic service delivery. An HIV-infected individual must have received at least one form of clinical care and one other type of non-clinical care. The clinical service requirement addresses the critical importance of early identification of HIV status and HIV-related clinical problems which may compromise an individual's immune status and physical wellbeing. For HIV-affected family members, the minimum requirement would be that the individual receive services in at least two of the five categories of clinical, psychological, social and spiritual care and prevention services. While quality is very difficult to measure through routine indicators, this reinforces

the message that PEPFAR is not simply interested in counting the number of people reached, but trying to reach individuals with appropriate and quality care.

PEPFAR partners will assure that a minimum standard of HIV-related services be adapted and implemented at facility and community-based sites for HIV-infected adults and children. Many facility-based services are integrated into comprehensive ART programs, providing wellness care for HIV-infected people prior to their eligibility for ARV therapy. The minimum care standard for facilities includes the following elements of the preventive care package and other essential care interventions:

- prophylaxis and treatment for OI, given according to national guidelines: cotrimoxazole prophylaxis for stage III-IV disease or CD4<200 or for HIV-exposed/infected children, TB screening and management, isoniazid preventive therapy in select sites and candidiasis screening and management where the Diflucan partnership exists;
- counseling and testing of partners and family members;
- nutrition counseling, clinical measurement and monitoring, micronutrient support according to WHO guidelines, and wrap-around nutrition support;
- STI care;
- routine screening and management of pain and symptoms;
- child survival interventions for HIV-infected children (immunizations, growth monitoring and safe infant/young child nutrition);
- integrated PwP strategies that include messaging, condoms, support for disclosure of status, referral for family planning and PMTCT services and ART adherence education, leading to healthy living, reduction of risk behaviors and reduced rates of HIV transmission;
- provision of at least one element of psychological, social, or spiritual care, or prevention services (emphasizing the holistic approach); and
- referrals for other services.

Support for malaria prevention (which is seasonal and in few geographic parts of South Africa) is leveraged with other donors. In addition, cotrimoxazole is purchased by the SAG and obtained through the national supply chain, and thus available at all facilities, including primary health care centers.

The minimum standard for services at CHBC levels includes messaging, mobilization and referral (with follow-up) for the above mentioned services plus routine screening of all PLHIV and their family members (including OVC) for OI, TB, symptoms and pain; prevention messaging and condom provision; personal hygiene strategies to reduce diarrheal disease, and distribution of ITNs where appropriate. Provision of at least one element of psychological, social, or spiritual care or prevention services is also required at community level, however, home and community settings often facilitate delivery of a more comprehensive response including the provision of bereavement care, household support, community support group meetings, etc. PEPFAR partners adhere to national standards developed for hospice care which are inclusive of the comprehensive care elements addressed above with emphasis on relief of pain and symptoms and the provision of culturally-appropriate end-of-life care. The package of services at facility and community levels also includes medication adherence support for ART, TB and OI. At all levels, attention will be given to increasing gender equity in accessing HIV and AIDS programs, increasing male involvement in community programs, reaching pediatric patients, addressing stigma and discrimination, and building partnerships with local NGOs, FBOs and CBOs.

### ***Palliative Care: TB/HIV***

***Total Planned Funding for Program Area: \$32,335,710***

USG efforts in mitigating the impact of TB/HIV are consistent with the National Department of Health (NDOH) and WHO TB/HIV guidelines, which highlight the need for integrated programming, decreasing the burden of TB among people living with HIV (PLHIV) and decreasing the burden of HIV among TB patients. USG efforts bolster the SAG capacity to address challenges related to TB/HIV coordination. USG partners work in all provinces to strengthen mechanisms of collaboration and ensuring implementation of NDOH guidelines. USG is providing extensive support to TB control programs in the crisis areas and has recently implemented a strong public-private partnership to fight the scourge of TB. To ensure sustainability, USG works closely with NDOH at all levels to develop policies and tools and build the capacity of service providers. Training of trainers and on-the-job training is also implemented. Because of staff rotation at the service provider level, USG has embarked on training all service providers to ensure skill retention.

PEPFAR supports ongoing and new efforts to increase access to HIV services (including routine counseling and testing, HIV care, wellness and ART) among TB patients. Addressing infection control has become an important priority for PEPFAR partners. Efforts to support infection control activities include training, policy development, implementation of assessments, and equipment purchase. TB/HIV and MDR surveillance efforts include enhancements in the electronic TB register (ETR.Net) software to include the ability to measure TB treatment outcomes by HIV status. TB/HIV and MDR data collection tools were revised and it is hoped that the new tools will help reduce barriers to more widespread TB/HIV and MDR surveillance. Partners continue to support TB screening among clients of HIV services.

Ongoing activities also aim to provide additional technical and financial resources for provincial and district health management teams to increase the effectiveness of referral networks between TB and HIV services and to improve the mechanisms of TB and HIV program collaboration. HIV-infected persons are referred to other facilities to receive TB treatment before initiation on ART. Routine M&E systems in HIV clinics to monitor TB treatment are weak and partners struggle to provide information on TB treatment for HIV-infected individuals. Partners are working to strengthen M&E systems to track this information.

USG continues to support the development of a National TB Reference Lab as a key activity aimed at improving diagnosis of TB among PLHIV. Additional laboratory activities will focus on quality assurance, expansion of TB culture and drug susceptibility testing, and supporting improvements in information systems (increase timeliness of laboratory reporting) and testing technology. Public-private partnerships will continue to expand access to TB/HIV services, including cotrimoxazole preventive therapy, expansion of access to ART and, on a limited basis, isoniazid preventive therapy among PLHIV. Emerging concerns about the interaction between TB, HIV and drug resistance came to the fore in 2006. Efforts to better understand the extent of these threats and to control them have already begun and will be accelerated through 2008. USG is also supporting several public health evaluations to identify improved methods to diagnose TB in HIV co-infected patients, enhance screening for TB in HIV CT and care settings, and improve referral networks between HIV and TB services.

