PEPFAR

THE U.S. PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

THE POWER OF PARTNERSHIPS

South Africa

Fiscal Year (FY) 2009

Country Operational Plan (COP)

Table of Contents

Table of Contents

INTRODUCTION:

The President's Emergency Plan for AIDS Relief (PEPFAR) 2009 Country Operational Plan (COP) summary presents a brief look at where we have come from and the way forward for 2009. The challenges have changed as the needs of South Africa have evolved. No longer is PEPFAR responding to an emergency situation, but to the development of sustainability, capacity building, and prevention. This is the focus of the fiscal year 2009 (October 1, 2008-September 30, 2009) COP. The change in focus is to facilitate effective programs and services, partnerships with the South African government (SAG) and donors, and leveraging of resources through these partnerships. Partnership will enable support for other health care needs by addressing gaps, avoiding duplication of services, and supporting SAG priorities. PEPFAR funds will provide support to public, private, faith-based (FBO), and non-governmental organizations (NGO) for HIV activities at the national, provincial, and district level through a broad-based network of prime and sub-partners.

South Africa faces a critical challenge with an increased number of individuals on antiretroviral therapy (ARV); an over stressed public health system, a major shortage of over 57,700 health care personnel, the rising tuberculosis epidemic, and the need for comprehensive prevention programs that reach across all populations in South Africa. According to the 2008 UNAIDS report, the number of individuals in South Africa who received ARVs have increased from 55,000 in 2004 to 428,951 in 2007. Additionally, in 2006 the estimate of people living with HIV was 5.7 million and the number of deaths due to HIV was estimated at 350,000. The PEPFAR program and the SAG face new challenges for fiscal year 2009 and beyond. To acknowledge the needs and efforts of collaboration with the SAG, PEPFAR conducted provincial meetings early in 2009. The outcome of these meetings will hopefully furnish reciprocal knowledge to all stakeholders.

In fiscal year 2009, the PEPFAR program in South Africa, with over 500 prime and sub-partners, will work toward achieving the September 2012 targets, which are to treat 3 million HIV-infected people, prevent 12 million new infections, and care for 12 million HIV-infected and affected individuals. Along with the long-term 2012 targets is the immediate need to work closely with the SAG in an effort to support and enhance the goals of *The HIV & AIDS and STI Strategic Plan for South Africa, 2007-2011* (NSP). PEPFAR partners in collaboration with the SAG, work in the following program areas:

• Prevention of Mother to Child Transmission (PMTCT) • Prevention of Sexual Transmission • Blood Safety • Injection Safety • Male Circumcision • Counseling & Testing	• Adult Care & Support • Pediatric Care & Support • TB/HIV • Orphans & Vulnerable Children	• ARV Drugs • Adult Treatment • Pediatric Treatment • Laboratory Infrastructure	• Strategic Information • Health Systems Strengthening • Human Capacity Development • Gender

Please find below the detailed program area narratives.

PREVENTION:

Total budget: $138,262,681

Prevention of Mother-to-Child Transmission (PMTCT):

The National Department of Health (NDOH), with support from many partners including the United States government (USG), has successfully scaled up the national PMTCT program from a pilot program in 2002 to a national program today. As of September 2008, PMTCT service delivery is available and accessible at all public hospitals and in about 90% of public clinics, community health centers, and mobile clinics. Despite the high coverage in terms of PMTCT service points, the national PMTCT cascade is relatively low. Data from the District Health Information System (DHIS) shows that 92% of pregnant women attending antenatal clinic facilities tested for HIV, 63% of HIV-infected pregnant women received ARV prophylaxis, and 61% of infants born to HIV-infected mothers received ARV prophylaxis in 2008. However, there are still challenges with data quality, given that the source of information is the DHIS. HIV rapid tests have been utilized nationally, and test results are returned to the women on the same day. CD4 tests and TB screening are done for all HIV-infected pregnant women, while HIV PCR testing is offered to all HIV-exposed infants nationally. The National Health Laboratory Services (NHLS) currently has over 50 laboratories providing CD4 tests in all nine provinces, with plans to expand CD4 testing capacity to each district. There are nine laboratories in five provinces that have the capacity to perform early infant diagnosis. Current PCR test utilization rates are between 60-65% of the NHLS's existing capacity (approximately (~)192,000 infants tested annually, total capacity of ~310,000 annually), indicating a shortfall of more than 100,000 of the national estimates out of a target of 300,000 for required testing. This results in challenges in the turn-around times, specimen collections, and result management within healthcare facilities, which contributes to difficulties in patient follow-up and treatment initiation. The NHLS use courier services to pick up and drop off specimen results, but this may not be adequate to meet the demands of clinics.

Since 2003, the USG has been supporting the NDOH through a range of 26 prime PMTCT partners that work directly at the facility level to facilitate the implementation of the PMTCT program. The support includes policy development, capacity building, implementation of early infant diagnosis, and integration of PMTCT into existing maternal, child, and women's health (MCWH) services. In FY 2008, to ensure that there is greater geographical and technical support for the national PMTCT program, the USG has been working in partnership with the NDOH and UNICEF to conduct a stakeholder analysis. This analysis will map all PMTCT stakeholder activities, identify gaps and overlaps in technical assistance, and provide recommendations to ensure better coordination among stakeholders. In addition, towards the end of 2008, the South African PMTCT program will be reviewed and resulting recommendations will be incorporated in implementation plans for the upcoming financial year. This will provide strategic direction to both the national and the PEPFAR PMTCT programs. In addition, the U.S. Centers for Disease Control and Prevention (CDC) is currently providing technical support to the NDOH for the review and update of the PMTCT and Infant

Feeding Training Curriculum in line with the new policy and guidelines. PEPFAR partners have played key roles in facilitating readiness for implementation by providing ongoing technical assistance to the provincial and local health structures to address operational challenges, by ensuring that all healthcare workers receive the necessary policy updates and training, and by strengthening linkages between antenatal care and HIV service delivery and social services.

The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP) has set a target of decreasing the mother-to-child transmission rate for the national PMTCT program to 5%. In February 2008, the NDOH released a new national PMTCT policy that fully integrates PMTCT into comprehensive MCWH services. The new policy and guidelines include:

- providing routine screening for STI and TB
- routinely offering VCT to all pregnant women and retesting at 32 weeks for those who initially tested negative
- providing a dual ARV prophylaxis regimen (AZT from 28 weeks plus a single dose of nevirapine at labor), as well as highly active antiretroviral therapy for eligible pregnant women and infants
- providing early infant diagnosis for HIV-exposed infants at six weeks, retesting six weeks after weaning, and providing cotrimoxazole prophylaxis to HIV-exposed infants, and
- improving maternal nutrition and safe infant feeding for HIV-exposed infants.

The NDOH is currently revising the adult treatment and pediatric guidelines, and is expected to implement these by the end of 2008 or early 2009. The revised guidelines will have significant impact on the PMTCT program, as pregnant women who are eligible for highly active antiretroviral therapy will have early access to treatment initiation. Thus, the PMTCT program targets will be revised accordingly.

The primary objectives for the FY 2009 PEPFAR program in South Africa are to support the NDOH in

- building local capacity to implement the 2008 National PMTCT policy effectively by increasing coverage of training and re-training for healthcare workers
- providing site-specific support through PEPFAR partners and the NDOH to implement and roll out the new PMTCT policy and guidelines
- building capacity for early infant diagnosis and follow-up for mother-baby pairs post delivery by improving linkages between PMTCT service points, MCWH, HIV pediatric care and treatment programs, and antiretroviral care and treatment for adults, and
- improving the quality of the national PMTCT monitoring and evaluation systems.

In addition, in FY 2009, 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 routine offer of counseling and testing
- strategies for follow-up of mother-baby pairs post delivery
- quality improvement; management and prevention of STIs, TB, and other opportunistic infections
- community outreach and referral to wellness and treatment programs for HIV-infected mothers and exposed infants, and
- scaling-up early infant diagnosis services.

Furthermore, support for activities which address cultural attitudes to infant feeding, male involvement in PMTCT, and increased uptake of services will be included. The USG will support the NDOH in facilitating quarterly meetings with all partners who are working on PMTCT programs in South Africa. These meetings will provide an opportunity for partners to share lessons learned and to prevent the duplication of tool and curriculum development. The quarterly meetings will ensure greater coordination among partners and government, particularly with respect to capacity building and training. All partners are required to use the NDOH curriculum as a generic training guide.

With the implementation of the new PMTCT policy and guidelines and the continued partnership with the NDOH, the South Africa USG team is optimistic that there will be an increase in the uptake of PMTCT services and a decrease in the rate of vertical transmission in FY 2009.

Prevention of Sexual Transmission:

South Africa, with a population of 48.3 million, has a highly generalized AIDS epidemic; the estimated HIV prevalence at mid-2007 was 18.1% for the 15-49 age group. Transmission is primarily heterosexual followed by mother-to-child transmission. HIV prevalence among pregnant women attending antenatal clinics was 28% in 2007, reflecting a small decline since 2005 after rising steadily since the early 1990s. HIV infection rates vary greatly by age and sex. Young adults have the highest infection rates; prevalence peaks at 33% for women aged 25-29 and at 23% for men in their thirties. Almost twice as many women as men are infected. In the 15-24 age group, the ratio of infected females to males is four to one. Young women aged 20-29 have extremely high HIV incidence at 5.6%; incidence in pregnant women is also high at 5.2%. Although incidence rates are higher in 15-24 year olds, adults over age 25 account for two-thirds of new infections, owing to their larger numbers.

Prevalence varies greatly across geographic settings. Among provinces, KwaZulu-Natal had the highest antenatal care prevalence in 2007 at 37.4%. Mpumalanga has the highest incidence among all the provinces (2.4%) based on 2005 survey estimates. Recent data from the 2007 National HIV and Syphilis Prevalence Survey indicates that one or two districts in each province contribute disproportionately to the epidemic. Urban informal settlements, which are a magnet for migrants, also have very high HIV rates; in a recent study, migrant men had HIV prevalence double that of non-migrants.

The vast majority of new infections in South Africa are believed to result from multiple and concurrent sexual partnerships in which consistent condom use is very low. Other factors associated with high HIV transmission include age mixing in sexual partnerships,

informal transactional sex, and early sexual debut. The mean age at first sex, currently about 17 years, is declining. Alcohol and substance abuse also contribute to risky sexual behavior and rates of sexual violence in South Africa are among the highest in the world. These behaviors are the key drivers of the HIV epidemic coupled with low rates of circumcision. Frequent labor mobility and low marriage rates, further contribute to HIV transmission.

Knowledge and awareness of HIV and AIDS are almost universal, and exposure to mass media and interpersonal sources of information about HIV and AIDS is high. However, current interventions and communication efforts are not having adequate impact on behaviors and personal risk perception is astonishingly low ; 66% of South Africans do not see themselves at risk of HIV, primarily because they do not understand the dangers of multiple and concurrent partnerships. In addition, high levels of HIV in the early stages of HIV infection while people do not know their status and do not take necessary precautions with sexual partners exacerbates rapid transmission among these dense sexual networks.

The South African Government recognizes the urgent need to scale up effective HIV prevention programs and the new Minister of Health has publically stated that HIV prevention is among the SAG highest health priorities. The South African National Strategic Plan for HIV & AIDS and STI, 2007-2011 (NSP) has the ambitious goal to reduce the rate of new HIV infections by 50% by 2011. The plan builds on national programs to address gender-based violence and mainstream HIV and AIDS interventions with priority to the rural poor, urban informal settlements, and marginalized groups. To help attain this ambitious goal, the Department of Health is in the process of finalizing an operational plan that will accelerate scale up of effective prevention programs with an evidence based approach that addresses the key drivers of the epidemic. The South African National AIDS Council (SANAC) is expanding its staff and providing stronger leadership for the prevention response.

The United States government (USG) PEPFAR team is working in partnership with SAG and other donors to intensify prevention efforts using a comprehensive, multisectoral, integrated approach. To support the SAG prevention program and to develop a strategic implementation plan for PEPFAR II, the South Africa PEPFAR team has initiated a series of actions to align the prevention portfolio with the epidemiological evidence and to effectively address the key drivers of the epidemic, especially multiple concurrent partners, low rates of consistent condom use, and early onset of sexual debut.

Abstinence and Be Faithful (AB) funding was increased in FY 2008 to $32,518,850 million for more than 50 partners with a target of 7 million people to be reached. As of March 2008, prevention efforts had reached 13,101,391 individuals with AB messages and 2,343,755 individuals with other prevention (OP) messages. A total of 981,425 individuals were reached with abstinence-only messages.

The FY 2009 COP funding levels are approximately $36,693,000 for AB and $22,259,000 for OP. In FY 2009, based on recommendations from the Prevention Technical Working Group, FY 2009 COP reviews, the PEPFAR South Africa Interagency Partner Evaluation, and the recent PEPFAR prevention partners summit, the USG has accelerated the

assessment of the overall prevention program and has developed immediate, mid and long-term directions for a strategic focus and to enhance program impact.

In FY 09 the prevention program will progressively apply a geographically oriented combination approach in areas of highest incidence, starting with greater emphasis in informal settlements, and high prevalence urban and rural areas. Following a program inventory and consultation with provincial government representatives, the program will saturate hotspot districts with effective combination interventions with a strong behavioral evaluation component and data use approach

The USG will intensify support for the National Department of Health (NDOH) and SANAC at national level and specific support to provincial and district governments to support their core prevention teams with a HIV prevention consultative core action group (or "Action Tank"). Further more, as the USG has begun a consultative process with Provincial government officials, the PEPFAR prevention team and select partners will help Provinces accelerate the scale -up of HIV prevention through an inclusive, broad-based process to develop a comprehensive, coordinated, evidence-based, target driven national prevention implementation strategy. In FY 09 the USG will work with select Provinces and Districts that have highest prevalence rates through an active and participatory approach that will engage key stakeholders and facilitate the alignment of prevention actions based on the local HIV epidemic.

With the SANAC prevention communication team that includes Soul City and Johns Hopkins, the USG will help build partner capacity and harmonize messages around the risks involved in plugging into sexual networks, the dangers of inter-generational and transactional sex, and how to correctly position the promotion of condom use in a context of longer term concurrent partnerships. These interventions will ensure that sexual networks are discussed clearly, graphically, and openly at the community and household levels. This effort will also assure coordinated messaging about the key risks at multiple levels and through a variety of venues –using Mass media, community outreach, small group and interpersonal discussions at community centers, clubs, clinics, universities and schools, and other venues.

The prevention portfolio has been shifted to have a greater emphasis on adults especially young women and older men who are at most risk of becoming infected. In addition, to address the abundance and fragmentation of school based peer education programs, the USG will conduct a qualitative assessment of peer education activities with the aim of consolidating programs and harmonizing interventions with the Department of Education's objectives. This will involve supporting the Department of Education's goal to institutionalize and standardize school based peer education programs and assessing the effectiveness of peer education interventions outside of the school setting.

The USG will begin to redirect select prevention activities towards more comprehensive programming for high risk groups, assuring coverage in known high incidence regions with multi-component prevention activities. CDC will conduct an assessment on sex workers and HIV to identify programming gaps. Based on the assessment findings programs will be reoriented to close the gaps and to more strategically address this important population. However, until the assessment is complete, the current activities

with MARPS, especially commercial sex workers will be progressively intensified and improved over the course of FY 09 to ensure that all programs are providing the essential package of interventions for the vulnerable populations. The USG will also document the MARP program to help identify best and promising practices. The Reproductive Health and Research Unit's comprehensive program addresses health care and supports needs of sex workers, including HIV testing. The services were evaluated last year and results of the survey will be used to re-orient the organization's services, including widening the reach of their program and strengthening referrals. The Human Sciences Research Council (HSRC) and the Joint Working Group for Gay, Lesbian, Bisexual and Transgender people will conduct research to identify gaps in programming for this vulnerable population. The findings will be used to expand targeted prevention interventions with men who have sex with men.