The PEPFAR TB/HIV program is complemented by USAID Operational Plan (OP) TB support. The activities supported include enhancing partnership with the NTCP to build national support by mobilizing resources and creating a conducive environment for expansion of TB services; and with provincial and district health departments as well as communities to create appropriate social mobilization and service delivery models for rapid DOTS expansion in the country; identifying strategic interventions to address challenges from increasing TB/HIV and MDR/XDR threats; supporting several districts identified for service improvement under the SA TB Crisis program; implementing facility-based and community-based TB and HIV/AIDS interventions; and building capacity of service providers to manage TB programs and to review the program to identify gaps and make recommendations for improvement.

In 2007, a brief review of PEPFAR TB/HIV partners indicated that while many partners were implementing TB/HIV activities, there existed a lack of uniform implementation of the DOTS strategy and efforts to ensure co-management of TB and HIV. Several partners noted they did not have standardized operational guidelines for TB/HIV integration or infection control guidelines. Through this effort, PEPFAR partners identified five overarching priorities: 1) expansion of integrated TB/HIV services; 2) continued provision of integrated TB/HIV training to all staff; 3) strengthening the relationship between organizations and NDOH; 4) ensuring availability of protocols and policies at all services; and 5) improving diagnostic, counseling and referral services.

Through liaison efforts with these donors, data indicates that other donors are focusing their efforts in some areas similar to USG efforts. In 2008, USG plans to increase coordination efforts with other donors to reduce duplication of effort. To maximize resources and avoid duplication, information obtained from donors along with current PEPFAR TB/HIV and USAID OP TB activities will help inform the SA USG TB/HIV team's efforts to develop a country-specific strategic plan in collaboration with NDOH. The plan will be driven by the SAG NTCP and NSP, as well as the OGAC and WHO TB/HIV guidelines. This plan will inform future COP planning and inter-agency planning with USAID TB resources, and establish networking mechanisms among partners to support sharing of best practices for TB/HIV integration.

TB/HIV programming will continue to receive priority attention in FY 2008. Since FY 2006 the USG effort to address TB/HIV services has been expanded. In FY 2007, over \$30 million was invested in TB/HIV-related activities, approximately 5% of the country USG PEPFAR budget. In keeping with OGAC guidance to expand TB/HIV programming, close to \$33,000,000 is requested in FY 2008 by close to 30 partners of which a majority are SA-based. Complimentary funding from USAID TB funds are expected to continue at \$3,000,000 per year.

Some areas in which PEPFAR supports efforts of the SAG:

- PEPFAR will continue to support TB surveillance through the national ETR.net information system. This system will be enhanced to better monitor care for HIV/TB co-infected individuals.
- PEPFAR will support the National Institutes for Communicable Diseases for the TB Reference Laboratory and improved laboratory infrastructure for TB diagnosis and quality assurance.
- The Hospice and Palliative Care Association will work towards improving integration of HIV and TB care through training of health care workers at all member hospices in South Africa..
- In the Eastern Cape, the Regional Training Centre will support human capacity development and performance improvement through training and mentoring of staff at hospitals and feeder clinics.

## ***Orphans and Vulnerable Children (OVC)***

### ***Total Planned Funding for Program Area: \$52,022,549***

The SA Government (SAG) Policy Framework for OVC is a blueprint for the care of OVC. Both the Policy Framework and the National Action Plan (NAP) provide a clear path for addressing the social impact of HIV and AIDS and for providing services to OVC. The USG OVC approach is consistent with the OVC Policy Framework. The USG provides direct assistance to the Department of Social Development (DOSD) and partners with diverse local and international organizations to scale-up existing, effective OVC programs that complement and support the DOSD efforts. At the end of March 2007, 23 PEPFAR partners had reached 151,461 OVC with primary and supplementary direct services. In addition, 24,521 OVC were reached indirectly and 7,796 caregivers were trained.

In FY 2008, USG funding for OVC activities will almost meet the 10% budget requirement (9.73%). In line with the Three Ones principle, the USG will continue to support the DOSD to strengthen coordination of OVC programs. Since FY 2006, the USG has supported a full-time Monitoring and Evaluation (M&E) specialist for the DOSD which will continue in FY 2008. The M&E specialist provides technical assistance to the DOSD Chief Directorate of HIV/AIDS and Chief Directorate of Children on M&E issues and the development of indicators for monitoring the NAP. Support has been provided to develop a management information system (MIS) to track, monitor and utilize data on orphans and vulnerable children at the DOSD. M&E assistance to the DOSD will be expanded in FY 2008 with two M&E advisors at the DOSD to strengthen information gathering and use at the national and provincial levels.

In FY 2008, USG partners will continue to focus on innovative ways to scale up OVC services through integrated systemic interventions; support and training of volunteers, caregivers and community-based organizations, and address service delivery issues. To ensure high quality, the USG has defined primary direct service provision as each child receiving a minimum of three services from a menu of eleven (an expansion on OGAC's seven services). These include: clinical nutrition interventions; targeted, short-term food and nutritional support with PEPFAR funding and leveraging food and/or food parcels from other sources including the DOSD, private sector companies and churches; shelter and care; child protection (i.e. birth registration, identification and inheritance issues); assistance in accessing general healthcare; health care support specifically for anti-retroviral treatment; psychosocial support; increased access to education (including uniforms, after school tutoring etc.); HIV prevention education or interventions (e.g. life skills, etc.); vocational training; and assistance in accessing economic support (accessing social grants, income-generation activities, etc.). In FY 2008 the USG will continue to emphasize quality improvements in the delivery of OVC services and will ensure that a standard-based approach to quality in program planning and implementation is piloted among USG-supported partners.

USG partners will focus on scaling-up OVC interventions to meet the enormous needs of OVC. Emphasis will be on improving the quality of OVC programs interventions, strengthening coordination of care, innovative new initiatives focusing on reaching especially vulnerable children, and strengthening the DOSD Child Care Forums (CCF) structure as well as local OVC coordinating mechanisms at the district level. USG partners will continue to integrate wrap-around programs into the delivery of OVC services. For example through Management Sciences for Health, Integrated Primary Health Care Project (IPHC), 23 small OVC community-based organizations will be linked to the child survival activities of the IPHC project through the community-based Integrated Management of Childhood Infections (IMCI) implemented in eight districts in conjunction with the Department of Health. IPHC is working with the local health facilities in these districts to ensure that OVC in their area are fully immunized and are able to access necessary child and adolescent health services. USG-funded programs continue to actively encourage and link with pediatric treatment programs and VCT programs to encourage HIV testing of OVC and to ensure that HIV-infected OVC have access to pediatric treatment and palliative care services.

DOSD recommended CCF as a national model to respond to the increasing needs of children and to provide support to OVC at the community level. CCFs are the communities' and local authorities' "eyes and ears" that identify OVC and ensure that they have access to care and essential services and are widespread through the country. CCFs are a mechanism to build capacity in community-based systems for sustaining care and support to OVC and households over the long term. The DOSD with support from UNICEF has contracted for a National Audit of CCFs, to determine how CCFs provide services at the local level to OVC. The audit will provide a picture of national coverage of CCFs and an analysis of the services provided by CCFs, their organizational and coordination features, funding sources and costs.

USG OVC assistance addresses gender issues. An increasing number of USG partners are finding innovative ways to include men as caregivers of OVC (FHI, National Association of Child Care Workers

and Heartbeat) and encourage men to be champions for community protection interventions for child, women and elderly-headed households. Heartbeat's After-school care programs provide a safe place for supervised homework, one-on-one academic tutoring, nutritious food, often provided by private sector companies, and a wide-range of psychosocial support to OVC. Heartbeat's mentoring program provides life skills and HIV prevention education. OVC support groups, dramas, storytelling and other psychosocial support interventions are facilitated by OVC themselves and involve significant child participation. Assistance has and will continue to focus on reaching especially vulnerable populations through Early Childhood Development Interventions with the CARE sub-partners, Sekhukhune Education Trust and NOAH. Partners like NACCW have added a component to reach disabled children. Studies have shown that disabled people, especially young people, are particularly vulnerable to being infected and affected by HIV and AIDS. Most OVC partners provide HIV prevention messages especially for older OVC and efforts will be made to include boys and girls with disabilities in all training, programs and services offered. USG partners will continue to focus on reducing gender-based violence and will continue to confront gender issues and gender dynamics that become apparent in the implementation of OVC programs.

USG assistance in South Africa aims to build the capacity of local organizations and encourage sustainable interventions for OVC. Two previous sub-partners of Starfish Foundation (Heartbeat and Hands at Work) have graduated, and are now receiving direct USG funding and managing their own programs directly. Training and mentoring of local community-based partners and expansion of income-generating activities strengthens capacity at the community and family level to sustain the protection, support and care of OVC. An increasing emphasis on vocational training and a need for a clear exit strategy for older adolescents (over 18 years) is addressed by partners such as the FHI sub-partner, South African Catholic Bishops Conference and its sub-recipients. This will ensure that that OVC do not drop out of school and that when they leave the OVC programs there are plans in place for them to further their education, access vocations and skills training and establish income generating activities that will enable their survival and secure income.

There are other donors supporting OVC in SA. The USG works closely with UNICEF including co-funding OVC research activities. The USG program in South Africa continues to complement the efforts of the DOSD and other donors to leverage resources and to ensure that there is no duplication of effort.

## ***Counseling and Testing (CT)***

### ***Total Planned Funding for Program Area: \$40,129,370***

Since 2000 the National Department of Health (NDOH) supported widespread implementation of a national program for voluntary counseling and testing (VCT). PEPFAR partners are located at sites where the government has requested support and as a result, are in areas of need.

USG and PEPFAR partners continue to support the NDOH in their efforts to update policy, training and mentoring in order to increase the demand for, and the availability of quality CT services. More than 45 PEPFAR-funded partners identify CT as a primary activity, and all treatment partners are funded for CT. Although some partners provide CT directly to the public while others support South African government (SAG) sites, all comply with SAG policies. SAG-supported sites integrate CT services within a comprehensive health service package. Levels of support to SAG sites vary among partners, but common elements are provision and training of lay counselors and professional nurses; and provision of technical assistance and mentoring. The SAG provides test kits to public health facilities.

The NDOH is involved in updating policy and PEPFAR partners will roll out the new policy as appropriate. PEPFAR partners in South Africa will deliver multiple types of HIV testing including diagnostic testing whenever indicated, confidential routine offer rapid testing in multiple clinical settings, and community-based family-centered VCT. PEPFAR partners will be evaluated on their CT training, and if task shifting policies are implemented, expansion on current practice may include lay counselors who can learn to do finger prick and perhaps oral rapid testing. In FY 2008, partners will carry out community activities that address gaps in the provision of CT services, particularly for discordant couples and special populations such as clients of traditional healers, family members of persons who test positive, prison inmates, the military, adolescents, and small children. Partners will ensure that there are systems for quality measurement among CT sites. USG partners will continue to provide public health messages on awareness, the need to determine one's status and promoting behavior change through health promotion messages including consistent and correct use of condoms.

As HIV care and treatment activities expand, partners are required to work within a functioning comprehensive referral system that includes NDOH public health facilities, faith- and community-based organizations, and the private sector. USG partners integrate secondary prevention strategies in care and treatment sites; provide simplified prevention messages and access to condoms; offer post-test counseling with support to encourage disclosure to partners and families; identify and counsel on reduction of substance use; help HIV-infected individuals and discordant couples to develop prevention plans; counsel on adherence to ART when indicated; integrate gender-based violence counseling, screening and referral; and provide linkages to basic palliative care, reproductive health, STI screening, and PMTCT for the unborn and breastfeeding child. PEPFAR-supported CT activities provide linkages for special populations such as clients of traditional healers, couples, children and prisoners. Partners will also ensure that persons with TB are tested for HIV and those who are HIV-infected are screened for TB.

Other PEPFAR CT activities, in collaboration with NDOH, include expanding laboratory accreditation and quality assurance programs for CT sites; supporting provincial health departments through regular CT meetings and an annual CT technical meeting; developing and updating CT training materials for provider initiated CT; and providing targeted training for all providers. PEPFAR partners working in public facilities will only purchase emergency back-up supplies to prevent stock-out.

During FY 2007, the USG held the first CT/PMTCT partner meeting. Partners and stakeholders discussed state of the art and evidence based models and furthered their commitment to increasing the number of persons tested. A CT technical review was completed by the PEPFAR technical working group co-chairs from Atlanta and Washington, DC. Several recommendations were made that have become part of the activities of PEPFAR partners.