The International Organization for Migration (IOM) will be working to reach migrant and mobile populations in Limpopo and Mpumalanga provinces with comprehensive prevention education. IOM will also target young women in their twenties in high transmission areas, including destination communities for migrants. The Medical Research Council (MRC) will continue with its bar-based intervention focusing on people frequenting taverns, a public-private partnership with the South African Breweries. MRC also links HIV treatment programs with prevention.

In the lead-up to the 2010 World Cup in South Africa, the media campaign features 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. 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 behaviors will be integrated into prevention education and disseminated to all audiences.

Effective media activities will be complemented by expanded community 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 NGOs. As a comprehensive activity, the mass media, linked to community outreach and grassroots social mobilization, should shape new community norms of responsible sexual behavior by working though local associations and organizations. The Population Concern International (PCI) program will be re-directed to focus in areas of highest estimated incidence in two provinces using their established social normative change theory. It is expected that this activity 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. Working with two well established national women's networks, PCI will also address gender-based violence with a focus on changing male behavior and community and cultural norms.

In FY 2009, the USG will encourage greater attention to the quality of interventions, particularly training and peer education. In addition, the USG will focus on the coordination of prevention activities to avoid duplication and to increase synergies. PEPFAR funded partners are encouraged to align their activities to the NSP and to sign

Memoranda of Understanding with relevant provincial governments in order to enhance sustainability and integrated programming. In addition, PEPFAR partners are encouraged to create linkages with partners working in the same areas and with other donor programs to ensure greater coordination and coverage. For example, a group of prevention partners meets monthly to share ideas and develop synergies with Soul City's "One Love" campaign (funded by the United Kingdom's Department for International Development) that addresses multiple concurrent partnerships.

Blood Safety:

Blood transfusion in South Africa is recognized as an essential part of the health-care system. South Africa has a strong blood safety program that is directed by the South African National Blood Service (SANBS) in 8 of the 9 provinces and the Western Province Blood Transfusion Service (WPBTS) in 1 of the 9 provinces. Both of the blood transfusion services are funded through a Track 1 mechanism using SANBS as the partner. Both blood transfusion services actively recruit voluntary blood donors and educate the public about blood safety. Blood donors are voluntary and not remunerated. Blood is collected at fixed donor clinics and mobile clinics that visit schools, factories, universities, businesses and other hard to reach areas where there are no fixed sites close by. All blood is routinely screened for HIV-1 and 2, hepatitis B and C, and syphilis.

SANBS operates in eight of the nine provinces in South Africa and is responsible for the delivery of transfusion services to 87% of patients in the country. The Western Province Blood Transfusion Service (WPBTS) provides blood to patients in the Western Cape, even though the National Health Act requires a single national blood transfusion service. SANBS, WPBTS, and the NDOH are discussing the way forward to comply with the provision of the National Health Act. FY 2008 funding will support processes in this merger.

In 2005, SANBS took steps to develop and implement a new donor policy. The previous policy which was based on using race as a major indicator of blood safety, was unacceptable to the NDOH. SANBS developed a new blood safety policy, the Donor Status Risk Management Model. This policy is based on the knowledge that repeat, regular blood donors are less likely than first-time donors to donate blood in the infectious window period. The model is supported by the introduction of individual donation nucleic acid test screening of all donations for HIV, hepatitis B virus, and hepatitis C virus, and an extensive structured donor education, selection, and exclusion program. The new risk model was successfully implemented in October 2005. New operational systems, training programs for staff, standard operating procedures, adaptation of the operational IT system, and the inclusion of measurement systems for monitoring and evaluation has been implemented and refined. This very significant achievement has been supported by the PEPFAR program.

Since the introduction of individual donation nucleic acid technology (IDNAT) screening of donations in October 2005, there have been no observed or reported cases of transmission of HIV or hepatitis B or C to recipients of more than 2,300,000 blood products. The look back programme is highly effective and in FY2009 103 look back investigations were triggered by donor HIV seroconversions. Although limited by the

fact that only 22% of patients who had received the blood could be traced, not one case of transmission of HIV or hepatitis was identified by this important evaluation system.

The success of the Donor Status Risk Management Model can be judged from the findings for the period October 2005 to March 2006. During this period, 277,920 units of blood were procured. Of these donations, 56% were from regular, repeat donors who provide very low-risk donations which were used for the manufacture of components. Red cells were issued from donations of repeat donors; these donors provided 29% of the blood supply. The higher risk blood, used primarily for the preparation of fresh frozen plasma, made up the balance. The prevalence of HIV in the donor groups differed significantly: component donations - 0.011%; red cell donations - 0.057%; and plasma donations - 0.53%. The number of undetected HIV-positive units in the blood supply by a window period incidence model estimated that approximately three HIV window period donations may have entered the blood supply during this period. The outcomes of the risk model, however, must be monitored carefully, and will need refinement and appropriate adjustments. The impact of the Donor Status Risk Management Model on blood safety, the measurement of outcomes, and optimization of the model, will be major components of the SANBS program in FY 2009.

SANBS has spent considerable time on planning and implementing strategies to expand the donor pool. SANBS has coordinated with the NDOH and the Department of Education to provide prevention education to potential young donors. This education aims to help young donors to protect themselves from infection and will result in their being "certified" as committed safe regular donors. PEPFAR resources will also be used to develop cultural and language-specific donor recruitment and HIV educational materials. In 2009, SANBS will utilize PEPFAR funds to expand and to 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 served by the organization. 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. The outcome of the program will be measured by donor recruitment and retention and by HIV prevalence in donors. 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 health-care providers. In the future, SANBS will link with other PEPFAR partners specifically working in antiretroviral treatment services to improve the referral network for persons who test positive.

The American Association of Blood Banks (AABB), another Track 1 partner, provides technical assistance to SANBS and WPBTS. SANBS has reported that the technical assistance provided by AABB has been of high quality and AABB has played an important role in the development of the new risk model in South Africa. AABB will focus on establishing an accreditation program for SANBS, improving training activities, strengthening the IT system, and providing technical assistance on policies and guidelines.

The blood safety activities represent an integrated program that contributes to objectives delineated in the USG Five-Year Strategy. PEPFAR will support incorporation

of messages regarding prevention, treatment and care into blood donor programs, and blood safety issues will be addressed in HIV and AIDS communication programs.

No other major donors are working directly in blood safety at this time.

Injection Safety:

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 utilize single use sterile syringes, that is, those observed to come from a new and unopened package.

The PEPFAR program in South Africa, in collaboration with the SAG, aims to address issues of medical HIV transmission through the Track 1 Making Medical Injections Safer (MMIS) project led by the John Snow Research and Training Institute, Inc. (JSI). The goals of this project are to:

- improve injection safety practices through training and capacity building
- ensure the safe management of sharps and waste, and
- 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 (a core activity) is provided to professional and non-professional staff. The project works at national, provincial, and district government levels in all nine provinces of South Africa. Buy in from the SAG, partnerships with local organizations, and synergies with other PEPFAR projects have been used to ensure sustainability and rapid scale-up. A multi-pronged approach is used in training. This consists of providing in-service and on-the-job training to three different levels of workers: senior management, middle managers and clinical personnel, and waste handlers, as a short-term approach. John Snow, Inc.(JSI)/MMIS will conduct pre-service training, incorporating injection safety content in the curriculums for nurses, doctors, and other professionals.

The NDOH with input from MMIS has developed national policy guidelines on infection control and prevention. In addition, MMIS is working with the NDOH to develop an agreed-upon set of norms and standards for injection safety. The Council for Health Service Accreditation of Southern Africa (COHSASA) will establish an accreditation process to assess compliance with these standards. These processes will comply with the results of the first national injection safety survey conducted by JSI, COHSASA, and the MRC in 2007.

MMIS/South Africa works to build strong partnerships with provincial governments, the national government, and other partners to implement injection safety activities in a sustainable manner. Working in partnership and integrating injection safety into existing programs and systems has been a cornerstone of MMIS/South Africa's approach to sustainability and ensuring a smooth transition towards the end of the project. To date, training activities have begun in 100% of the 52 districts nationwide.

The NDOH's 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 South African 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, 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.

Major strides were made recently towards the sustainability of training and capacity efforts in injection safety and health care waste management. MMIS/South Africa partnered around pre-service training with local entities, teaching institutions, and government to see the enrollment of students in newly created qualifications containing injection safety content. One of these collaborations was to co-sponsor with the Ethekwini Municipality's for two nursing managers to attend the recently created Honours Degree in Infection prevention and Control at the University of KwaZulu-Natal. The other major achievement was the launch of the country's first nationally standardized pre-service curriculum on phlebotomy through a partnership with South Africa's National Blood Services. The standardization of the curriculum came as a result of advocacy efforts led by MMIS since 2008 and aimed at brokering consensus between the Health Professional Council of South Africa (HPCSA) and the South African National Blood Services around minimum standards and requirements for a national certificate for phlebotomists. Now institutionalized, these courses will continue to be held by the respective institutions.

Improving injection safety and proper waste disposal practices are vital systems-strengthening activities for the over-burdened health system. These activities further the USG Five-Year Strategy by supporting an increase in health system capacity and quality of care.

No other major donors are working directly in injection safety at this time.

Male Circumcision:

Traditional male circumcision takes place within some of the provinces in South Africa. Although traditional circumcision takes place among several tribal groups, it is primarily the Xhosa people who engage in the practice. In FY 2008, the Medical Research Council (MRC) undertook a country-wide situation analysis to determine the status of traditional circumcision within the country. The findings of the analysis should be released in April 2009, and these should provide the USG team with a better understanding of the traditional context of male circumcision. In addition to MRC, Jhpiego and the Reproductive Health and HIV Research Unit (RHRU) in conjunction with SANAC are expanding the male circumcision situation analysis. The MRC's situation analysis also investigated the prevalence of reported adverse events and unsafe circumcision practices. Although the USG team had hoped to initiate activities in FY 2007 and FY 2008, these activities have not taken place because South Africa does not have a national male circumcision policy. FY 2009 activities have not been defined, even though funds have been allocated to this activity. When the SAG implements a male circumcision policy, USG activities will be determined in collaboration with the SAG. In the interim, the USG team has set up a task team to focus on male circumcision and to continue to liaison with the SAG. Male circumcision remains a priority for the USG team and as soon as the SAG provides the go-ahead, the USG will reprogram funding and implement activities. Anticipated support in this area includes potential support to the SAG for rollout of a national policy, assistance with the development of a nationally accredited curriculum, and training and implementation of safe, clinical male circumcision.

Counseling and Testing (CT):

South Africa has a highly generalized HIV epidemic with prevalence of 18% among sexually active adults. The NSP outlines priority areas: prevention; treatment, care and support; research, monitoring and surveillance; and human rights and access to justice. Since 2000, the NDOH has supported widespread implementation of a national program for VCT. The predominant model of CT that was used between years 2000 and 2006 has been VCT, but a variety of models have been implemented since then to reach the different target populations in the country.

In early 2008, NDOH updated the policy and guidelines to ensure that CT service outlets provide caring, high quality, uniform, and equitable services in South Africa. The document also provides a guide for the implementation of a more comprehensive national CT program that should improve CT uptake among the target population. In addition, the NSP promotes the use of Routine Offer of counselling and testing (ROCT) .

Until recently in South Africa, the Child Care Act 74 of 1983 was the single most important law regulating children's access to medical treatment or procedures. The new Children's Act 38 of 2005 revoked the Child Care Act 74 of 1983 and was further amended in 2007. A major amendment in 2007 was the clause decreasing the age of consent to an HIV test from 14 to 12 years

The USG and PEPFAR partners continue to support the NDOH in their efforts to update policy, guidelines, training, and mentoring in order to increase the demand for and the

availability of quality CT services. In 2009, 53 PEPFAR-funded partners identified CT as a primary activity. This includes all treatment partners who routinely receive a CT budget to ensure smoother referrals, access to treatment, and maintaining people into care. Some partners work independently, while others support NDOH sites; but all comply with NDOH policies. NDOH-supported sites integrate CT services within a comprehensive health service package. Levels of support to NDOH 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 SA USG team conducted an internal, paper-based, partner evaluation with all partners this year. Partners submitted an early modified COP, which probed in areas that needed clarification in various aspects such as improved service delivery and gaps for each program area. The data from the partner evaluation provided a broad review of the PEPFAR CT partners. The South African USG CT team is actively responding to the need for improvements in areas such as TB screening for all CT partners and utilization of multiple CT models per partner and site.

An increasing number of partners are offering mobile, stand-alone, and traditional VCT services. In addition, there has been evidence of a steady increase of partners providing ROCT, known as provider-initiated testing and counselling. A few partners are piloting home-based CT, a new model in South Africa, but one that might complement other models to increase access in South African. In all nine provinces, there is at least one partner proposing to implement home-based CT. Home-based CT is mainly proposed in rural areas where services are not easily accessible. Workplace CT is another important model that is being implemented by several partners in South Africa. Finally, couple HIV counselling and testing is being implemented on a large scale in the country. The biggest challenge in South Africa, however, is attracting clients to come as couples for CT. Partners have therefore proposed interesting and innovative ways of attracting couples, such as opening for longer hours and partnering with churches and other organizations where people go as couples. Partners aim to attract both married and cohabitating couples.

The 2008 COP indicated that there was a large gap in geographical distribution of services, particularly in the provinces of Free State, Northern Cape, and the North West. This year, however, partners are distributed more evenly, and all the provinces have some coverage with a variety of models. Each province has more than five partners providing CT services. Provinces such as KwaZulu-Natal and the Eastern Cape, which have a higher disease burden, have more partners working in the area. Models such as home-based and mobile CT are largely used to serve the rural populations.

The FY 2007 CT target was estimated by reviewing the ART targets for each year over a five-year period in order to reach 500,000 persons on ART by September 2009. Over the past three years, approximately 19 people were tested for HIV per every one person placed on ART. The September 2008 and 2009 CT targets are estimated at 2,036,000 for each year.

About 80% of public health facilities offer VCT nationwide through 4,000 public VCT service points. Though this may seem adequate, recent data show that only 2% of persons who need to be tested undergo testing. This means that while testing services are accessible in most health facilities around the country, only a few people in the

target population (age 14–49)utilize the services. One of the target populations for CT services is men and partners have proposed methods of attracting men to test for HIV. The NSP sets new targets for CT to ensure that all persons at risk get tested, especially those at highest risk who present at clinics for family planning, sexually transmitted infections, antenatal, and TB services and those in high transmission areas. The NSP recommends provision of ROCT in health facilities. It sets a target of 75% of all public health facilities using this model by 2011. The ROTC model is used in addition to the standard VCT and other CT models.

The South African government provides test kits to public health facilities as well as to selected stand-alone and mobile CT facilities. Some NGOs, however, need to purchase their own supplies. This makes it difficult to calculate average cost per target, and in an attempt to remedy this, partners have been asked to provide an explanatory narrative in their COP entries to explain costs related to CT services. Given all the different circumstances, the average cost per target for South Africa in the 2009 COP is $22.50 USD (R225.00).

All partners described their training activities in COP FY 2009. The PEPFAR guidance for COP FY 2009 discouraged training on traditional VCT. Instead, partners were encouraged to identify gaps and provide more training on ROTC, couple counseling, and quality assurance. The South Africa USG team will review partner training activities in 2009 to ensure that multiple aspects of training and evaluation are taking place.

As more people become willing to undergo HIV testing and counseling, the need for quality assurance increases. In addition to increased demand for CT services, the NDOH approved, last year, five test kits to be used. This meant that each province was assigned different combinations of test kits, which may have led to a lack of standardized procedures and thus decreased quality of testing. The USG is currently working with the NDOH and the NICD to strengthen quality management systems and particularly, quality assurance and quality improvement.

The amended Children's Act that allows children aged 12 and upwards to consent to HIV testing has also affected CT service providers. Many counselors are not comfortable discussing sexual issues with children and adolescents as they have not received any training on these target populations as yet. There is an urgent need for more training on counseling children and adolescents.

In FY 2009, USG programs will support the SAG in their efforts to update policy, guidelines, training, and mentoring to increase the demand for and the availability of quality CT services that are primarily conducted in government facilities. All USG CT activities are linked to clinical care, support, and treatment activities in order to ensure that individuals who test positive for HIV have access to needed services. USG programs use several different models to achieve the best results including mobile CT programs targeting high-risk populations, underserved communities, and men, as well as stand-alone and traditional voluntary counseling and testing (VCT) services, home-based CT in rural areas where services are not easily accessible, couple HIV counseling and testing, and workplace CT services.

CARE:

Total budget: $129,647,683

Adult Health Care and Support

Challenges are great for Care and Support (C&S), as the majority of SAG funding for HIV & AIDS is for ART-related services. With the transition to a newly elected government in South Africa in FY 2009, it is envisioned that even greater cooperation between the SAG and USG will allow for collaboration on key issues, including accelerating accreditation of facilities, decentralizing care and treatment services to nurse-driven clinic level, and establishing better monitoring and evaluation indicators and systems in the public sector.

In FY 2009, the USG will continue to use a minimum requirement for someone receiving C&S, including palliative care, which reflects a minimum standard of HIV-related services, thus aligning the program more closely to World Health Organization (WHO) standards. An HIV-infected individual must have received at least one form of clinical and one other type of non-clinical care. 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.

South Africa has a generalized mature HIV epidemic and HIV care and treatment services are required across the entire population. However, population-based data has shown that the highest burden of HIV is in urban and peri-urban areas. The USG utilizes prevalence information to direct its assistance to areas of greatest need, especially to ensure equitable access to ART for lower-density rural populations. C&S is delivered at all levels including hospitals, clinics, workplaces, hospices, and home-based programs in communities.

The key C&S priorities for the USG in FY 2009 are to strengthen quality HIV and AIDS palliative care service delivery and implement standards of care. PEPFAR will support this effort by working closely with the SAG to:

- 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
- 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
- building active referral systems between community home-based caregivers (CHBC) and facility services
- developing quality assurance mechanisms, including integration of supervision systems and standardization of services and training, and
- translating national policy, quality standards, and guidelines into action, particularly national adoption of the basic care package.

PEPFAR partners will advocate for new national guidelines to improve access to pain management including the authority for nurse prescription and a national palliative care policy. In collaboration with SAG, FY 2009 funds will scale up direct delivery of quality palliative care services.

All PEPFAR-funded care partners follow SAG standards, policies, and guidelines. The USG program continues to strengthen comprehensive high quality care for HIV-infected and affected people by:

- scaling up existing effective programs and best practice models in approximately 900 public, private, and NGO sites in all 9 provinces
- providing direct care and treatment services through prime partners and their sub-partners
- increasing the capacity of the SAG to develop, manage, and evaluate care and/or treatment programs, including recruiting additional health staff, training and mentoring health workers, improving information systems, conducting public health evaluations, and providing infrastructure assistance
- increasing demand for and acceptance of ART through community mobilization
- ensuring integration of ART programs within palliative care, TB, reproductive health, sexually transmitted infections (STI), and PMTCT services, and
- assisting in the accreditation of facilities for ART initiation.

Key linkages are made with prevention and wellness programs that provide ongoing support for patients once they have tested positive for HIV, including opportunistic infection (OI) management, cotrimoxazole prophylaxis, and prevention with HIV-infected individuals. Care and treatment services are an ideal setting for formulating prevention messaging to HIV-infected clients and their families. Wellness programs are linked to strong community programs, notably home-based care networks that extend care from the facility level to the home.

Proposed care and treatment activities for FY 2009 include patient information systems, logistic support for commodities and pharmaceuticals, and public-private partnerships to deliver ARV services at workplace settings and through private practitioners serving the uninsured in remote areas. A significant contribution of PEPFAR-funded care and treatment partners to strengthen the health system is to address the human resource needs in the public sector through different strategies, including consultancies and secondments, national and international fellowships, internship and mentorship programs, and comprehensive clinical and management training all in collaboration with the SAG policies.

The USG supports a holistic, family-centered approach to HIV and AIDS care that begins at the onset of HIV diagnosis, continues throughout the course of chronic illness, and finalizes in end-of-life care. In order to ensure that all HIV-infected clients have access to basic care services and to minimize loss to initiation (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, who are eligible, receive cotrimoxazole as per national guidelines. This package of services will be offered at community level through support groups. These support groups, primarily run by people living with HIV (PLHIV), will serve as a link between the health facilities and the community to ensure a continuum of care. CT 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 2009 investments will result in an improved continuum of clinical, psychological, spiritual and social care, and prevention services for PLHIV. The NDOH leads and coordinates national efforts to advance palliative care. Partnering with the NDOH at all levels, the 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, as well as reproductive health services, STI sites, workplaces, and community home-based caregivers (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 minimum care standard for facilities includes the following elements of the preventive care package and other essential care interventions, including:

- prophylaxis and treatment for OIs, per national guidelines, cotrimoxazole prophylaxis for stage III-IV disease, CD4<200 or HIV-exposed/infected children; TB screening and management; isoniazid preventive therapy in selected sites, and candidiasis screening and management where the Diflucan/fluconazole partnership exists
- CT to partners and family members
- nutrition counseling, clinical measurement and monitoring, micronutrient support according to WHO guidelines, and wrap-around support
- STI care
- routine screening and management of pain and symptoms
- child survival interventions for HIV-infected children (e.g., immunizations, growth monitoring, and infant/young child nutrition)
- integrated PwP strategies including messaging, condoms, support for disclosure, referral for family planning, PMTCT services, ART adherence education, leading healthy lives, 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, and
- referrals for other services.

The minimum standards for services at CHBC levels include messaging, mobilization, and referral (with follow-up) for the above mentioned services. In addition, it also includes 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 insecticide treated nets where appropriate. Home and community settings often facilitate delivery of a more comprehensive response including the provision of bereavement care, household

support, and community group meetings. PEPFAR partners will continue to strengthen adherence to national standards 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 non-governmental and faith- and community-based organizations.

Pediatric Care and Support:

Care activities in South Africa include adult and pediatric care and support, TB/HIV services and activities, and support for OVC. With 5.7 million HIV-infected individuals, the care needs of patients suffering from HIV and AIDS place a severe strain on health services. In FY 2009, USG care activities will strengthen quality HIV and AIDS care and support service delivery, implement standards of care, and scale-up direct delivery of quality care and support services. PEPFAR will support and strengthen the integration of the basic care package and family-centered services across all care and treatment programs for adults and children living with HIV increase the number of trained healthcare providers, build multidisciplinary teams to deliver quality care with symptom control, and improve human resource strategies. PEPFAR partners will also ensure active referral systems between community home-based caregivers and facility services.

The key PEPFAR C&S priorities focusing on pediatrics in FY 2009 are to strengthen quality HIV and AIDS palliative care service delivery and to implement standards of care. PEPFAR will support this effort by:

- 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
- 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
- building active referral systems between CHBC and facility services
- developing quality assurance mechanisms, including integration of supervision systems and standardization of services and training, and
- translating national policy, quality standards, and guidelines into action, particularly national adoption of the basic care package. PEPFAR partners will advocate for new national guidelines to improve access to pain management including the authority for nurse prescription and advocate for a national palliative care policy. In collaboration with SAG, FY 2009 funds will scale-up direct delivery of quality palliative care services.

In FY 2009, the USG will continue to use a minimum requirement for someone having received C&S, including palliative care, which reflects a minimum standard of HIV-related services, thus aligning the program more closely to WHO standards. An HIV-infected individual must have received at least one form of clinical and one other type of non-clinical care. 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.

Tuberculosis/HIV:

South Africa has one of the highest estimated TB rates in the world, ranking fourth among the 22 high burden countries. According to 2006 National TB Control Programme (NTP) data, there were more than 341,165 reported cases of TB, at a rate of 628 per 100,000 populations. The real prevalence is unknown but the WHO estimates it to be much higher than these statistics.

Of all new and re-treatment cases notified in 2006, only 110,235 or 31% were tested for HIV. Of those, 55% tested positive. Of the detected HIV-infected TB patients, 98% received cotrimoxazole therapy, and 40% had initiated ART. Systematic TB screening among PLHIV has been low; 29% of patients screened were infected with TB. Isoniazid Preventive Therapy is not widely implemented.

MDR/XDR-TB continues to create many challenges for the SAG. Between 2004 and early 2007, South Africa reported 898 cases of XDR-TB. Due to lack of culture and drug susceptibility testing services in Limpopo and Mpumalanga, these provinces did not report any cases during that period. The total number of reported drug-resistant cases may represent a small proportion of the actual incidence. Reported case fatality rate among HIV-infected individuals with MDR/XDR-TB is alarmingly high. Ghandi et al (2006) reported 95% mortality among HIV-infected patients with XDR-TB in KwaZulu-Natal. The median survival was 16 days from time of diagnosis, and this was established among 42 patients with confirmed dates of death (Gandhi, et al.). This has serious public health consequences, for South Africa, and for the African region.

NTP results in 2006 show a case detection rate of sputum positive TB cases at 71%. Nevertheless, there has been little progress in treatment outcomes; cure rate for new smear positive cases is still low at 58% and the overall treatment success rate is 71%, lower than the African regional rate of 76%. Default rates at 10% are high. High treatment interruption rates of drug-sensitive TB and consequent low cure rates, together with the HIV epidemic, have contributed to the emergence of drug-resistant strains that require urgent attention.

South Africa adopted the WHO Directly Observed Treatment Short Course in 1996, and since 2006, this strategy has been expanded to all districts. Phased implementation of TB/HIV collaborative activities by sub-districts started in 2002. The aim was to focus on the primary health care level and build capacity among staff to manage co-infected patients and thus prevent unnecessary hospital admissions and deaths. By the end of 2006/7, 211 sub-districts were implementing TB and HIV activities (87%). In 2005, the SAG declared TB a national crisis and developed the TB Crisis Management Plan focusing on three provinces, Gauteng, KwaZulu-Natal, and Eastern Cape, with four districts within those provinces having the highest burden of TB and poor treatment outcomes. The SAG intensified efforts to reinforce service delivery systems and

processes at facility levels and to increase community awareness and engagement in TB control. Since then, two crisis districts have graduated from the crisis level.

In 2007, the NDOH created a separate directorate for National TB Program and finalized the five-year National TB Strategic Plan, which highlights TB/HIV. Additionally, the NSP espouses integration of TB and HIV services as essential to ensuring that co-infected patients receive appropriate care and treatment. SAG investment in TB control is significant, but due to decentralized funding channeled through provincial treasuries, NTP is unable to quantify the resources committed to TB control. Sixty-eight percent of total central level funding for TB is dedicated to MDR-TB.

Although interaction between TB and HIV has been recognized and collaborative efforts are being scaled-up, TB and HIV programs continue to be implemented separately. As outlined in NTP's strategic document, collaborative activities between NTP and HIV & AIDS and STI departments has not been fully realized because of lack of written formal guidelines on collaboration, and because of limited integration of services at health facilities. This includes inadequate technical support, guidelines, and registers for monitoring and evaluating integrated TB and HIV services. Other constraints to effective TB/HIV collaboration include:

- human resource constraints at district and facility levels and within laboratory services
- lack of decentralization of laboratory networks (services and systems) resulting in decreased access to sputum smear microscopy, delays in reporting results, scarce and overburdened culture and drug susceptibility testing services, and communication challenges between NTP and laboratories
- different program approaches and cultures of TB and HIV services (i.e., TB services are decentralized into primary health-care clinics, are nurse-driven, and TB control occurs at facility level, which lacks wide-spread community engagement, while HIV and AIDS care services are usually hospital-based, physician-driven, and have established linkages with communities)
- threat of nosocomial transmission of TB and MDR/XDR-TB, with evidence of facility and community transmission in the context of large-scale HIV care and treatment programs
- little attention to appropriate TB infection control measures in healthcare facilities and congregate settings, although NTP has recently developed TB infection control policy and guidelines
- TB/HIV records not fully integrated at facility level, especially in HIV clinical and care settings as entry-point to TB management
- referral and counter referral systems between TB and HIV programs are not yet in place. Improved collaboration between TB and HIV programs is required to ensure access to integrated quality-assured diagnostic, care, and prevention services for PLHIV and those at risk for TB infection and disease.

USG activities are consistent with NDOH and WHO TB/HIV policies and guidelines and continue to build on past achievements. PEPFAR will scale-up efforts that improve effective coordination at all levels, decrease burden of TB among PLHIV, decrease burden of HIV among TB patients, improve prevention, detection, and management of

MDR/XDR TB in HIV-infected patients, strengthen laboratory services and networks, and strengthen health systems to ensure quality and sustainable care.

USG resources and technical assistance complement NDOH efforts in a broad range of TB/HIV activities at organizational and service delivery levels. At an organizational level, USG supports the strengthening of mechanisms for collaboration at all levels, and developing and implementing strategies to address TB/HIV, and MDR/XDR TB. PEPFAR will continue to support NDOH's efforts to improve linkages for joint policy development, planning, implementing, and monitoring TB/HIV integrated activities. Other activities include improved surveillance of TB/HIV and MDR-TB and enhanced human resource development that respond to needs posed by integrated TB/HIV programs. Activities at service delivery level include those that streamline continuity of care for co-infected patients by ensuring effective referral linkages between TB and HIV services as well as between these services and community and home-based care. To decrease burden of TB in PLHIV, USG-supported activities will include scaling up the Three Is. This includes:

- Intensified TB case finding in HIV services (e.g., VCT, PMTCT, and OVC, strengthening referrals to TB program for diagnosis and treatment, or provide TB treatment in settings where appropriate)
- Isoniazid Preventive Therapy for clients in whom TB has been ruled out, and
- Infection control (IC).

TB IC (aligned with the WHO-10 point plan) will include training, developing policy, assessing facilities, and purchasing equipment. In addition, nutritional support (e.g., food gardens), health education, and empowerment programs are supported. To decrease the burden of HIV in TB patients, activities will include scaling-up provider-initiated HIV counseling and testing in TB clinics, prompt referral to HIV treatment and care services for those dually infected, cotrimoxazole for co-infected patients and in some instances, initiation of ART within TB clinics, including facilities that provide MDR treatment.

Activities to prevent, detect, and manage MDR/XDR TB patients build on current efforts outlined in NTP's Strategic Plan and will feature scaling-up TB IC practices in health care and congregate settings and community-based directly observed treatment through USG-supported initiatives, such as home-based care. In addition, systems will be strengthened to improve timely access to quality assured culture and drug susceptibility testing and to improve coordination with provincial health departments to ensure appropriate case management of all suspected and confirmed MDR/XDR TB patients. Social mobilization efforts that inform and engage communities to reduce stigma, improve early access to diagnosis and care of TB and HIV, and enhanced community-based directly observed treatment will also be supported. TB/HIV and MDR surveillance efforts include enhancement of the ETR.Net software that renders measurement of TB treatment outcomes by HIV status. TB/HIV and MDR data collection tools have been revised, and the new tools should help encourage widespread TB/HIV and MDR surveillance.