PEPFAR support also includes the following:

- PEPFAR funds will be used to employ two full-time CT technical advisors to be placed at the NDOH. They will assist with the coordination of CT activities, enhance capacity of NDOH CT staff by providing support for the NDOH annual CT technical meeting, and support the implementation of provider-initiated testing and counseling.
- Support will be provided for the accreditation of non-medical CT facilities according to the NDOH requirements as well as the revision of all current training materials relating to CT.
- Several partners will provide extensive training for health workers (lay and professionals) and mentoring to professionals at the provincial level.
- PEPFAR will support the South African Department of Provincial and Local Governments to promote CT awareness and uptake among employees.

## **ARV Services**

### **Total Planned Funding for Program Area: \$210,154,634**

The 2003 South Africa Government (SAG) Comprehensive Plan for HIV and AIDS Care, Management and Treatment (Comprehensive Plan) provides a blueprint for universal access to antiretroviral treatment (ART) over a five-year implementation period (2004 – 2009). The goals of this plan are reiterated in the new South African HIV and AIDS and STI National Strategic Plan, 2007-2011 (NSP). The USG is ideally positioned to support the implementation of the NSP by ensuring equitable access to quality HIV care and treatment through support to the SAG by PEPFAR-funded partners.

South Africa has a generalized mature HIV epidemic, and HIV care and treatment services are required across the entire population, though population-based data has shown that the highest burden of HIV is in urban and peri-urban areas. The 2006 antenatal HIV seroprevalence survey data also provided additional information on district-level prevalence rates. The USG utilizes this information to direct its assistance to these areas, especially to ensure equitable access to ART for lower-density rural populations.

A key element in the Comprehensive Plan is to strengthen public healthcare capacity to deliver integrated HIV and AIDS services. Only 13.7% of South Africans have access to medical insurance, and thus the major focus of the PEPFAR program is on the public sector. Of the 26 partners directly supporting ART, all work in the public sector, with most supporting programs in the private and/or NGO sector.

From April 2004 through March 2007, the SAG has treated more than 270,000 individuals in the public sector, including 27,000 children. Private sector clinics and doctors, and NGOs, are treating an estimated additional 50,000 individuals. The USG expects to meet its FY 2008 direct target of 382,011 individuals receiving treatment through support to public sector, faith-based organizations, non-governmental organizations and private sector programs. The NSP goal is to have ~1.6 million people on treatment by the end of 2011.

The capacity to deliver pediatric ART services varies significantly, although additional funding in FY 2007 has been devoted to improving access to pediatric ART, especially through training activities and technical assistance. PEPFAR partners continue their efforts to reach a pediatric target of 15% of the total treatment population by the end of FY 2008. In FY 2007, 11% of all patients on treatment were children (up from 9% in FY 2006). In FY 2008 the pediatric treatment target is 11%. In addition to the training activities, emphasis in FY 2008 is placed on early diagnosis for infants and children, the referral of children from PMTCT programs to treatment services to better integrate HIV and AIDS services, onsite mentorship, and on linkages between OVC programs and pediatric treatment programs. Based on OGAC guidance, partners are also incorporating nutrition support, especially for children.

The key priorities for the USG in FY 2008 are: (1) human capacity development, especially at primary healthcare level; (2) strengthening down and up-referral systems; (3) improving pediatric HIV care and treatment; (4) encouraging counseling and testing (CT) earlier for adults and children (including the use of PCR and dried blood spot technologies); (5) ensuring that all HIV-infected clients are screened for TB; (6) continuing to strengthen the integration of treatment programs within other health interventions (e.g. PMTCT and reproductive health); and (7) reducing both loss to initiation of treatment of people that test HIV positive, and loss-to-follow-up once on treatment.

The NSP contains strategies for initiating and managing patients on ART at the primary healthcare level. A key focus in FY 2008 is to build capacity at clinics to initiate ART, and only referring patients with

complications to the secondary hospital level. There is a key policy change regarding ART initiation guidelines which PEPFAR partners will support.

The USG is committed to assisting the SAG to enhance the capacity of the public healthcare system and to increase the number of South Africans receiving care and treatment, drawing on evidence and experience, using SAG policies and guidelines. Specifically, the USG program will strengthen comprehensive high quality care for HIV-infected people by: (1) scaling up existing effective programs and best practice models in the public, private and NGO sectors; (2) providing direct treatment services through prime partners and their sub-partners; (3) increasing the capacity of the SAG to develop, manage and evaluate treatment programs, including recruiting additional health staff, training and mentoring health workers, improving information systems, conducting public health evaluations, and service infrastructure assistance; (4) increasing demand for and acceptance of ARV treatment through community mobilization; (5) ensuring integration of ART programs within palliative care, TB, reproductive health, STI and PMTCT services; and (6) assisting in the accreditation of facilities for ART initiation. The collective effort of all USG treatment partners has resulted in ARV care and treatment services available at over 350 sites in all 9 provinces of South Africa. Services are available at health facilities and mobile outreach systems, to improve quality, ensure equity and provide accessibility.

Key linkages are made with prevention programs (especially prevention with positives), wellness programs, which provide ongoing support for patients once they have tested positive for HIV, including opportunistic infection management, cotrimoxazole prophylaxis, and prevention with HIV-infected individuals. Wellness programs are linked to strong community programs, notably home-based care networks that extend care from the facility level to the home. The safe water and bednet elements of the standard package of care are not applicable in South Africa, as the SAG has significant programs to address these areas of need. Malaria control efforts in the small section of the country that is affected by malaria are funded by the SAG and the Global Fund.

The SAG has instituted routine CD4 testing as part of CT to maximize identification of treatment-eligible individuals. In addition, the USG and several partners are working with the SAG on improving early infant and child diagnosis and effective pediatric treatment. The laboratory services network in South Africa is well developed, and allows for the effective monitoring of patients once on ART as per the standard treatment guidelines.

Support for communications programs to improve demand for treatment and to improve treatment literacy remains an important focus in FY 2008. Special challenges that are being addressed are health-seeking behavior among men and youth, and strengthening prevention messages, especially on concurrent relationships. Treatment literacy is also a key focus.