The USG, in collaboration with NDOH and NHLS, supports strengthening laboratory services to ensure effective health systems response to appropriate and timely referral

and counter referral. This includes activities that enhance good practices in sputum collection, improve turn-around-times for test results for sputum smear microscopy and culture, and activities that ensure availability of HIV test kits and enhance quality assurance programs. New initiatives to improve information systems to enhance program and clinical management include the design, development, and pilot test of an integrated electronic TB/HIV Patient Management System. Features of this system are automation of routine TB registers, suspect TB-Register, pre-ART and ART-registers, electronic interfaces between laboratory and program registers for uploading laboratory requests, and downloading laboratory results, that can also produce reports at facility, districts, provincial and national levels. The USG supports NHLS by leveraging resources for accelerating implementation of rapid PCR assay that allows for typing of TB strains in a short time.

Emerging concerns about interaction between TB, HIV, and drug resistance came to the forefront in 2006. Efforts to understand and control these threats have begun and will be accelerated through 2009. The USG also supports several public health evaluations to identify improved methods for rapid screening and diagnosis of TB in co-infected patients and to improve referral networks between HIV and TB services.

With regards to sustainability, the USG works closely with NDOH to enhance collaboration, develop policies and tools, and build capacity of service providers. The USG will work closely with public and private sector partners to capture best practices and to ensure that these support policy development. Increased emphasis on strengthening management systems, such as human capacity development, planning, supportive supervision, monitoring, and evaluation, will also help to sustain gains.

The USG TB/HIV program is complemented with non-PEPFAR funds through USAID's Operational Plan (OP) for TB. USAID provides extensive support to implement NTP's TB Strategic Plan at all levels. This includes development, implementation, and scale-up of service delivery models to address challenges from increasing TB/HIV and MDR/XDR TB incidences, as well as strategies to improve linkages with communities. These efforts are reinforced at community level through implementation of culturally sensitive social mobilization activities. USAID's Operational Plan for TB provides extensive assistance to crisis districts and continues to support expansion of strong public-private partnerships. USAID is also supporting the development of training materials for management of TB in children. Mechanisms, such as the PEPFAR TB/HIV Task Force, are well established to enhance coordination within and among the PEPFAR team.

The PEPFAR TB/HIV team continues to liaise with international donors and complement activities with agency-specific non-PEPFAR funded activities to ensure collaboration. Several international donors support TB/HIV activities, including Belgian Technical Corporation, UK DFID, Italian Institute of Health, Japanese International Cooperation Agency, Bill and Melinda Gates Foundation, The Global Fund, and the EU. Recent information indicates that there is some donor overlap. In 2008/2009, PEPFAR will increase coordination efforts to reduce duplication of efforts and resources. Collection and review of up-to-date information on donor supported TB/HIV activities will feed into PEPFAR's efforts to develop a country-specific TB/HIV strategic plan in collaboration with the NDOH by March 2009. The plan will be driven by the NTP and NSP, as well as by OGAC and WHO TB/HIV guidelines. A task force, with representation

from SAG, USG, and implementing partners, will meet regularly to influence the development of USG's TB/HIV strategic plan. In addition, a two-day workshop with TB/HIV implementing partners will be held in early 2009 to provide a venue for sharing best practices, discuss common issues and gaps in TB/HIV, and make recommendations that will feed into the plan. This plan will inform PEPFAR II planning as a South Africa inter-agency team and will establish networking mechanisms among partners to support sharing of best practices.

PEPFAR will ensure regular monitoring and supervision of OGAC program indicators through regular site visits by multidisciplinary teams (TB and HIV) and development and implementation of a standard checklist for these site visits. These activities will be enhanced through the South African PEFPAR Partner Assessment Contract in FY 2009. In addition, all USG Activity Managers will ensure that all assessment and/or training modules include appropriate components of TB/HIV integration and management.

TB/HIV programming will be prioritized in FY 2009. Since FY 2006, USG efforts to address TB/HIV services have been expanded. In FY 2008, over $30 million (R300 million) was invested in TB/HIV, approximately 5% of the PEPFAR budget in South Africa. In keeping with OGAC guidance to expand TB/HIV programming, close to $31 million (R 310 million) is requested in FY 2009 by 34, mostly indigenous, partners.

In FY 2009, PEPFAR activities will intensify efforts to respond to the challenges of the world's largest TB and HIV co-infection numbers and increasing rates of both MDR-TB and XDR-TB. The USG, in coordination with the SAG, will scale up efforts to strengthen effective coordination between TB and HIV services from national to district levels, and improve linkages for joint policy development, planning, implementing, and monitoring of TB/HIV integrated activities. PEPFAR activities will work to improve surveillance of TB/HIV and MDR-TB, provide training and technical assistance for staff working in integrated TB/HIV programs, increase access to TB/HIV services, and ensure effective referral linkages between TB and HIV services as well as between these services and community and home-based care. The USG program hopes to provide intensified TB case finding in HIV services and referrals to TB programs for diagnosis and treatment, as well as routinely offered HIV counseling and testing in TB clinics and prompt referral to HIV treatment and care services. USG partners will work with the NDOH to improve infection control policies and systems in hospitals and clinics in order to limit the spread of TB. Laboratory partners will scale up timely quality assured laboratory services for TB/HIV and rapid diagnostics for TB and MDR-TB to improve early detection and management of persons suspected with MDR/XDR-TB. USG efforts will also improve information, monitoring and evaluation, and management systems to enable a concerted and effective response.

Orphans & Vulnerable Children:

South Africa's HIV pandemic continues to create a rapidly growing number of vulnerable children who are without adult protection and have uncertain futures. Of South Africa's 18.2 million children (38% of the population), about 3.8 million children have lost one or both parents (21% percent of all children)[1]. The burden of HIV and

[1] SA Child Gauge 2007/2008, Children Institute, University of Cape Town

AIDS on children has greatly increased in the last five years with the number of orphans increasing substantially by 750,000 due to the effects of the HIV epidemic. While it is estimated that 1.4 million children have been orphaned by AIDS, a much larger number are considered to be highly vulnerable to the pandemic that surrounds them, according to 2007 Actuarial Society of South Africa estimates using a 2003 model.

Working in all nine provinces, the USG approach supports programs that are firmly aligned with and in support of the South African strategies that include the *Policy Framework for Orphans and Vulnerable Children made Vulnerable by HIV and AIDS in South Africa*, (July 2005), the *National Action Plan for Orphans and Vulnerable Children and Other Children Made Vulnerable by HIV and AIDS*, the *National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS*, and the NSP. In November 2007, the Children's Amendment Act No. 41 of 2007 was passed, and provides a framework for a comprehensive range of social services needed to support vulnerable children and their families. At the core of the Children's Act is the South African government's commitment to delivering social services that will strengthen and support families and communities to care for and protect children.

The USG provides direct assistance to the National Department of Social Development (NDSD) and works together with both local and international partners to improve and scale-up existing, effective OVC programs to provide protection, care and support services to OVC. At the end of March 2008, 23 PEPFAR partners had reached 215,056 OVC with primary and supplementary direct services. In addition, 10,978 OVC were reached indirectly and 17,418 individual caregivers were trained to provide quality services to OVC.

PEPFAR programs in support of the NDSD maintain a focus on the child through the family and the household. Families are the most influential force in the lives of children and adolescents. This is central to the USG program in South Africa and to the activities supported by Hands at Work, Child Welfare, World Vision, and other PEPFAR-funded OVC partners. These OVC programs aim to strengthen the capacity of the family and the community. This family focus is a critical opportunity to expand reach to other members of the family and the community and is an opportunity to integrate the OVC programs with other prevention, treatment, and care interventions. In FY 2009, care for the caregivers continues to be a central area of focus for USG partners in addition to continued training of volunteers, caregivers, and community-based organizations to address service delivery issues. The National Association of Child Care Workers (NACCW) "Isibindi" Child and Youth Care workers model of care ensures that ART is available for adults and children as part of their delaying orphanhood program. Child and youth care workers are trained to identify households and families that require clinical services and through a system of referrals to a network of clinical care services specifically linked to Isibindi ensure that mothers and caregivers get tested early and access ART. This intervention has resulted in mothers accessing ART and 294 children (October-March) being assisted to access pediatric ART and their households receiving home-based care and adherence support. USG-supported OVC programs continue to link with pediatric and adult treatment programs. Initially this is done through VCT programs to encourage HIV testing of OVC and their caregivers to ensure that both HIV-infected OVC and their caregivers have access to treatment and palliative care services. In FY 2009, the USG will continue to work with OVC partners like Children in Distress to

highlight the scale-up and integration of OVC interventions in PMTCT, VCT, treatment, and wrap around programs.

To ensure quality, the USG has defined direct service provision as each child receiving a minimum of three services from a menu of eight services. These include

- targeted, short-term food and nutritional support
- shelter and care
- child protection
- assistance in accessing healthcare
- psychosocial support
- increased access to education and vocational training (including school fees, uniforms, tutoring etc.)
- assistance in accessing economic support (accessing social grants, income-generation projects, etc.),and
- community mobilization.

In FY 2009, the USG will support the NDSD to review and develop quality standards for these basic services. Once developed and shared with stakeholders, these standards will reflect an expected level of service delivery and performance and will be used to assess the overall impact of services provided to each child. These standards will be used by NDSD and partners to define quality and to measure and improve services provided to children to ensure a positive impact. Save the Children UK is currently field-testing a quality assessment tool using a modified version of the Child Well Being Assessment tool, which has now been simplified and translated into one of the local languages.

Better data and increased understanding of the multi-faceted needs of adolescent OVC and identification of OVC interventions that are effective in addressing these needs are critical to the scale-up of service delivery for OVC in South Africa. The scale-up of services for OVC is desperately needed to maximize impact and minimize wasted expense. Program design and resource allocation needs to be guided by a base of documented evidence. To fully implement National Plans of Action for OVC, governments, donors, and program managers need information on how to reach a greater number of OVC more cost effectively with services that improve their well-being. Working hand in hand with the NDSD, the USG will participate in a public health evaluation that will evaluate programs for adolescent OVC with the overall goal of improving the impact of service delivery for this highly vulnerable and underserved population. This activity will enhance USG and NDSD programmatic efforts by providing a better understanding of the situation of adolescent OVC, identifying best practices for meeting their needs, and documenting promising practices.

Working with the NDSD, the USG will provide documented evidence of the effectiveness of the NDSD recommended models of care for vulnerable children. The USG will support the NDSD in documenting the Child Care Forum (CCF) model to respond to the increasing needs of children and to provide support to OVC at the community level. CCFs are a mechanism to build capacity in community-based systems for sustaining care and support to OVC and households over the long term. Prior to the scale-up and replication of this model, the USG will assist the NDSD in providing evidence of the effects and effectiveness of this model of care. The same process will also be used for the

NACCW Isibindi model, which is implemented as a social franchise with the NACCW entering into formal partnerships with implementing organizations linking NDSD, the donor, the community, and implementing partner in a network of social delivery. This model has encouraged the private sector to fund Isibindi projects, often co-funding them with NDSD. Initial documented evidence on the model shows the impact of the activities undertaken and the multi-disciplinary approach that allows resources to be accessed from multiple sources (both government and non-government). The Isibindi model is an award-winning best practice model of care that the NDSD would like to scale-up and replicate.

USG partners will focus on improving the quality of OVC program interventions, strengthening coordination of care especially at the district level, and expanding initiatives that reach especially vulnerable children (e.g., under fives, disabled children). Several USG-funded programs have developed focused interventions to reach the especially vulnerable child. For example, NACCW has been working to reach disabled children and has trained disability facilitators to identify, refer, and provide ongoing therapeutic services to disabled children. Several USG partners in FY 2009, e.g., South African Catholic Bishop Conference and Woz'obona Childhood Community Service Group, will replicate this intervention. In addition, USG assistance has and will continue to focus on reaching especially vulnerable populations through Early Childhood Development Interventions with Nurturing Orphans for Humanity, CARE-South Africa's local sub partners, Hands at Work, and Woz'obona Childhood Community Service Group.

In collaboration with NDSD, USG has begun the development of a vulnerable children service directory and web database, which will be completed in FY 2009. The directory will increase the level and effectiveness of referrals for vulnerable children to receive comprehensive services. As part of this activity, service delivery mapping will be done, which will provide information that the USG and NDSD will utilize in strategic positioning of expanded or new service sites for OVC.

The USG supports programs that focus on supporting child-headed households, such as safe parks and other safety zones for providing young girls with sustained interaction from a trusted adult, and providing information on life skills and HIV prevention education. The USG continues to support the Vhutshilo (Tshivenda, meaning "life") peer education program, a structured 13-session curriculum-based peer led prevention and support group intervention for vulnerable 10 – 13 years olds using 16-19 year old peer educators. This program has been replicated in several other OVC programs. The program promotes resilience in vulnerable children by building or strengthening social structures through which young vulnerable children learn new skills, receive and provide support from their peers in similar circumstances, and build trust to maintain strong social connections. In FY 2009, the USG will assess the impact of this peer education intervention in terms of its psychological and HIV prevention education effects on vulnerable children. This activity will be a basic programmatic evaluation, and to the extent possible, threats to internal validity will be managed.

In FY 2009, USG will continue to bring OVC partners and the NDSD together in annual meetings to disseminate and share promising practices and innovations. This will provide an opportunity for partners to build their knowledge base, hear innovative

interventions, share lessons learned and emerging good practices, and note the results from research in the OVC arena. In 2008, the USG documented, in video format to allow for widespread sharing between partners, the successful voluntary savings and loan methodology that allows poor rural women to save and make small loans in a closed savings environment. With technical assistance from MEASURE Evaluation, the USG developed and documented 32 case studies on the various OVC program models within South Africa. A synthesis report considering results from all 32 case studies will help to identify various strategies in meeting the needs of OVC and their guardians, highlight gaps in service delivery, and identify best practices relating to improving the effectiveness and increasing the scale of OVC interventions. The USG and the NDSD hosted the Nigeria OVC team (both Nigerian government and USG), providing a learning opportunity for south-to-south sharing that resulted in strong links and learning between the two programs.

In South Africa, the USAID Prevention and OVC Team lead serves as the OVC program focal point and is supported by a two-person OVC technical team with a small OVC working group to monitor and review USG OVC activities in South Africa.

In FY 2009, USG assistance will continue to build local capacity, encourage coordination, and support NDSD strategic programming. While several OVC partners have developed innovative gender and child participation interventions (e.g., NACCW's girl child program and World Vision's *The Courage to Become Me program*) most partners still face a challenge in incorporating gender into their day-to-day implementation of activities. In FY 2009, the USG will focus on providing technical skills and training in gender integration to enable the partners to integrate gender into all their activities (especially in the area of vocational training). Working to shift gender roles, OVC partners will be encouraged to include gender equality into implementation of their program and working in communities, to have discussions and to take action for a more gender equitable community. Having adequate systems and processes in place to measure progress and quality in the area of monitoring and evaluation is critical in assuring that positive impact is being made in improving the well being of OVC. Increased human capacity development efforts are needed in this area. USG will continue training to build the human resource capacity of both the partners as well NDSD in the area of monitoring and evaluation.

The USG continues to work closely with the United Nations Children's Fund (UNICEF), including sharing information and assessment results. The USG program in South Africa continues to complement the efforts of the NDSD and other donors to leverage resources and to ensure that there is no duplication of effort.

USG care and support of OVC will include providing financial and technical assistance to OVC programs, focusing on mobilizing community- and faith-based organizations to improve the number and quality of services provided for OVC. These programs encompass the entire care and support continuum, including psychosocial and nutritional support, maximizing OVC access to SAG benefits, and strengthening OVC support through referrals for health care, support groups, and training. Working with the SAG, USG will document the effects and effectiveness of two models of care and support for OVC that the SAG would like to scale up and replicate. In collaboration with the SAG, the USG will support the development of a vulnerable children service

directory and web database that will increase comprehensive services coverage for vulnerable children and guide strategic expanded or new service sites for OVC. In FY 2009, the USG will develop innovative gender and child participation interventions, provide technical skills and training in gender integration to enable the partners to integrate gender into all their programs, and support training to measure and ensure progress and quality monitoring and evaluation.

TREATMENT:

Total budget: $213,129,130

Antiretroviral Drugs

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 (including several generic drugs) through the Medicines Control Council. Due to these stringent controls, parallel importation is not within the SAG policy.

Currently, of the 98 generic ARV drug formulations that have been approved by the FDA and can be purchased with PEPFAR funding, there are only 23 that are also registered by the Medicines Control Council and can be purchased in South Africa with PEPFAR funding, 12 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 PEPFAR 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 funds support NGO partners to expand treatment to specific target groups, including people with TB, men, and people in workplace settings. Another important focus extends ART through general practitioners at community clinic sites, especially in rural communities, which serves to increase access beyond the current SAG accredited roll-out 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 SAG. Some of these NGO and private partners either obtain (at no cost) or procure their drugs through provincial health departments.

In FY 2009, there will be an emphasis on creating capacity at the primary health-care 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 within 24 hours. Some of the treatment partners may utilize the Partnership for Supply Chain Management in FY 2009 for limited procurement, distribution, and to handle emergency procurements in the event of stock-outs.

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 NDOH awards centralized tenders for all ARV drugs procured by provinces. There were no reported stock-outs of ARV drugs in FY 2008. There were shortages of cotrimoxazole, but this was due to the global manufacturing shortage. 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 occur in PEPFAR programs that obtain drugs through the SAG, private sector pharmaceutical suppliers are positioned and ready to provide the necessary back-up supplies in FY 2009.

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. As a result, the SAG is in the process of revising the national guidelines to allow for switching first-line drugs, including tenofovir, to deal with these adverse reactions. These revised guidelines may raise the threshold for ART initiation to a CD4 count of 250, which will increase the number of people eligible for ART and thus lead to an increase in drug procurements.

The USG provides critical onsite assistance through its partners at public sector facilities. This assistance aims to strengthen and improve 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 2009.

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 ART in the Western Cape and KwaZulu-Natal provinces, and one PEPFAR partner, CAPRISA, receives Global Fund support for the purchase of ARV drugs.

In FY 2009, USG programs will build on the achievements of the last five years of supporting the largest ART program in the world. The USG will develop human capacity, especially at primary healthcare level, strengthen integration of HIV care and treatment into primary health care, build capacity for nurse-initiated ART, improve pediatric HIV care and treatment, and encourage early identification of those in need of HIV care and treatment services through provider-initiated CT and improved linkages to CT services.

Partners will also ensure CD4 testing for those that test positive for HIV, integrate TB care for HIV-infected clients (including screening and treatment), continue to strengthen the integration of treatment programs within other health interventions (e.g., PMTCT, cervical cancer screening, and reproductive health), and reduce loss to initiation of treatment of people that test positive for HIV and loss-to-follow-up once on ART.

During FY 2009, PEPFAR will support the NICD and the NHLS to improve the quality of HIV diagnostic tests and expand access to HIV, CD4, and TB testing nationally. PEPFAR programs will assist the SAG in training staff in 4,000 VCT sites on proper HIV testing procedures and quality management systems and training South African epidemiologists and laboratory workers. PEPFAR support will enable NICD to provide strategic information on HIV-1 and TB national drug resistance and transmission, other opportunistic infections in people living with HIV, and trend data of HIV incidence to help inform the decisions of policy makers and program officials regarding their HIV prevention and ART roll-out programs. PEPFAR will support new collaborative NHLS activities to increase national coverage of HIV and TB testing and treatment monitoring, ensure quality in all laboratories, strengthen laboratory reporting systems in support of rural clinics and laboratories, and improve infection control. In addition in FY 2009, PEPFAR will increase national coverage of HIV testing in remote rural areas.

Adult and Pediatric Treatment:

The *2003 Comprehensive Plan for HIV and AIDS Care, Management and Treatment* (Comprehensive Plan) states that its primary aim is comprehensive prevention, care, and treatment for all in need with the target of universal access to ART over a five-year implementation period (2004–2009). The goals of this plan are reiterated in the new South African *National Strategic Plan for HIV & AIDS and STI, 2007-2011* (NSP). The joint effort of the SAG and USG have contributed significantly to these goals and targets, and with the support of the PEPFAR program, 550,000 people are currently on ART in South Africa, and more than 1.4 million people receive appropriate care and support, including palliative care. South Africa has exceeded its PEPFAR treatment target of 500,000 set for September 2009 one year early and continues working with the SAG to progress to meeting the care and support targets. The PEPFAR-funded treatment programs have maintained excellent retention since implementation in 2004. Cumulatively, only 15% of patients started on ART have died, stopped ART, or were lost to follow-up. Treatment and care partners are progressively improving their capacity to measure outcomes.

The key treatment priorities for the USG in FY 2009 are working in cooperation with the SAG to:

- developing human capacity, especially at primary healthcare level
- strengthening decentralization of HIV care and treatment, including building capacity for nurse-initiated ART
- improving pediatric HIV care and treatment
- encouraging early identification of those in need for HIV care and treatment services (e.g. provider-initiated CT)

- CD4 testing for those that test positive to dried blood spot polymerase chain reaction (PCR)
- integrating TB care for HIV-infected clients, including screening and treatment
- continuing to strengthen the integration of treatment programs within other health interventions (e.g., PMTCT, cervical cancer screening and reproductive health), and
- reducing loss to initiation of treatment of people that test HIV positive and loss-to-follow-up once on ART.

PEPFAR partners will advocate for new national guidelines to improve access to pain management including the authority for nurse prescription. In collaboration with SAG, FY 2009 funds will scale up direct delivery of quality palliative care services.

All PEPFAR-funded care and treatment partners follow SAG standards, policies, and guidelines. The majority of care and treatment partners are local entities, and in addition, the three Track 1[2] treatment partners will start to transition to local implementing partners in FY 2009. The USG program continues to strengthen comprehensive high quality care for HIV-infected and affected people by:

- scaling up existing effective programs and best practice models in approximately 900 public, private, and NGO sites in all 9 provinces
- providing direct care and treatment services through prime partners and their sub-partners
- increasing the capacity of the SAG to develop, manage, and evaluate care and/or treatment programs, including recruiting additional health staff, training and mentoring health workers, improving information systems, conducting public health evaluations, and providing infrastructure assistance
- increasing demand for and acceptance of ART through community mobilization
- ensuring integration of ART programs within palliative care, TB, reproductive health, sexually transmitted infections (STI), and PMTCT services, and
- assisting in the accreditation of facilities for ART initiation.

Key linkages are made with prevention and wellness programs that provide ongoing support for patients once they have tested positive for HIV, including opportunistic infection (OI) management, cotrimoxazole prophylaxis, and prevention with HIV-infected individuals. Treatment and care services are an ideal setting for formulating prevention messaging to HIV-infected clients and their families. Wellness programs are linked to strong community programs, notably home-based care networks that extend care from the facility level to the home.

The capacity to deliver pediatric care and ART services varies significantly within the country, although additional funding in FY 2008 has been devoted to improving access to pediatric care and ART, especially through training activities and technical assistance. These efforts will continue in FY 2009 where despite a budgetary reduction for PEPFAR in South Africa, services for mothers and children (PMTCT, OVC, pediatric care and treatment) have been prioritized and in some cases funding have even increased.

[2] Centrally-funded US partners

In addition to the human capacity development activities, emphasis in FY 2009 is placed on early diagnosis for infants and children, the referral of children from PMTCT programs to treatment services to integrate HIV and AIDS services more efficiently, onsite mentorship, and linkages between OVC programs and pediatric treatment programs. Based on the Office of the US Global AIDS Coordinator (OGAC) guidance, partners are also incorporating nutrition support, especially for children. The NDOH has requested that community Integrated Management of Childhood Illnesses (IMCI) activities be integrated into the community component of care and treatment and this is reflected in the activities of care and treatment partners in FY 2009.

Laboratory Infrastructure:

In 2001, South Africa restructured its public sector medical laboratory service and created the NHLS, a parastatal organization funded through the NDOH and further supported by its fee-for-service revenue generating activities. The NHLS is accountable to the NDOH through its Executive Board and is responsible for public sector laboratory service delivery to approximately 85% of South Africa's health systems. The NHLS governs activities and funds the NICD to provide surveillance, research, and programmatic operations. The NHLS also funds the National Institute of Occupational Health (NIOH) to develop policies and to support occupational health exposure surveillance. The public service delivery arm of NHLS is comprised of approximately 260 laboratories, which include all provincial diagnostic pathology laboratories, tertiary level, secondary, and primary laboratories in the nine South African provinces and their associated district hospital laboratories. Each district laboratory supports a network of local clinics that provide primary care services.

In previous years, PEPFAR has provided limited direct support to the NHLS with a significant portion of COP activities focused within the NICD to carry out the majority of laboratory related activities of the COP. In FY 2008, a new Cooperative Agreement was awarded to the NHLS, expanding laboratory support activities across the NHLS, NIOH, and providing continued support of the existing PEPFAR supported NICD activities. PEPFAR funds will be used to continue to address gaps identified by the NDOH, NHLS, NIOH, and NICD, and to address laboratory-specific unmet needs and policy or administrative issues that impede full implementation of public laboratory programs that support the national ART rollout and the *Tuberculosis Strategic Plan for South Africa, 2007-2011*. Consistent with the priorities identified by the NDOH, and implemented by the NHLS, NIOH, and NICD, 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 second year PEPFAR partner that aims to establish a network of HIV monitoring laboratories and associated service access tools to ART settings in resource-constrained areas where existing public NHLS laboratory coverage is limited or stretched.

Toga is an organization based on the framework of an existing private molecular diagnostics laboratory. Toga provides molecular diagnostic support to the National Pathology Support Services, and as such, has become an integral part of the suite of pathology services offered by that organization. Toga is comprised of 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 HIV laboratory support and clinical management. Toga is committed to driving increased access to molecular HIV diagnostic testing and treatment monitoring for all South Africans under the framework of the national HIV and ART rollout and scale-up.

With the continuing expansion of HIV and TB services within NHLS and with significant increases in MDR/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 63 CD4 laboratories in the 9 provinces within the NHLS system, but coverage within each health district is limited. There are only 15 laboratories in 5 provinces that are able to provide viral load testing, and only 9 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 will ensure that viral load and infant PCR services are available in all the provinces. NHLS also recognizes their limited TB laboratory capacity due to high burden and inability to capture and report MDR/XDR-TB cases to the National TB Control Programme (NTP). In response, NHLS will roll out the line probe assay, a diagnostic service that currently exists in 6 laboratories, to 20 existing facilities in 2009, and an additional 11 sites in 2010. There is an urgent need to provide increased access to TB diagnoses and referral services and to strengthen the management and reporting of MDR/XDR-TB cases, data mining activities, and surveillance analysis from the existing NHLS Data Warehouse. Finally, it is critical that data is integrated into the existing national Electronic TB Register (ETR.Net) surveillance system. The NHLS Data Warehouse system can extract laboratory data from existing NHLS laboratory information systems and data can be imported into the ETR.Net database. The current system does require strengthening and NHLS is actively working to improve the capacity and utility associated with this system, as well as a new patient management system to be piloted this year.

National policies and standards on infection control programs within laboratories are limited. The NIOH is authorized to develop policies for occupational health. PEPFAR funds will be used to promote an infection control network and to develop robust and manageable infection control policies and surveillance activities. 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 and monitoring 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 will expand and strengthen existing regional support mechanisms and will enhance collaboration with other PEPFAR-funded countries through the African Center for Integrated Laboratory Training (ACILT). Expansion of services includes, but is not limited to, extending 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. All regionally supported activities will be funded

by requesting countries within their COP submissions and are not directly funded by South African PEPFAR monies.

During FY 2009, PEPFAR funds will be used to continue support to NICD. Support includes:

- evaluating HIV incidence testing methodologies
- using EQA to monitor PCR DNA testing of infants and of molecular testing associated with ART for the NHLS
- providing quality assessments of HIV rapid test kits for the NDOH
- assisting the NDOH in training staff in 4,000 VCT sites on proper HIV rapid testing procedures and quality management systems, 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 the National TB Reference Laboratory in equipping and readiness preparation when completed in early 2009, and
- providing laboratory training for clinical laboratorians and renovating temporary student housing to accommodate long term-training sessions, as well as facilities under ACILT.

NICD will continue to support important strategic information activities to help inform the decisions of policy makers and program officials regarding their HIV prevention and ART roll-out programs. These activities include HIV-1 and TB national drug resistance and transmission surveillance, sentinel surveillance of opportunistic bacterial and fungal pathogens in HIV-infected persons, microbiological etiological and antimicrobial resistance surveillance for other opportunistic infections provision of training for South African epidemiologists and laboratory workers; and collection of trend data on HIV incidence. Detailed descriptions of these activities can be found in the Strategic Information section in the COP.

New collaborative NHLS activities aim to:

- increase national coverage of HIV and TB diagnostics (line probe assay rollout in 20 facilities) 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 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 ACILT.

Toga aims to increase national coverage of HIV diagnostics in remote rural areas by engaging local and provincial government and placing six additional Togatainers in FY 2009. Toga has developed a Togatainer laboratory based on the Measure to Roll Out principle as a means of rolling out treatment capacity and developing a near real time laboratory information management system. Togatainer addresses the need for peripheral deployment of these required laboratory services, 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).

OTHER PROGRAM AREAS:

Total budget: $66,313,553

Strategic Information:

For FY 2009, South Africa Strategic Information (SASI), as part of the larger PEPFAR program, is oriented toward further aligning health management information systems (HMIS) and M&E systems to SAG standards. SASI will enhance the use of SI with an emphasis on strengthening surveys and surveillance, understanding data quality and using geographic information systems (GIS), and moving toward comprehensive SI capacity building activities. SASI accomplishments include:

- developing and using an electronic, web-based partner reporting system, the Data Warehouse (DW)
- incorporating systematic data quality assessments into partner performance cycles
- developing a South Africa SI Manual (the South Africa-specific indicator guide) for use by implementing partners
- hosting M&E capacity building workshops held several times per year, and
- conducting innovative evaluations of partner performances, which are embedded into the FY 2009 COP process, and include key members of the SAG and USG HQ technical staff.

Despite these accomplishments, the SI team faces significant challenges in FY 2009 including:

- the disparate nature of HMIS among PEPFAR-supported implementing partners, the SAG systems supported by the Departments of Health and Social Development, and partners' systems supported by other donors
- the tendency for abundant collection and reporting of results-oriented data among all stakeholders without due attention paid to data quality or an understanding or appreciation of their broader use, and
- a lack of human capacity in the USG country team, resulting in SI team members spending much time on COP issues and partner management rather than core SI functions. Addressing these challenges is an essential goal for FY 2009; implementation plans are outlined below.

The SI team plans and implements activities as one USG team and receives final inter-agency vetting and approval. In previous years, the team deliberated within the context of an SI Technical Working Group consisting of members from the other USG agencies and program areas. The "Staffing for Results" exercise conducted in 2008 led to a decision to disband the SI Technical Working Group. With the added strength of the new hires mentioned above, the SASI team plans to develop a more broadly based Technical Team that will greatly enhance its ability to plan and lead SI activities that benefit the program.

The SASI team developed the DW to which PEPFAR partners submit their plans and reports. All USG partners currently use the same templates and reporting guidelines. Results for OGAC reports are jointly drafted by all USG agencies. In FY 2009, a high priority is placed on guiding the transition of the DW toward two objectives, one short term and one long term.

Short term objective: shift the DW functionality from that of an in-bound reporting platform to an interactive database that will allow users to customize queries on indicator results by program area, by site, and by geographical unit across reporting periods. This objective is managed by the new JSI Enhanced Strategic Information (ESI) Project and its implementation is facilitated by a new lead developer on the DW team, and by a change control management system that assigns quantitative monitoring scores to each item of the transition. This objective is short term because it should largely be tested and completed during FY 2009. USG will hire an information specialist who will assist in the technical and managerial aspects of this objective.