The USG has also developed innovative partnerships with the private sector to provide ART. Some of the private sector partnerships also include public-private partnerships between industry and the South African government.

Proposed activities include such innovative approaches as: strengthening primary healthcare capacity to manage patients on ART in community-based settings; the utilization of multiple network models to improve diagnosis of adults and children; care for those who are positive, but not yet requiring treatment; high quality treatment with strong treatment adherence components and strong referral systems, with specific efforts in FY 2008 to strengthen tracing of patients and reducing the number of people lost both to initiation of treatment after testing positive, and lost-to-follow-up after treatment initiation; improving the efficiency of support functions for treatment programs including community support and clinical training and mentoring, patient information systems, logistic support for pharmacies; and public-private partnerships to deliver ARV services at workplace settings, and through private practitioners in remote

areas serving the uninsured. In FY 2008, funding has also been provided to treatment partners to strengthen TB screening and diagnosis.

In addition, the USG will focus in FY 2008 on implementing the recommendations from the 2007 review by the Adult Treatment Technical Working Group, including additional assistance to the SAG on accrediting facilities to provide ART, especially clinics; ensure greater geographic consolidation; and scaling up efforts to ensure equitable access to ART.

In FY 2007, the USG competitively selected additional partners to provide care and treatment services, with 26 partners providing direct treatment support in FY 2008. There will be a competitive process to award funding for those contracts and cooperative agreements ending in FY 2008, which may include new partners. This is aimed at supporting the NSP goal of 1.6 million people on ART by December 2011.

PEPFAR support includes:

- Several USG staff and PEPFAR partners participated in the development of the National Strategic Plan for 2007-2011 and the corresponding M&E framework.
- In an effort to ensure sustainability, several partners will be assisting provinces in fast-tracking the accreditation process of health care facilities to provide ART.
- Several partners provide extensive training to healthcare providers, including pharmacists, laboratory workers, doctors, nurses and home-based care workers.
- Management Sciences for Health aims to strengthen pharmaceutical service delivery at all levels, resulting in improved quality of care to all patients.
- The Supply Chain Management System Partnership will indirectly support the entire national ARV rollout in South Africa through its activities aimed at strengthening ARV patient information and reporting capabilities utilizing the down-referral system.

## ***ARV Drugs***

### ***Total Planned Funding for Program Area: \$42,751,919***

The South African Government (SAG) has taken leadership in the introduction of antiretroviral treatment (ART) through a five-year phased nationwide equitable rollout program. The goals of this plan are reiterated in the new South African HIV and AIDS and STI National Strategic Plan, 2007-2011 (NSP). According to the NSP, the total financial need for funding for ART alone in 2008 is US\$453 million. The USG is thus ideally positioned to support the implementation of the NSP. The FY 2008 USG budget to support ART in South Africa is US\$262 million.

The USG ensures that all local policies, guidelines and processes are adhered to, including the SAG requirement of accreditation for facilities to provide ART services through a formal SAG process. The SAG has established standard treatment guidelines and protocols, and uses an extensive process to review and register ARV drugs through the Medicines Control Council (MCC), which includes several generic ARV drugs. Due to these stringent controls, parallel importation is not within the SAG policy.

Currently, of the 51 generic ARV drug formulations that have been approved by the FDA and can be purchased with PEPFAR funding, there are only nineteen that are also registered by the

MCC and can be purchased in South Africa with PEPFAR funding – eleven of which are first line drugs (as per the SAG national guidelines). However, as most of the treatment partners work in public health facilities, drugs are provided by the SAG, and not purchased with PEPFAR funding, allowing resources to be directed to other important treatment-related activities such as training, community mobilization, and human capacity development. Since there are a limited number of PEPFAR partners that procure ARV drugs, most individual partner budgets are not negatively impacted by the availability of generic drugs that can be purchased. In addition, many PEPFAR treatment partners access branded drugs through access pricing mechanisms, resulting in further savings.

Outside of the public sector, PEPFAR funding supports NGO partners to expand treatment to specific target groups, including people with TB, men, and people in workplace settings. Another important focus extends ARV treatment through general practitioners at community clinic sites, especially in rural communities, increasing access beyond the current SAG accredited rollout sites. The USG has also developed innovative partnerships with the private sector to provide ART. Some of the private sector partnerships also include public-private partnerships between industry and the South African government. Some of these NGO and private partners either obtain (at no cost) or procure their drugs through provincial health departments.

In FY 2008, there will be an emphasis on creating capacity at the primary healthcare level to initiate and manage patients on ART. This would also require the strengthening of drug distribution and storage systems at this level. South Africa has a strong private pharmaceutical industry. The USG in South Africa does not manage the procurement of drugs and commodities centrally; these arrangements are made directly by PEPFAR treatment partners. Those PEPFAR partners that do purchase ARV drugs obtain them through monthly procurements from reliable private pharmaceutical distributors. Drugs are pre-packaged individually for each patient and delivered to the relevant site. Emergency deliveries can be made in 24 hours. Some of the treatment partners may utilize the Partnership for Supply Chain Management (PFSCM) in FY 2008 to streamline procurement and distribution.

In addition to supporting implementing partners, the USG supports the ARV rollout by strengthening drug distribution and monitoring systems through logistics management, patient information, drug supply and training. The National Department of Health awards centralized tenders for all ARV drugs procured by provinces. There were no reported stock-outs of antiretroviral drugs in FY 2007, though there were distribution problems due to a month-long public sector strike, which included the public health sector. Despite this, the SAG's emphasis on strengthening key delivery systems (with PEPFAR assistance) continues to improve distribution systems and overall effective drug management capacity. If stock-outs were to occur in PEPFAR programs in FY 2008 that obtain drugs through the SAG, private sector pharmaceutical suppliers are positioned and ready to provide the necessary back-up supplies.