Long term objective: shift the PEPFAR-specific orientation of the DW to a platform that has inter-operability with SAG routine health information systems . The new information specialist, working closely with the JSI/ESI Project, will also be responsible for assisting the longer term goal of incrementally adapting the USG results reporting platform to be effectively (if not completely) aligned with the District Health Information System (DHIS) and other SAG management information systems to which all SAG public health facilities report on a monthly basis. This long-term goal is essentially about moving away from the narrow PEPFAR reporting functionality that currently defines SASI to a set of roles and responsibilities that is centered on alignment with SAG reporting systems, enhancing the evidence base for multiple purposes, and creating opportunities for data use applications among a broad set of stakeholders.

The SI team leads the formulation and review of country targets. Direct targets are an aggregate of partner targets. The USG Activity Managers and SI Advisor jointly review partners' targets to ensure that they are reasonable and achievable. All partners report treatment activities on a quarterly basis by site. A customized version of the Track 1 treatment form is used. All other partners report on a semi-annual and annual basis.

The total SAG targets for prevention of mother-to-child transmission and TB/HIV are based on national estimates to which PEPFAR provides input. For FY 2009, the SI team will provide substantial leadership and technical assistance toward finalization of a national OVC management information system that will be linked to the OVC results reporting templates of PEPFAR-funded partners, and to other non-PEPFAR OVC organizations. This activity will be implemented in response to requests from the NDSD

and is an important example of how SI contributes to the third of the Three Ones[3]. Upon completion of this national harmonized database, the SI team expects to have acquired the necessary OVC data to estimate the number of OVC benefiting from USG indirect support.

The ART and CT targets are based on current uptake and projections and reflect modifications in national policy. The total HIV C&S target is difficult to measure since it is not collected at the national level as defined by OGAC. The SI team has a wealth of experience in formulating targets and in developing data systems to assist with the supporting of results reporting against such targets. During FY 2009, the SI team will further enhance the underlying reporting and data systems and will continue to provide technical assistance to USG and to the OGAC SI Division in how results and targets are formulated, interpreted, and reported in the field.

M&E is a priority in the NSP and the USG will continue to respond to these needs by providing direct funding and targeted technical assistance to various 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. During FY 2009, the USG aims to increase collaboration and harmonization of M&E systems. Currently, a DHIS exists, but it is not implemented in all provinces, and the quality of the HIV data is variable. The SI team plans to align the PEPFAR results reporting systems with the DHIS. Additionally, the SI team continues to emphasize data quality of reported results via targeted capacity development workshops involving SAG M&E personnel that affects DHIS reporting as well as PEPFAR required results. Finally, 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 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.

The SI team emphasizes rapid and comprehensive responses to SAG requests for technical assistance in SI. For FY 2009, the response strategy involves forming close partnerships with relevant SAG stakeholders so that assistance is more sustainable (i.e., all SI tools are shared and adapted for the particular context). The team's long-term goal is to turn over SI functions and activities to SAG counterparts and local partners. The strategy is based on rigorous M&E capacity development at increasingly lower levels and harmonization of measurement and data collection objectives.

The SI team has worked with several provincial departments of health to provide technical assistance in M&E in the past year; this support will be continued in FY 2009. Coordination with the NDOH had been strained, but collaboration is expected to accelerate during FY 2009. This is partially because of the groundwork laid during FY 2008 and partially because of the new enthusiasm for public health and HIV activities engendered by the new direction and leadership within the NDOH.

[3] Internationally endorsed concept led by UNAIDS; **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners. **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate. **One** agreed country-level Monitoring and Evaluation System.

Seroprevalence and behavioral surveillance activities in the general population are primarily supported through the NICD, the MRC, and the HSRC. These organizations and the SAG drive the process; PEPFAR provides partial support for these surveys, and the SI team provides technical assistance with survey design and implementation. Johns Hopkins University in collaboration with USG PEPFAR partners will implement the next national communication survey during FY 2009 to monitor trends in behavior in relation to media exposure. The SI Team plans to incorporate these surveillance activities and survey findings into its capacity development activities to enhance data use among partners and stakeholders. Thus, the analysis and further use of these survey results will be an important set of activities for FY 2009. The USG continues to provide technical assistance for these activities, including direct personnel support at the national and provincial health departments, development of surveillance systems, and training to specific NDOH programmatic units.

To date there is not a comprehensive SAG HMIS strategy. As a result, the SI team looks for key opportunities to leverage PEPFAR resources toward the use of systems that complement existing SAG systems and help pave the way toward harmonization. For FY 2009, the USG HMIS strategy addresses the challenge of harmonizing systems toward national standards. PEPFAR supports HMIS at the partner level, but the USG has not been prescriptive about design and implementation. Many treatment partners have developed systems in the absence of a national or provincial MIS. An HMIS assessment of treatment partners was conducted in FY 2008. Results indicated the importance of harmonization of such systems to ensure communication with facility level systems and interoperability with the DHIS, which will be the focus of data quality improvement activities.

A local PEPFAR contractor routinely conducts Data Quality Assessments (DQA) to build partner M&E capacity, and to better ensure that results reported to OGAC are valid and reliable. Through FY 2008, the rapid increases in PEPFAR funding and number of partners in SA limited the time and resources that could be expended on evaluating partner performance and using data effectively for program planning. The SA Team responded by awarding a contract to a SA organization to enhance the ability of USG Activity Managers to measure partner performance and to assess data quality. The SI team has made considerable progress in improving data quality among implementing partners; however, data quality within the SAG M&E system remains a concern. Priority for strengthening data quality with the SAG systems is a priority for FY 2009. Specific activities toward this priority include continued revision and testing of a less academically oriented DQA tool. The objective is to implement a practical, programmatically oriented approach that is centered on tracing and verifying reported results against source documentation, and doing so in a participatory manner that represents a departure from traditional audit practice and to a large extent from the current Global Fund DQA methodology.

The USG conducted a substantial partner evaluation in FY 2008 as part of FY 2009 COP preparation. The evaluation critically reviewed partners' performance, current and future plans, and budgets. Results of the evaluation directly affected FY 2009 COP budgets awarded to implementing partners and provided useful feedback to partners on current and future implementation strategies. SAG members were fully involved in

this partner evaluation process. A further refined methodology will be used during the FY 2010 COP preparations.

The USG supports a comprehensive and systematic approach to partner M&E capacity building that will continue during FY 2009. These activities include:

- M&E workshops that assist all stakeholders in understanding the role of evidence in decision-making and how to initiate, implement, and enhance evidence-based management
- Short and Long Term development of the USG-supported results reporting system as mentioned above to assist USG and implementing partners as well as SAG and the broader donor community with getting the most out of routine health information capture, management, analysis, and use
- DQA initiative mentioned above, and
- Establishment of a fellowship program to place recent South African master's degree graduates with partners in need of more intensive M&E training.

The success of these four initiatives is substantial and has been documented in previous COP narratives. The plan for FY 2009 is to go beyond the standard five-day M&E training workshops and offer a series of trainings that reflect a broader range of SI topics to a wider set of participants. The SASI team intends to test various methodologies and metrics to evaluate training effectiveness. The vision for capacity building involves a comprehensive program in SI training, akin to a graduate program in an applied field with an emphasis on developing cadres and networks of skilled SA practitioners.

Finally, in January 2009, the SI team has requested that a team of people with SI expertise from USG HQ agencies visit South Africa to conduct an external evaluation of the SI portfolio. The primary objective of this visit will be to guide a long- and short-term vision of the SI strategy in South Africa.

The USG will support the NDOH in designing and implementing an integrated M&E system. To facilitate the management of the PEPFAR monitoring and reporting process, the USG has implemented a single consolidated data warehouse that serves as the focal point for all PEPFAR data collected by partners. By collaborating with and assisting the SAG in strategic information systems as well as strengthening the implementing partners' strategic information systems, the USG also will support specific public health evaluations in order to improve prevention, care, and treatment programs; identify potential new interventions; and document best practices. The USG also will support the SAG in strengthening its M&E system.

Health Systems Strengthening:

The NSP emphasizes the strengthening of health systems as one of the key pillars in mitigating HIV and AIDS and meeting the Millennium Development Goals. During the last two years, PEPFAR has aligned its programs to strengthen the public health system through programming. Some of the main areas of focus for health systems strengthening have included:

- developing management and leadership at national, provincial and district levels
- developing and implementing policy at national and provincial levels
- strengthening monitoring and evaluation capacity of civil society organizations and the NDOH
- improving quality of services at district and facility levels
- integrating HIV and AIDS programs into other primary health-care services
- strengthening pharmaceutical systems within the public sector
- strengthening the NHLS and developing capacity at district and provincial levels to train health-care providers on HIV and AIDS and TB programs, and
- strengthening the human resource system for the health and social welfare workforce.

PEPFAR South Africa has and will continue in FY 2009 to work in collaboration to strengthen the capacity of the SAG to develop policies that are in line with international guidelines while taking cognizance of the local context of HIV, AIDS and TB. PEPFAR South Africa has and continues to support parastatal organizations such as the HSRC and MRC to conduct HIV prevalence and behavior change studies that will inform policies at national and provincial levels.

PEPFAR South Africa will continue to strengthen the national laboratory system by building on existing activities. These include support for strengthening the national laboratory information management system for multi- and extensively drug-resistant TB, support for the African Centre for Integrated Laboratory Training, a southern African regional activity, and renovation of 20 national laboratories to allow NHLS to perform line essays on sputum that will allow for two-day turn-around time on TB sputa.

PEPFAR-funded partners, will continue to assist the NDOH to strengthen their Health Promotion and Quality Assurance Training Centres through direct technical assistance to the HRH Unit. These centers are the hub for knowledge translation and in-service training and quality assurance for the primary healthcare system in all provinces. The Health Promotion and Quality Assurance Training Centers are mandated to manage the training of health-care providers at district level within each province. These centers are currently funded through the South Africa National Conditional Grant, but the provinces lack the capacity to set up these structures and systems to implement the programs. PEPFAR, through its partners, provides technical assistance to these training centers in development of curriculums, assessment of curriculums, integration of HIV and AIDS training into existing primary health care training programs, updated training programs to reflect policy changes (e.g., PMTCT policy), and provision of mentoring to staff at the centers in the management and implementation of such programs.

The PEPFAR program in South Africa will continue to address strengthening policies and capacity in FY 2009 through support to the SAG, particularly through the placement of CDC activity managers within the national HIV and AIDS and STI Directorate to assist in policy development.

In FY 2008, PEPFAR South Africa assisted the NDOH in developing the new PMTCT policy that now authorizes dual antiretroviral treatment for pregnant mothers. In addition, PEPFAR assisted with the development and implementation of the new

counseling and testing policy that recognizes routinely offered counseling and testing. In FY 2009, the focus will be on the implementation of these policies through training of healthcare providers and through PEPFAR partners. Health Policy Initiative will continue to work with the NDOH's HIV and AIDS Comprehensive Care, Management, and Treatment (CCMT) sub-directorate focusing on capacity building programs for costing of HIV and AIDS care and treatment interventions at the provincial level. The programs will also include costing for TB and STI. This activity will expand in scope by developing a tailor-made costing model for the CCMT managers. This model will also standardize and guide a benchmarked approach within all provinces in ensuring effective resource needs required for HIV and AIDS care and treatment in their specific province. This will greatly affect the production of more realistic budgets and will ensure adequate funding.

PEPFAR continues to encourage partners to integrate gender-related issues into all program areas to address gender violence, male norms, and behaviors within the cultural context, women empowerment, and alcohol and substance abuse in relation to violence and HIV transmission. Approximately 60% of partners have a gender-related component in their COP.

In FY 2009, PEPFAR South Africa will continue to provide direct technical assistance to the NDSD to set standards for quality of care for OVCs and to assist in the development of a policy framework on the Children's Act (see OVC program area narrative).

Pediatric Care is highlighted this year as a new program area. Although PEPFAR partners have been supporting pediatric care as a component of the care and treatment programs in the past, several activities will be highlighted in FY 2009. The focus will be on a family-centered approach to pediatric care, support, and treatment, and on integration of pediatric HIV care and treatment into routine primary health-care settings. There will also be a special focus on the community component of the Integrated Management of Childhood Illnesses (IMCI) to integrate pediatric HIV care and treatment into these modules. In addition, community health workers and home-based caregivers will be trained on IMCI to strengthen infant follow-up and to improve child health outcomes at the district level. PEPFAR will work closely with counterparts at the NDOH to integrate pediatric HIV care into existing child health programs (e.g., IMCI and the immunization program). PEPFAR aims to meet some of the Millennium Development Goals for child survival by strengthening and integrating the PMTCT program into the mother-child and women's health programs with a special emphasis on the community aspect.

In FY 2009, the USG will continue to strengthen and expand quality of care at facility and community level in the following areas:

- external Quality Assurance (EQA) for laboratory services
- CDC/WHO quality management systems training to ensure quality HIV rapid test kits
- laboratory surveillance system to identify and record opportunistic infections (there are currently 15 sentinel sites country-wide)

- quality assurance implementation by partners in all program areas with a special emphasis on therapeutic monitoring of patients on antiviral treatment and pharmacovigilance, and
- proficiency testing for viral loads and infant PCR tests.

PEPFAR will continue to train local organizations in monitoring and evaluation, recording and reporting on data, and using information in decision-making. Direct technical assistance will continue to be provided to the national, provincial, and district health system in the use of information for decision-making.

The United States government will continue to support and strengthen the national health system to improve patient care through:

- harmonizing health information systems (lab, pharmacy, patient information systems, etc.)
- strengthening pharmaceutical management systems, and
- improving infection control for TB programs at all levels of government.

A significant focus of South Africa's PEPFAR program addresses institutional capacity issues by building the capacity of local non-governmental, faith-based, and community-based organizations. 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 Community Grants Program include formal training, on-site mentoring, improved monitoring and evaluation systems, good governance, and resource mobilization.

The South Africa PEPFAR team works with other donor organizations in coordinating efforts in South Africa through participation in the donor coordination forum. PEPFAR collaborates with other donors to maximize support to strengthen the South African health system. PEPFAR is represented on the EU Plus Working Group on HIV and AIDS where information sharing and programmatic issues are discussed. The USG is also represented on the NDOH Donor Coordination Forum. There are several health system areas where joint funding is coordinated (e.g., the national Human Resource Information System (DFID and PEPFAR) and the Clinical Associates Program (DFID, PEPFAR, EU, and WHO).

PEPFAR continues to support the GFATM management structure through representation from our partners on the South Africa National AIDS Council and its Resource Mobilization Committee, which serves as the coordinating and management structure for the GFATM. PEPFAR also coordinates with private sector donors to this area including Atlantic Philanthropies and Elma Philanthropies.

Human Capacity Development – Human Resource Capacity:

According to the *National Department of Health's National Human Resources for Health Plan, 2006* (HRH), there are 67 doctors per 100,000 people in South Africa. Of these, 75% of general practitioners work in the private sector, which leaves about 15 doctors per 100 000 uninsured people. The majority of public sector doctors work in urban

areas. This leaves as few as 3 or 4 doctors per 100 000 people in some rural areas. Between 1990 and 2005, SA medical schools produced approximately 19 500 graduates.

However, over this period, registered doctors only increased by 9 304, the rest are working outside of SA. The 2003 OECD study found that 12 136 SA-qualified medical practitioners were working overseas in 8 surveyed countries (UK, USA, Australia, Canada, Finland, Portugal, France, Germany).