The first-line regimen for ART in South Africa is stavudine (d4T), lamivudine (3TC) and either efavirenz or nevirapine. Most patients are still on the first-line regimen. Switches are mainly due to side-effects, adverse reactions, and sub-optimal regimens used in the private sector prior to the national treatment guidelines. Stavudine accounts for the highest number of adverse

reactions to ART, mainly lactic acidosis. The international evidence that shows the efficacy of alternatives to stavudine is monitored by the USG. Some PEPFAR partners are assisting the SAG in the review of guidelines, and thus it is expected that in FY 2008 the first-line regimen may change.

The USG also provides critical on-site assistance through its partners at public sector facilities aimed at strengthening and improving the quality of logistics, recording, and ordering systems to ensure proper management of drugs and other commodities required for treatment. These activities will continue and expand in FY 2008.

There are no other donors that provide service delivery support for the provision of antiretroviral treatment, though DFID/United Kingdom provides support to the SAG in strengthening drug delivery systems. The USG and DFID are collaborating to ensure there is no duplication of effort. The Global Fund supports ARV treatment in the Western Cape and KwaZulu-Natal provinces, and one Emergency Plan partner, CAPRISA, receives Global Fund support for the purchase of ARV drugs.

## ***Laboratory Infrastructure***

### **Total Planned Funding for Program Area: \$12,877,750**

In 2001 South Africa restructured its public sector medical laboratory services and created (NHLS), a parastatal organization. In 2008, PEPFAR funds will be used to address gaps identified by the NDOH, the National Health Laboratory System (NHLS), NIOH, and NICD to address laboratory-specific unmet needs and policy or administrative issues that impede full implementation of public laboratory programs in support of the National antiretroviral treatment (ART) rollout and the National TB Strategic Plan. Consistent with the priorities identified by the NDOH, and implemented by the NICD and NHLS, PEPFAR will continue to provide funding to assure the accuracy and quality of testing services in support of rapid scale-up of HIV testing and TB diagnostic capacity, and to build long-term sustainability of quality laboratory systems in South Africa. In addition, PEPFAR funds will be used to fund Toga Integrated HIV Solutions (Toga), a new PEPFAR partner that aims to establish a network of HIV monitoring laboratories and associated service access tools to resource constrained ART settings.

Toga is a private molecular diagnostics laboratory situated on the outskirts of Johannesburg. Toga provides molecular diagnostic support for AMPATH (National Pathology Support Services), and as such has become an integral part of the suite of pathology services offered by that organization. Toga is a cohesive team consisting of clinical virologists, scientists, and technologists who have accumulated considerable experience in the field of molecular biology. Toga is a valuable resource that assists with laboratory and clinical management and is committed to driving access to molecular diagnostic testing for all South Africans.

With the continuing expansion of HIV and TB services within NHLS, and with significant increases in multidrug- and extensively drug-resistant TB (MDR and XDR-TB) cases within South Africa, additional support is required to strengthen HIV and TB diagnostic capacity and information management infrastructure. NHLS has responded to this need by planning to expand HIV diagnostics and treatment monitoring capabilities in all nine provinces. There are 46 CD4

laboratories in the 9 provinces within the NHLS system, but coverage within each health district is limited. There are only 13 laboratories in 5 provinces that are able to provide viral load testing, and only 8 laboratories in 5 provinces are able to provide infant PCR diagnostics. NHLS will expand services to provide at least one CD4 laboratory per health district, and ensure that viral load and infant PCR services are available in all 9 provinces. NHLS also recognizes their limited TB laboratory capacity due to high burden and inability to capture and report MDR and XDR-TB cases to NHLS and the National TB Program (NTP). There is an urgent need to provide increased access to TB culture and referral services, and to strengthen the management and reporting of MDR and XDR-TB cases, data mining activities, and surveillance analysis from the existing NHLS Data Warehouse (DISA). Finally, it is critical that data is integrated into the existing national Electronic TB Register (ETR.Net) surveillance system. The NHLS DISA system can be used to extract laboratory data from existing NHLS laboratory information systems and maybe used to import data into the ETR.net information system. The current system does require strengthening and NHLS is actively working to improve the capacity and utility associated with this system.

National policies and standards on infection control programs within laboratories are limited. The National Institute of Occupational Health (NIOH) falls under the NHLS, and is given a mandate to develop policy for occupation health. PEPFAR funds will be used to promote an infection control network and to develop robust and manageable infection control policies. Collaboration with other PEPFAR partners will assist in the development of such policies and will lead to enhancement of existing infection control measures and implementation of national infection control standards for laboratory staff and other healthcare workers.

With the availability of significant technical and scientific resources within South Africa, NICD and NHLS are well placed to continue to provide regional laboratory support within Sub-Saharan Africa. Both organizations plan to expand and strengthen existing regional support mechanisms and to enhance collaboration with other PEPFAR-funded countries through the Regional Laboratory Training Center (RLTC). Expansion of services includes, but is not limited to, extending external quality assurance (EQA) programs, TB and HIV laboratory diagnostic technical support and services, regional HIV rapid testing kit evaluations, integrated TB/HIV training programs, and other HIV and TB related laboratory technical assistance.

During FY 2008 NICD will continue evaluating HIV incidence testing methodologies; using EQA to monitor PCR DNA testing of infants and of molecular testing associated with ART; providing quality assessment of HIV rapid test kits; assisting the NDOH in training the staff of nearly 4,000 VCT sites on proper HIV rapid testing procedures and quality management utilizing the WHO/CDC HIV Rapid Test training package; implementing an operational plan to scale up early HIV diagnosis in infants utilizing PCR testing of dry blood spots; assisting NICD in developing a national TB reference laboratory; and providing laboratory training for clinical laboratorians.

NICD will support important strategic information activities to help inform the decisions of policy makers and program officials regarding their HIV prevention and ART rollout programs. These activities include HIV-1 drug resistance transmission surveillance; sentinel surveillance of opportunistic bacterial and fungal pathogens in HIV-infected persons; microbiological

etiological and antimicrobial resistance surveillance for sexually transmitted infections; provision of training for epidemiologists and laboratory workers; collection of trend data for HIV incidence; and HIV-1 drug resistance transmission surveillance. Detailed descriptions of these activities can be found in the Strategic Information section in the COP.

New collaborative NHLS and NICD activities aim to increase national coverage of HIV and TB diagnostics and treatment monitoring capabilities; ensure uniform quality assurance measures among laboratories; support activities to initiate new and strengthen existing EQA programs; strengthen laboratory reporting systems and specimen transport needs in support of rural clinics and laboratories; promote efforts to synchronize infection control activities in collaboration with the NIOH; investigate, assess, validate and implement new automated laboratory diagnostic equipment and high capacity instrumentation for high burden diagnostics and service delivery needs; and expand upon the regional support and collaboration with other PEPFAR-funded countries through the established RLTC.

Toga aims to increase national coverage of HIV diagnostics in remote rural areas by engaging local and provincial government. Toga has developed a Togatainer laboratory based on the MeTRo (Measure to Roll Out) principle as a means of rolling out treatment capacity and developing a near-real time laboratory information management system. Recognizing that laboratory services in the public sector are provided through regional centralized laboratories, with limited peripheral capacity for specialized testing (e.g. CD4 and viral load), Togatainer addresses the need for peripheral deployment of laboratory services. Toga will deploy three Togatainers capable of performing HIV and TB diagnostics, syphilis testing, and HIV disease monitoring.

Continued PEPFAR funding to NICD with combined support to NHLS, as well as Toga Integrated HIV Solutions will focus efforts to address existing gaps in laboratory testing outreach, penetration, and quality of overall services.

## ***Strategic Information***

### ***Total Planned Funding for Program Area: \$23,116,338***

M&E is a priority in the HIV&AIDS and STI Strategic Plan for South Africa, 2006-2011 (NSP) and the USG will continue to respond to these needs by providing both direct funding and targeted TA to various South African Government (SAG) departments. In collaboration with the NDOH and other key stakeholders, the USG has contributed to the development of the NSP's M&E framework. In the future, the USG will aim to increase collaboration and harmonization of M&E systems, even though the latter is a challenge. There is a District Health Information System (DHIS) but not all provinces use it and the quality of the HIV and AIDS data that are collected is not always reliable. Data are included in the UNGASS report but timeliness and reliability of data reporting remain a concern.

Several SAG departments work independently of the NDOH on HIV and AIDS issues. While the USG embraces the goal of supporting one M&E system, it is often necessary to assist in building M&E systems within the different departments, taking care to assure integration whenever possible. In collaboration with other donors, the USG has supported efforts for the development of a national orphans and vulnerable children (OVC) management information system (MIS), as well as TA for an OVC M&E

framework. The rollout of a national OVC M&E system has not yet been implemented; PEPFAR will continue to support this effort in FY 2008.

The Global Fund provides targeted support in South Africa; in the recent round, this support is primarily in HIV prevention. PEPFAR and Global Fund results have a minimum overlap.

The USG supports a comprehensive and systematic approach to partner capacity building in M&E. These activities include: (1) M&E workshops that assist partners in developing M&E plans; (2) the development of a data warehouse to assist USG and partners with the collection, reporting and analysis of data; (3) the DQA initiative; and (4) the establishment of an fellowship program to place recent master's degree South African graduates with partners in need of more intensive M&E TA. Significant progress has been made toward this goal - over 100 partners (350 people) attended a five-day M&E training and 42 partners participated in a DQA, both resulting in increased capacity to report and use program data effectively. In addition, the PEPFAR fellowship program will be expanded to other PEPFAR countries.

With increasing PEPFAR funding and number of partners in South Africa, it has become challenging to allocate time and resources to evaluate partner performance and use data effectively for program planning. The USG (with input from SAG counterparts) conducted an extensive partner evaluation in 2006. A follow-up partner evaluation is planned for 2008. This process aims to critically review partners' performance, their results, and quality of services and then provide feedback to partners to improve their programs. This will also feed into the budget decisions for next year's COP.

South Africa has set aside \$4,000,000 for Public Health Evaluations (PHEs) to be determined at a later stage. In the next two months, the SASI team will lead an effort to review the current PHE portfolio, opportunities to engage in multi-country studies, and information gaps in key program areas. The funds will be reprogrammed reflecting a strategic plan for PHEs.

#### Surveillance and Surveys

Seroprevalence and behavioral surveillance activities in the general population are primarily supported through the National Institute for Communicable Diseases and the Human Sciences Research Council (HSRC) and surveillance for most-at-risk populations through the Medical Research Council and HSRC. These organizations and the South African government drive the process, while PEPFAR provides partial support for these surveys. Johns Hopkins University, in collaboration with several other USG partners, routinely implements a national communication survey to monitor trends in behavior in relation to media exposure. Surveys and surveillance activities are described in partner COPs and in the Planned Data Collection section. The SASI team has been instrumental in assisting with the design and implementation of several studies and surveillance activities.

The USG continues to provide TA for SI, including direct personnel support at the national and provincial health departments, development of surveillance systems and training to specific programmatic units within the NDOH. All PEPFAR partners are required to report their activities to the SAG. However, since the DHIS does not capture non-public sector activities, the SAG has not developed a standardized system by which partners can report their activities. The SASI team plans to work towards improving the inclusion of PEPFAR data in SAG M&E systems.

#### Management Information Systems (MIS)

The USG Task Force will place more emphasis on an MIS strategy in FY 2008. PEPFAR funds support information systems at the partner level, but to date the USG has not been prescriptive about the design and implementation of those systems. Many treatment partners have developed their own systems in the absence of a national or provincial MIS. A key priority is to improve the harmonization of such systems to ensure that they communicate with other systems at the facility level and that they efficiently feed into

the DHIS. An MIS specialist will soon be hired and will lead an assessment of USG-supported MIS to devise an investment strategy in MIS and work towards aligning systems within PEPFAR-supported programs. The MIS specialist will also work closely with the South African government in this effort.

With the assistance of MEASURE Evaluation, PEPFAR partners have formed a task team to develop a standard MIS for OVC. These efforts will continue in FY 2008.