If one compares these numbers to the 4000+ vacancies (30% vacancy rate) in the public sector, then one starts to grasp the true impact of the brain drain. Since the 1970s, SA has had the same 8 medical schools producing doctors for the country at the same rate of intake, about 1200 per year. ON top of that

while all medical schools still have the same intake on an annual basis, fewer doctors are graduating at the end of the process. Of the 442 800 black learners who wrote matricin 2006, only 3338 passed higher grade math with a mark of C or higher. That means that the annual intake of students into medical training has not changed significantly over this period, but also the students entering are more poorly prepared to even complete medical school.

The NSP promotes improved HIV and AIDS management including the provision of ART within a redeveloped primary health care strategic platform. The program policies are comprehensive but implementation is slow, and the need to strengthen the capacity of government managers and health-care providers looms large.

The 2009 PEPFAR program will continue to focus on critical sustainability objectives, which include:

- increasing the number of health-care workers, professional staff, and volunteers that can deliver HIV and AIDS services. This will be achieved through policy development and training to enable task shifting from more specialized to less specialized cadres of health-care workers. PEPFAR will work closely with professional councils and associations in South Africa to achieve this objective
- capacitating pre-service education institutions to increase the intake of nurses, physicians, and other health professionals by developing up-to-date curriculums and better placement of professors and tutors. PEPFAR recommends that current in-service training partners develop and rationalize their curriculums into pre-service training institutions' curriculums. This activity will be undertaken in collaboration with the nursing and medical councils, other professional associations, and key university programs, and it will also focus on improving children's access to care and treatment services. This activity will also involve better tracking through the HRIS of newly graduated health care workers and their recruitments into the South African health and social welfare workforce.
- Recruiting doctors and other foreign-qualified health care workers into South Africa to decrease the rural health workforce vacancy rates.
- Increasing the number of health and social welfare workforce retained in South Africa public sector positions, thus decreasing the number of physicians, nurses, and other health professionals who leave the workforce or migrate out of South African communities. This objective will be achieved through the development of

sustainable retention and placement strategies through DOH HR unit, RUDASA, HPCSA and support from the African Health Placement Programme.
- increasing the support to strengthen HIV and AIDS leadership and management through support to HIV and AIDS management teams in PEPFAR priority provinces and districts , through training provincial DOH programs in strategic planning, management, costing and implementation of their HIV/AIDS and primary health care plans. .

The South African HRH calls for nursing, medical, and pharmaceutical councils to develop human resources plans to meet the needs and demands of the public health system. The pharmaceutical and medical councils have developed their plans and have started implementing new cadres of workers to fill the gaps in the workforce. The pharmaceutical council, for example, has introduced a mid-level worker, the pharmacist assistant. PEPFAR supports this initiative through the provision of training and through placement of pharmacist assistants at PEPFAR-supported sites. In addition, the medical council (through the NDOH) has introduced a new mid-level category of worker, trained through the three-year Clinical Associates Program. PEPFAR supports this program by co-funding 78 students for a three-year study period. Finally, the nursing council is reviewing the nursing regulations and competencies necessary for the development of ARV nurse prescribers who could operate at primary health care levels. PEPFAR will expand this work to look at pre-service training for data capturers in the provinces, work with M and E programs in Schools of Public Health and continuation of the post-graduation M and E Fellowship program under the University of Pretoria.

In FY 2009, negotiations with the South African government will include:

- developing Human Resources Directorates (HRD) in the provinces and some districts by scaling-up costing and providing technical expertise on strategic planning
- using the HRH's guiding principles as the benchmark for PEPFAR's Partnership Framework negotiations
- providing technical assistance to help move the Human Resources Information System (HRIS) through Phase 3, provincial roll-out, and to improve links to the public service system and the private sector.
- mobilizing technical experts from within the region to assist with human resources planning and team strengthening among the provincial HRDs, with a long-term goal of disseminating and training staff on the HRIS system, and
- providing technical assistance to the national HRDs on the development of policy for other mid-level workers, such as community caregivers, that will develop and initiate scopes of practice and national HR recognition.

PEPFAR partners are focusing on in-service training and accreditation of training curriculums with the South African Qualifications Authority and the National Health and Welfare Sector Education and Training Authority. In FY 2009, the PEPFAR South Africa program will encourage partners to integrate in-service training programs with pre-service training programs to promote best practices and innovative approaches, including collaboration with the nursing and health professions councils, and to implement quality assurance mechanisms, such as accredited curriculums. Pre-service programs will be expanded to strengthen teaching capacity in tertiary institutions.

Currently, PEPFAR partners only use a limited amount of their funds for long-term training of health workers, and funds are usually dispersed as bursaries or bonding programs. These programs include the Field Epidemiology and Laboratory Training Program and the Clinical Associates Program. PEPFAR will also begin leveraging opportunities with distance education programs under the University of Stellenbosch and UNISA.

PEPFAR provides training support to PEPFAR-funded partners, to the provincial Health Promotion and Quality Assurance Training Centres. Expansion to multiple provinces will take place in 2009. These Centres, established by the NDOH, aim to coordinate in-service training (focused on HIV and TB) of health-care providers in the public sector. In-service training accounts for approximately 90% of total prime partner programming in PEPFAR's South Africa program (per the *Human Capacity Development Assessment Of Partners, 2008).*

FY 2008 funds were set aside for a joint annual program statement call for proposals focusing on task shifting. However, PEPFAR has not received any innovative submissions thus far. At the same time South Africa reframed the ART policy for treatment initiation policy to allow nurses now to initiate patients on ART. PEPFAR will be working with the South Africa Nursing Council to strengthen both the pre-service training and in-service supervision support necessary to make this task-shifting activity a success. PEPFAR will work closely with the Health Professions Council of South Africa and the Pharmaceutical Council of South Africa to task-shift care and treatment responsibilities of newly created clinical officer and pharmaceutical assistant cadres. Additional professional councils and associations in South Africa will work to achieve this objective for the SI, medical and lab sector. These funds will be carried over to FY 2009; some funds will be allocated to another annual program statement that will be issued to call for proposals to address gaps in program. The remainder of the funds will be allocated to the NDOH for scale-up and expand support to the regional training centers, HRIS, the Clinical Associates Program, Palsa Plus training methodology, and the redevelopment of the primary health-care platform.

In FY 2009, PEPFAR is in discussion with NDOH to initiate a pilot approach to assist the DOH HRIS system roll-out. The objective will be to improve the quality, availability and use of health worker information for improved decision-making and service delivery, specifically looking at HIV/AIDS services. One or two provinces will be selected to adopt the DOH oracle system and an HRIS strengthening program. HPCSA will also benefit from additional HRIS staff strengthening since the system will larger reside in that professional association body, Another large, private sector service delivery group, like NetCare will be piloting use of HRIS. In all cases, the national DOH will assist in the data identification to be collected and reported on, installation of the systems and upgrades through the oracle-based system or new piloted systems

Building on FY 2008 assistance to the provinces, PEPFAR will continue to support training of provincial teams in costing HIV/AIDS strategic plans, using a team management approach. In addition, activities like assisting strategic planning to develop primary health care to meet current demands on the system, the task shifting pilot in Eastern Cape that has given nurses the authority to prescribe ARVs, and training a new cadre of clinical officers will be continued. These activities will be carried out in

collaboration with the NDOH and the professional councils. Nurses will receive special focus since they withstand the worst of burden. This activity also includes the development of job descriptions and job competency requirements for all categories of health-care workers in the health system.

PEPFAR will continue to support a placement program to assist government recruitment of medical professionals since there is still a severe shortage of skilled workers. The African Health Placement Program recruits, locally and internationally qualified health-care professionals, and fast tracks them through the recruitment process and afterward deploy workers in rural areas in the provinces where there are critical needs, and ensures adequate site support. In 2008 place 5 times the amount of foreign qualified rural doctors in South Africa than all 8 South African medical schools combined (approximately 165). This program also works on retention programs for those rural clinical staff.

The NDOH has established a rural incentive scheme based on monetary rewards. The HRH clearly states the need to review retention policies, to examine successful practices and to develop award/recognition policies so the need for a national retention strategy looms large and may be part of the PEPFAR Partnership Framework. In addition, the HRH states that the NDOH should develop policies to encourage professionals who have left South Africa to return to the country. PEPFAR does provide incentive and salary support to the NDOH, non-governmental, faith-based, and community-based organizations that offer HIV and AIDS services. This support includes salaries for nurses, auxiliary staff, lay counselors, and community caregivers. Approximately 20,500 staff in the government, in private, and in civil society sectors are directly supported through PEPFAR funds.

In FY 2009, PEPFAR will increase the management and leadership capabilities of the new HIV and AIDS managers and the provincial and district human resources managers. A performance-based management and quality assurance system is required to track service delivery and to provide equitable career structures for health workers. Standards-based management is a practical management approach used to improve performance, efficiency and quality of health services. In FY 2009, PEPFAR will explore expansion into the development of a performance improvement and quality assurance system for NDOH sites.

South Africa is transitioning the Twinning Center program to a "to be determined" activity, and some of the current twins will graduate into local twins. Many PEPFAR partners use short-term volunteers to be the mentors, preceptors, or coaches for staff on the ground in facilities but there is a lack of translation and follow-though for the workforce. In FY 2009, PEPFAR will explore the possibility of recruiting more long-term clinical volunteers into programs, through twinning or other alliances. The Peace Corps continues to expand their program with volunteers working in community HIV and AIDS outreach and school and community resources. The Peace Corps will soon sign a memorandum of understanding with the NDOH and the NDSD. This memorandum of understanding will facilitate the identification of community-based organizations in the rural areas that require capacity building and that will benefit from volunteer placement. Several volunteers are currently deployed on two to three year assignments to build structural and human capacity within these communities.

Gender:

As part of the PEPFAR South Africa Interagency Partner Evaluation, the USG team collected information from all partners regarding gender-related activities in all program areas. Analysis of the data is on-going and will be used to develop a gender strategy in early 2009. In addition, the USG team with assistance from the Office of the US Global AIDS Coordinator (OGAC) Technical Working Group will be conducting site visits to programs in the South Africa PEPFAR portfolio to provide technical assistance to strengthen the gender component of existing programs.

In March 2009, the USG team will hold a Prevention Partners meeting, during which a considerable amount of time will be allocated to gender in relation to HIV prevention. In FY 2009, PEPFAR South Africa will draw on the collective expertise of existing partners to help integrate gender into the wider South African portfolio. In this respect, partners will share expertise on how to incorporate gender into program planning and implementation.

Gender priorities by program area are:

- PMTCT: PEPFAR South Africa will intensify its efforts to better engage men in PMTCT services. Objectives of these activities include increased uptake of couples' counseling; reduction in gender-based violence towards PMTCT clients; higher rates of follow-up care and ART for women, their partners, and their children; and improved ART adherence among PMTCT clients. University Research Corporation's Health Care Improvement project, for example, will advocate for strategies to address male norms and behaviors, specifically seeking their involvement in PMTCT and highlighting the importance of partner testing and partner support at all levels. In addition, the University Research Corporation's Health Care Improvement PMTCT program will sensitize staff to the importance of male testing and participation in PMTCT programs. Male counselors are being trained at some facilities to enhance the current system. Kagiso Communications is implementing a male involvement in PMTCT campaign entitled "you can count on me." The aim of the campaign is to mobilize men to take responsibility and support their partners while encouraging participation in PMTCT.
- Prevention of Sexual Transmission: Together with the SAG's National Prosecuting Authority, USAID supports South Africa's Sexual Offences and Community Affairs unit of the National Prosecuting Authority to upgrade and expand a network of Thuthuzela Care Centers for victims of rape and sexual violence, a one-stop-shop where comprehensive services such as medical examination, counseling, PEP, statement taking, and investigations are provided to survivors of sexual assaults and rape. In addition, PEPFAR South Africa is supporting groups such as GRIP, whose teachers and peer group programs address the obstacles that women and girls face in accessing health care, ranging from cost of treatment, transportation, and child care, to appropriate appointment schedules and guarantees of privacy and confidentiality. GRIP's programs meet the unique needs of women, including the empowerment of women, young people and children and those who are victims of sex trade, rape, sexual abuse, assault, and exploitation.

- OVC: PEPFAR South Africa will increase funding for all OVC activities to include a gender strengthening component. For example, the gender component of Heartbeat's OVC program is to train childcare workers to identify possible victims of abuse through Heartbeat's child protection workshops. The childcare workers are also trained to follow a specific procedure when a child is raped, including contacting the social worker. Each staff member signs a child protection policy when joining Heartbeat.
- Counseling and Testing: In South Africa, PMTCT and CT are the two primary ways of encouraging male utilization of health services. CARE will introduce programs targeting men and boys in the households reached through appropriate male reproductive health education for this purpose, as well as to perform referrals for VCT. CARE will also train men to be more involved in their families' well being through training them on parenting skills and supporting their partners' uptake of reproductive health services, PMTCT, ART, and child health services.
- Care and Treatment: PEPFAR South Africa will assist partners to ensure equitable access to care and treatment services by working with partners to identify and address barriers women and men may selectively face in adhering to treatment or receiving ongoing care. Pathfinder International will provide training to service providers on gender issues related to young men and women's sexuality and sexual rights so they feel comfortable when accessing HIV and AIDS services. Training will include sound gender-based communication skills valued by youth of both sexes, such as confidentiality and an open-minded approach to questions instead of making pre-conceived judgments. Additional gender differences to be addressed include: sexually active young women and/or girls living with HIV and AIDS must not be stigmatized by health providers who blame them for being too young to seek services. Special care will be taken to provide youth-friendly, gender-sensitive services to these young people, including counseling, partner involvement and testing, and stigma reduction.

  In order to explore the promotion of gender sensitivity within a palliative care context, the Hospice Palliative Care Association (HPCA), in consultation with its member hospices and management portfolios, has developed comprehensive gender guidelines. These guidelines are aimed at assisting the national organization and member hospices to incorporate gender awareness into all service areas and to promote gender sensitivity at organizational and patient care levels. A national HPCA Gender Task team has been established to facilitate the implementation of these guidelines and to act as a national and local resource group.

- Male Circumcision (MC): Although the USG team had hoped to initiate activities in FY 2007 and FY 2008, these activities have not taken place, and FY 2009 activities have not been defined, even though funds have been allocated to this activity because South Africa does not have a national male circumcision policy. When the SAG decides to implement a male circumcision policy, activities will be determined in collaboration with the government. In the interim, the USG team has set up a task team to focus on male circumcision and to continue liaising with the SAG.

Approaches and programming plans related to each of the 5 gender strategies:

1. Increasing gender equity in HIV/AIDS activities and services: PEPFAR South Africa will work to set sex-disaggregated targets for all reporting indicators and develop new program indicators and targets to measure additional aspects of gender equity in prevention, care, and treatment services. Analysis of performance trends against these targets will enable program managers to monitor gender equity and adjust program strategies accordingly.
2. Reducing violence and coercion: In FY 2009, EngenderHealth may partner with South African Police Services to build capacity of individual precinct's youth desks to implement Men as Partners programming in their communities.
3. Addressing male norms and behaviors: In FY 2009, PEPFAR South Africa will continue to seek ways to encourage men to seek healthcare services. The Reproductive Health Research Unit, for example, has seen that men access care for TB far more than for ART. This suggests that the TB program may be a mechanism to increase HIV testing, staging, and ART access among men. EngenderHealth focuses on challenging men to change their attitudes and behavior, accepting that abstaining from sexual intercourse, being faithful to one partner, or getting tested for HIV is a gender norm that 'real' men display.
4. Increasing women's legal protection: GRIP's interventions review, revise, and encourage enforcement of laws relating to sexual violence against minors, including strategies to more effectively protect young victims and punish perpetrators. GRIP is ensuring institutional capacity building of government departments within the Criminal Justice system and intervenes with lawyers, prosecutors, law enforcement, and service providers on the legal rights of women's and children's access to justice. GRIP also works with governments and other civil society groups to eliminate gender inequalities in civil and criminal code.
5. Increasing women's access to income and productive resources: In FY 2009, PEPFAR South Africa will continue to support CARE's Voluntary Savings and Loan program, since small income generating and food security activities increases women's access to productive resources and reduce their vulnerability to secondary infection or new infection. The project also recognizes that the majority of people caring for OVC and providing care and support to PLHIV is women and will seek out opportunities to support them in these roles.

In FY 2009, PEPFAR South Africa will continue to support youth programs targeting young girls. Youth for Christ is implementing a school-based program focusing on gender norms targeting young girls. The program aims to increase their sexual decision making capacity and allow them to make informed choices around their bodies and health.

In FY 2009, PEPFAR South Africa will support the Human Sciences Research Council in surveillance of HIV and risk behavior among MSM. In addition, the Men as Partners program of EngenderHealth is inclusive of the HIV needs of MSM, primarily helping heterosexual men understand the concept of sexual orientation and how gender norms are linked to sexual orientation. With a human rights focus, Men As Partners works to reduce homophobia and heterosexism among individuals and communities throughout

South Africa, as well as offer inclusive programming that meets the needs of MSM. Lastly, the MRC places priority on MSM for counseling and testing actions.

PEPFAR South Africa, USAID/Democracy and Governance, the Women's Justice and Empowerment Initiative, the PEPFAR Special Initiative on Sexual Gender-Based Violence, and Democracy and Governance Rule of Law and Human Rights Justice System Funding coordinate activities for expansion of the network of Thuthuzela Care Centers.

PEPFAR South Africa will offer assistance to the new staff at the NDOH to develop a revised National Gender Policy, as the most current policy is from 2000. This may include support for a situational analysis, stakeholder workshops, and policy drafting.

A comprehensive gender assessment will need to be conducted to systematically analyze areas of need and best practices to build upon. However, without having conducted such an analysis, the following salient issues arise as clear challenges and gaps:

- while Thuthuzela Care Centers are a widely recognized best practice in providing sexual violence services, including PEP, more needs to be done to effectively meet the need for comprehensive sexual violence services
- a lack of social workers in health facilities impedes proper continuity of care, outreach, and referrals to legal and other services
- stronger linkages can be made with programs supporting women's legal rights and protections, access to income, and productive resources
- a concerted effort needs to be made to support the South African government to develop a gender-aware male circumcision policy
- a better understanding of young girls' particular HIV vulnerabilities is needed and OVC partners should work together to develop a strategy to address them
- cultural norms and practices remain a challenge to implementation. As a result, in order to address gender, there is a need to address culture and the interpretation of culture, and
- there is a lack of understanding on how to implement and/integrate gender into existing programs.

South Africa's current gender policy, National Gender Policy Framework, was drafted, in 2000, by the Office on the Status of Women, South African Office of the Presidency. PEPFAR South Africa expects that a revised gender policy will be a top priority for the new South African leadership.

Other Donors, Global Fund Activities, Coordination Mechanisms:

The USG is the largest bilateral donor to South Africa's health sector. It is one of nearly 20 bilateral and multilateral donors providing technical and financial assistance in support of South Africa's *HIV & AIDS and STI Strategic Plan for South Africa, 2007-2011.* In addition to the Global Fund, other major donors include the European Union, the United Kingdom, Belgium, the Netherlands, Australia, France, Sweden, and Germany. Two Global Fund grants for AIDS and TB programs provide funding to expand treatment services in the Western Cape, as well as a broad package of HIV prevention, treatment, and care activities in KwaZulu-Natal The primary HIV/AIDS coordinating

body is the South African National AIDS Council's Resource Mobilization Committee (RMC). The USG meets regularly with key officials of individual Ministries (Health, Social Development, Treasury, Defence, Education, and Correctional Services), to ensure that USG assistance complements and supports the SAG's plans for prevention, care, and treatment. The USG and implementing partners also meet with SAG officials at the provincial level to ensure synergy with provincial priorities and activities. In FY 2009, The PEPFAR team will work closely with the NDOH and other SAG departments to develop a joint five-year strategic plan for HIV, AIDS, and TB programs in South Africa and to negotiate an associated Partnership Compact. This has been facilitated by recent changes in the South African government, with these changes to be consolidated after the South African elections in April 2009. The South Africa PEPFAR team will work closely with the SAG to help strengthen the public health infrastructure, service delivery, and capacity through the platform of HIV and AIDS programs and to plan for and enable measured and progressive transition of services to the South African public health system.

Acronyms

Acronym	Description
AABB	American Association of Blood Banks
AB	Abstinence and being faithful
ABC	Abstinence and being faithful and condomize
ACILT	African Center for Integrated Laboratory Training
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
ARV	Antiretroviral
C&S	Care and Support
CBO	Community-Based Organizations
CCF	Child Care Forum
CCMT	Comprehensive Care, Support, and Treatment
CDC	U.S. Centers for Disease Control and Prevention
CHBC	community home-based caregivers
CINDI	Children in Distress
COHSASA	Council for Health Service Accreditation of Southern Africa
Comprehensive Plan	2003 Comprehensive Plan for HIV and AIDS Care, Management and Treatment
COP	Country Operational Plan
CT	Counseling and Testing
DFID	Department for International Development
DHIS	District Health Information System
DOD	Department of Defense (USA)
DQA	Data Quality Assessment
DW	Data Warehouse
EQA	external Quality Assurance
ETR	Electronic TB Register
EU	European Union
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GIS	Geographic information system
GRIP	Greater Nelspruit Rape Intervention Project
HIV	Human Immunodeficiency Virus
HMIS	health management information systems
HPCA	Hospice Palliative Care Association
HRD	Human Resources Directorates
HRH	National Human Resources for Health Plan, 2006
HRIS	Human Resources Information System
HSRC	Human Sciences Research Council
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
JSI	John Snow Institute, Inc.
M&E	monitoring and evaluation
MCWH	maternal, child, and women's health
MDR	Multi-drug resistant (TB)
MMIS	Making Medical Injections Safer

Acronym	Description
MRC	Medical Research Council
MSM	Men having Sex with Men
NACCW	National Association of Child Care Workers
NDCS	National Department of Correctional Services
NDE	National Department of Education
NDOH	National Department of Health
NDSD	National Department of Social Development
NGO	Non-governmental organization
NHLS	National Health Laboratory Service
NICD	National Institute of Communicable Diseases
NIOH	National Institute of Occupational Health
NSP	South African National Strategic Plan for HIV & AIDS and STI, 2007-2011
NTP	National TB Control Programme
OGAC	Office of the US Global AIDS Coordinator
OI	opportunistic infection
OVC	Orphan and vulnerable children
PCR	polymerase chain reaction
PEP	Post exposure prophylactic
PEPFAR	U. S. President's Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PwP	prevention with positives
ROTC	Routine Offer of Testing and Counselling
SAG	South African government
SAMHS	South African Military Health Service
SANBS	South African National Blood Service
SASI	South Africa Strategic Information
STI	Sexually Transmitted Infections
Toga	Toga Integrated HIV Solutions
UK	United Kingdom
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States dollars
USG	United States government
VCT	voluntary counseling and testing
WHO	World Health Organization
XDR	extensively drug-resistant (TB)

Funded Program Areas by Partner

Codes:

AB	-	Sexual Prevention: Abstinence/Be Faithful	**MS**	-	Management & Staffing
BC	-	Basic Health Care and Support	**OVC**	-	Orphans and Vulnerable Children
BL	-	Biomedical Prevention: Blood Safety	**PC**	-	Pediatric Care and Support
CIRC	-	Male Circumcision	**PMTCT**	-	Prevention of Mother to Child Transmission
CT	-	Counseling and Testing	**PTX**	-	Pediatric Treatment
HSS	-	Health Systems Strengthening	**SI**	-	Strategic Information
ID	-	Injecting and non-Injecting Drug Use	**TB**	-	TB/HIV Care
IN	-	Biomedical Prevention: Injection Safety	**XD**	-	ARV Drugs
LAB	-	Laboratory Infrastructure	**XS**	-	Adult Treatment

	BL	XS	XD	OVC	AB	OP	MS	BC	SI	CT	PC	ID	TB	PMT CT	PTX	LAB	HSS	CIRC
Absolute Return for Kids (ARK)		X						X		X	X			X	X			
Academy for Educational Development - CAP														X				
Academy for Educational Development UGM		X	X	X				X										
Academy for Educational Development VCT Program										X								
Africa Centre Program		X						X		X	X		X	X	X			
African Medical and Research Foundation - CT Program										X								
African Medical and Research Foundation Care Program				X				X										
AgriAIDS						X		X		X								
American Association of Blood Banks	X																	
Anglican Church of the Province of Southern Africa				X														
Aurum Institute for Health Research		X	X		X	X		X		X	X		X	X	X			
Boston University		X																
BroadReach HealthCare		X	X			X		X		X	X		X	X	X			
CARE International				X														
CARE International– CDC Mechanism					X			X			X			X				
Catholic Medical Missions Board										X								
Catholic Relief Services		X	X					X		X	X		X	X	X			
CDC Comforce							X											
CDC Management & Staffing							X											
Child Welfare South Africa				X														
Childline Mpumalanga				X														

	BL	XS	XD	OVC	AB	OP	MS	BC	SI	CT	PC	ID	TB	PMTCT	PTX	LAB	HSS	CIRC
Children in Distress				X														
Children's Emergency Relief International				X														
Columbia University		X	X					X		X	X		X	X	X	X	X	
Columbia University – USAID Program											X		X	X	X			
Community Grants Program				X			X	X										
CompreCare				X	X													
Department of Defense							X											
Education Labour Relations Council					X	X				X								
Elizabeth Glaser Pediatric AIDS Foundation		X	X					X		X	X		X	X	X		X	
EngenderHealth					X	X				X								X
Family Health International Centre		X			X	X		X			X			X				
Family Health International FABRIC				X														
Family Health International UGM				X	X	X		X		X				X				
Foundation for Professional Development		X	X					X	X	X	X		X		X			
Fresh Ministries					X													
Genesis Trust					X			X		1								
GoLD Peer Education Development Agency					X	X												
Grip Intervention Program					X			X		X								
Hands at Work in Africa				X				X										
Health & Development Africa				X														
Health Policy Initiative					X				X								X	X
Health Science Academy		X																
Heartbeat				X														
HIVCare		X	X					X		X	X		X		X			
Hope Education					X													
Hospice and Palliative Care Association				X				X		X	X		X					
Human Sciences Research Council						X			X					X				
Humana People to People in South Africa					X	X		X		X								
Ingwavuma Orphan Care				X	X			X		X	X							
Institute for Youth Development SA		X																
International Organisation on Migration						X		X		X								
JHPIEGO ARV Program		X															X	
JHPIEGO CT Program										X								
JHPIEGO Prevention Program								X	X					X				X
John Snow International - ENHANCE SI				X					X									
John Snow International Injection Safety												X						
Johns Hopkins University Center for Communication Programs		X		X	X	X		X	X	X			X	X			X	X
Kagiso Media, South Africa						X								X				
Khulisa Management Services									X									
Khulisa QM																	X	
Leonie Selvan Communications					X													
Lifeline Mafikeng					X	X				X								
LifeLine NW - Rustenburg					X	X		X		X								

	BL	XS	XD	OVC	AB	OP	MS	BC	SI	CT	PC	ID	TB	PMT CT	PTX	LAB	HSS	CIRC
Living Hope					X			X		X								
Management Sciences for Health IPHC				X														
Management Sciences for Health SPS		X	X						X				X	X	X		X	
McCord Hospital/Zoë-Life		X	X	X				X	X	X	X		X	X	X		X	
Medical Care Development International				X	X	X		X		X				X				
Medical Research Council TB						X		X	X	X				X				
Medunsa University																	X	
Montefiore Hospital					X	X				X								
Mothers2Mothers														X				
Mpilonhle				X	X	X		X		X								
Muslim AIDS Project					X													
Natal University for Health														X				
National Association of Childcare Workers				X				X										
National Department of Correctional Services		X				X		X	X	X			X					
National Department of Education				X	X	X												
National Department of Health (NDOH) In Support– Lab																X		
NDOH Cooperative Agreement																	X	
NDOH In Support – AB					X													
NDOH In Support – CT										X								
NDOH In Support – Other Prevention						X												
NDOH In Support – Palliative Care								X										
NDOH In Support – PMTCT														X				
NDOH In Support – Strategic Information									X									
NDOH In Support – TB/HIV													X					
NDOH In Support – Treatment		X																
National Health Laboratory Service									X							X		
Nosizwe Consulting														X				
Nurturing Orphans of AIDS for Humanity				X														
Olive Leaf Foundation				X	X			X		X								
Olive Leaf Foundation Track 1				X	X													
Path Aidstar OVC caregivers				X														
Path Aidstar TBD OVC: Referral				X														
PATH PMTCT														X				
Pathfinder International		X						X		X				X				
Peace Corps				X	X		X	X		X								
Perinatal HIV Research Unit		X	X			X		X		X	X		X	X	X			X
Pop Council OVC Mapping				X														
Pop Council Program					X	X								X	X			
Population Services International VCT Program										X								
Project Concern International					X	X												
Project Support Association of Southern Africa				X				X		X								
Reproductive HIV Research Unit		X				X		X	X	X	X		X	X	X		X	X
Research Triangle International						X		X		X	X							

	BL	XS	XD	OVC	AB	OP	MS	BC	SI	CT	PC	ID	TB	PMTCT	PTX	LAB	HSS	CIRC
Right to Care		X	X					X		X	X		X	X	X			
Right to Care UGM		X						X		X			X		X			
Salesian Mission					X													
Salesian Missions CT										X								
Save the Children UK				X														
SCMS		X	X			X												
Scripture Union					X													
SEAD Consulting									X									
Senzakwenzeke				X														
Solidarity Center					X	X				X								
Sophumelela Clinic Inc					X			X		X	X							
Soul City		X			X	X												
South Africa Clothing and Textile Workers Union		X			X	X		X		X			X					
South African Business Coalition on HIV and AIDS		X	X		X	X		X		X							X	
South African Democratic Teachers Union				X	X	X				X							X	
South African Institute of Health Care Managers		X																
South African National Blood Service	X																	
South African National Defence Force		X		X	X	X		X	X	X				X			X	
South African National Defence Force		X	X												X			
Southern African Catholic AIDS Conference		X		X				X										
St Mary's Hospital		X						X		X	X		X	X	X			X
Starfish				X														
TB Care Association		X								X			X	X	X			
Toga Laboratories																X		
Training Institute for Primary Health Care				X	X			X										
Tshepang Trust		X	X					X		X			X					
Tutu TB Centre SU										X			X	X				
Ubuntu Education Fund				X	X	X		X		X								
University of KwaZulu-Natal - CAPRISA		X	X					X		X			X					
University of KwaZulu-Natal, Nelson Mandela School of Medicine				X	X	X		X						X				
University of Pretoria (ChiP)									X									
University of Pretoria SA																		
University of Washington I-TECH		X											X				X	
University of Western Cape						X							X	X			X	
University Research Corp SA VCT										X								
University Research Corp TB TASC													X					
University Research Corporation –HCI		X						X		X	X		X	X	X		X	
US Embassy – Public Affairs Section							X											
US Embassy PEPFAR Secretariat							X											
USAID Management & Staffing				X	X	X	X											

	BL	XS	XD	OVC	AB	OP	MS	BC	SI	CT	PC	ID	TB	PMTCT	PTX	LAB	HSS	CIRC
Walter Sisulu University - UNITRA RTC		X						X			X		X	X	X			
Wits Health Consortium - National Health Laboratory Services														X		X		
Woord en Daad				X	X	X		X		X			X					
World Vision South Africa				X	X			X										
Woz'obona Early Childhood Community Service Group				X														
Xstrata Coal SA & Re-Action!		X		X				X		X	X		X		X		X	
Youth for Christ SA					X	X												