## ***Policy Analysis and System Strengthening***

Total Planned Funding for Program Area: \$10,353,500

The challenges of HIV and AIDS are compounded by the need to strengthen the health workforce and associated systems in South Africa to sustain the capacity and skills to deliver HIV/AIDS prevention, treatment and care services. According to the 2006 National Human Resource for Health Plan (HRH), there are 67 doctors per 100,000 people where 62.3% of general practitioners work in the private sector. In many public sector clinics and hospitals, the vacancy rate averages 31% with increases in 2007 due to the long public health sector strikes. The new HIV & AIDS and STI Strategic Plan for South Africa, 2007-2001 promotes increased access to HIV and AIDS management including the provision of ART at primary health care level. The program policies are comprehensive but implementation is slow and the need to strengthen the capacity of health-care managers and providers looms large.

Not only is the human resource strained by the increasing workload due to HIV and AIDS, but health care workers are also suffering themselves from HIV infections and family members living with the disease. It has been estimated that approximately 16% of health care workers in South Africa are HIV-infected and many have members of their household suffering from HIV and/or opportunistic infections. In FY 2008, USG CT programs will target health care workers at government sites to ensure they know their status, and treatment and care programs will extend to health professions. HIV and AIDS have been cited as one of the leading causes for nurses to leave the public health care sector. Nurses in particular have high attrition rates in the health system and there is significant stigma preventing them from seeking treatment and care. It is imperative for PEPFAR to support new health workforce's HIV workplace programs through public sector and professional councils.

The PEPFAR program in South Africa will continue to address policy analysis and capacity strengthening in FY 2008 through an expansion of mechanisms and activities that focus on (1) in-service and pre-service training; (2) task-shifting and support for new care-providing personnel; (3) workforce planning and management; (4) quality assurance and performance standards; (5) retention, incentives, recruitment and staffing; (6) public-private partnerships; (7) strengthening leadership and policy and; (8) reducing stigma and gender inequalities. Many of the above activities under policy analysis and systems strengthening activities relate to specific program areas and are included in those sections of the FY 2008 COP. All initiatives are consistent with South Africa's National HIV and AIDS Strategy, and the HIV & AIDS and STI Strategic Plan for South Africa, 2007-2001 and its policies related to human resource management.

The USG will emphasize the cross-cutting areas of HCD and sustainability in the transition to PEPFAR II, and will hire an HCD technical advisor. For each partner, the USG requires a sustainability plan and focus on reduction of stigma and discrimination. Gender inequalities and aggressive sexual behaviors, including violence, drive the spread of HIV in South Africa and therefore the USG incorporated gender as an overarching strategy in most programs.

There are significant efforts to provide training to healthcare providers. Current USG partners are focusing on supervision skills training, job aids, counselor tools, monitoring, coaching and clinical preceptorship programs to ensure training impacts are sustained. In FY 2008, the USG South Africa program will encourage partners to promote best practices and innovative approaches that include on-the-job training, supervision follow-up, and quality assurance mechanisms, including nationally accredited curriculums. Pre-service programs will be aligned with task analysis assessments tied to the health needs of South Africans and capacitate those training institutions to produce a South African qualified workforce.

The USG team in South Africa will allocate FY 2008 funds for a joint APS focusing on task-shifting to meet current demands on the system. This activity will focus on: (1) assessment of tasks performed by a variety of health care practitioners (doctors, nurses, pharmacists) at primary health care levels comparing this with the current prescribed scope of practice for these categories and the need/demand within the health care system; and (2) making recommendations for other categories/levels of health-care workers with a prescribed scope of practice. This activity will be carried out in collaboration with the NDOH and the professional councils with a special focus on nurses since they bear the brunt of burden. This work will also include the development of job descriptions and job competency requirements for all categories of health-care workers in the health system.

Workforce planning and management systems are weak in the national and provincial level. There is a national payroll system sitting within the Public Service Administration but there is not an adequate human resource information system to track health workers. With DFID support, the USG will look into potential assistance to improve the health workforce data to plan and manage staff. Management training is a large gap at all levels of the government and private systems in South Africa. In FY 2008, the USG program will increase the management and leadership capabilities of the new HIV/AIDS managers and the provincial and district HR managers.

A performance-based management and quality assurance system is needed in South Africa for tracking service delivery standards and helping to provide equitable career structure for health workers. Standards-based management is a practical management approach for improving performance, efficiency and quality of health services. In FY 2008, the USG will explore potential expansion into the development of a performance improvement and QA system for NDOH sites; and continue to expand the Nursing Capacity Building project enhancing leadership skills, networks and resources for nurses. With the additional FY 2008 funding, the new Quality Monitoring and Assessment Program will assist the USG team to assess adherence to SAG and PEPFAR clinical and administrative policies.

The NDOH currently has in place a rural incentive scheme, based on monetary incentives. The HRH plan clearly states the need to review retention policies, look at successes, develop award/recognition policies and attract back professionals who have left South Africa. USG does provide incentives and salary support to NDOH, NGOs, FBOs, and CBOs at HIV/AIDS service sites, including support for nurses' salaries, auxiliary staff, lay counselors and community caregivers. Around 20,500 staff in the government, private and civil society sectors are supported directly by South Africa's PEPFAR funds.

USG will continue to support a placement program to assist government recruitment of medical professionals to meet the severe shortage of workers. Locally and internationally qualified health-care professionals on both remunerated and voluntary bases are recruited against vacancies in the public sector, fast-tracking them through the recruitment process, ensuring adequate site support and incentives (see Foundation for Professional Development).

The USG uses its many links to businesses in South Africa to promote the expansion of initiatives to reach the private sector workforce. These efforts focus on integrated workplace programs, private services

linked within OVC programs, as well as private sector provision of HIV services of prevention, counseling and testing, and treatment for employees. PEPFAR South Africa pilots best practices on a small scale at the provincial or district level with plans to replicate nationally. This has proven to be an effective mechanism for moving policy forward and expanding private sector partnerships.

A significant focus of South Africa's PEPFAR program addresses institutional capacity issues by building the capacity of local NGOs, FBOs and CBOs. The goal is to build institutional capacity to increase the effectiveness and capacity of these partners to achieve expanded and quality services while strengthening the management of their financial and human resources. Pact, Care and the Ambassador's HIV/AIDS Community Grants Program include formal training, on-site mentoring, improved monitoring and evaluation systems, good governance and resource mobilization.

The USG program is collaborating with other donors in this program area to maximize support for human capacity building, workplace policy development, public-private partnerships and organizational capacity building among NGOs working in HIV/AIDS.