

A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

Terra Nova

HOW TO ACHIEVE A SUCCESSFUL PEPFAR TRANSITION IN
SOUTH AFRICA



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Cover photo credit: *Left*, waving the South Africa flag in support of the national team, photo by babasteve, <http://www.flickr.com/photos/babasteve/4711380526/in/photostream/>; *top right*, Jacob Zuma during the Opening Plenary of World Economic Forum on April 2011, photo by World Economic Forum, <http://www.flickr.com/photos/worldeconomicforum/5687240931/in/photostream/>; *bottom right*, U.S. President chairs Security Council Summit, photo by United Nations, http://www.flickr.com/photos/un_photo/3952224844/in/photostream/.

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TERRA NOVA

HOW TO ACHIEVE A SUCCESSFUL PEPFAR TRANSITION IN SOUTH AFRICA

Suzanne C. Brundage¹

Executive Summary

Seven years ago, the President's Emergency Plan for AIDS Relief (PEPFAR) made its first investments in South Africa, the heart of the global HIV/AIDS pandemic. These historic investments quickly grew to become the largest single bilateral health account in the world. The resulting story of U.S. engagement in South Africa is one of strategic choice, sustained commitment, and significant human impact. In the past three years, it has also been the story of increased South African ownership and action, as its government has brought unprecedented levels of money and political will to the battle against HIV/AIDS. As an integral part of that engagement, South Africa and the United States have launched a new strategic dialogue, an accelerated partnership to engineer full ownership and capacity by South Africa of HIV/AIDS and related health programs.

Today, the United States and South Africa have together entered uncharted territory. South Africa is home to a profoundly important transition in U.S. foreign assistance. The United States and South Africa are negotiating a complex, multiyear handoff that will shift financial and managerial responsibilities for HIV/AIDS to the South African government and move the United States away from direct service delivery and into technical assistance. Moreover, over the next several years U.S. health assistance to South Africa will be scaled down significantly from its FY 2011 level of \$560 million. A successful transition, requiring special care and determination by both countries, will result in a long-term sustainable approach and the deliberate strengthening of the South African government's financial and managerial capacities. Both outcomes promise big wins for U.S. global health approaches and could provide an important model of U.S. foreign assistance success that draws praise in the United States from Democrats and Republicans alike. Smaller but no less significant transitions are under way in Botswana and Namibia, which will also provide important lessons for the U.S. government.

To facilitate the transition, in the last two years the Obama administration has intensified its senior-level dialogue with the South African government, expanded its direct technical support, and involved key external expertise (e.g., consultation done by McKinsey & Company for the U.S. government) to assist in building data, knowledge, and analytic and planning capacities. Much progress has been made in laying the foundation for a durable, smooth handoff of lead responsibilities to the South African government. But much additional work is needed, at a higher level, to sustain success.

Negotiated change contains several implicit risks and has begun to stir anxiety. South Africa and the United States share an awareness that in a transition of this complexity and scope vital health services could be disrupted, even in spite of overt, genuine commitments by both governments to avoid

1. Suzanne C. Brundage is assistant director and research associate of the CSIS Global Health Policy Center.

such interruptions. The transition could trigger loud and potentially damaging criticism leveled at the United States, fueled by nongovernmental organizations (NGOs) that may see their role diminishing as a result of these changes, or tied to enduring anti-American sentiment. Also, the essential trust and cooperation carefully built up in recent years between U.S. and South African authorities could fray under the considerable pressure of the challenges that lie ahead. Such fraying would make it far more difficult to advance the delicate implementation negotiations under way.

These risks do not belie the continued political and programmatic progress in U.S.–South African health collaborations. That said, the U.S. and South African governments in this next phase will each need to acknowledge and address these risks preemptively. Health investments are at the core of the U.S.–South African bilateral relationship, and the stakes are considerable for both U.S. foreign policy and its global health approaches. The United States, in close partnership with South Africa, can take five key steps to build on recent gains, manage the risks and tensions associated with the transition, and raise the prospects of continued success:

Get the facts out. The CSIS delegation was struck, across several conversations, by the considerable frustration within the South African government, emanating from a perceived lack of transparency by the United States in accounting for its total PEPFAR investment and how monies are spent. At times this frustration crept toward resentment. These sentiments may seem surprising or unwarranted, given the active high-level U.S.–South African dialogue and collaboration under way in building the South African government's policy, analytic, and planning capacities. But they are nonetheless real, undeniable, and a potential significant hazard. One important step to ameliorate frustration and resentment is to expedite a clearer and more comprehensive mapping of U.S. funding flows and programmatic support, as a priority area in the U.S.–South Africa relationship.

Strengthen the U.S.–South African negotiating teams. Considerable progress has been achieved in the past two years in building the U.S.–South Africa dialogue over fortifying South African leadership in its HIV/AIDS programs. Despite these gains, more needs to be done to quickly step up the quality and reliability of the negotiations. Both the United States and the South African government need more coherent and better equipped senior-level teams empowered to drive forward a well-planned, negotiated transition. That process should be accelerated at both the national and provincial levels, with direct regular government-to-government communications. Careful sustained action at the provincial levels and below is needed to tailor plans to the variable demands across different local areas.

Outline a five-year framework. A strong need exists to lay down visible concrete milestones soon for the next five years in order to align expectations, eliminate uncertainty, and minimize speculation and misunderstandings. The sooner concrete budgetary and policy targets are spelled out for an orderly five-year transition (2012–2017), the easier it will be to begin implementation planning in earnest. The PEPFAR Partnership Framework Implementation Plan, expected to become public in December 2011, could be valuable in advancing the planning stage. The five-year framework should provide an initial roadmap for establishing a hybrid model of service delivery between South African government agencies and South African nongovernmental organizations, with continued U.S. support. Given their efficiencies, capabilities, and expertise, NGOs will continue to play an important service delivery role, but in a new context where they will partner directly and increasingly with the South African government instead of the U.S. government. This new hybrid partnership will test the adaptability of NGOs, the U.S. government, and the South African government. New salary structures, hiring practices, and service delivery maps will be necessary, requiring complex negotiations and planning at local, regional, and national levels.

This will include interim arrangements that ensure full service coverage during the transition and long-term arrangements that become the new permanent structures for HIV/AIDS services. This process will require that the South African government be in the lead.

The framework should include an upfront policy statement that the ultimate goal is not to terminate U.S. support; indeed, it should be made clear that the U.S. intention is to remain committed, well beyond 2016, to support prevention efforts and critical technical and training needs appropriate to South African national priorities. To that end, the United States should systematically and proactively define the endgame and quickly set forth concrete budgetary guideposts. Work should accelerate to arrive at a carefully costed, mutually agreed figure for continued support into the future. The CSIS delegation believes it is important to get a figure (or range) on the table soon in order to guide planning and shape expectations, in both South Africa and the United States. It would not, for instance, be unreasonable to argue that \$100 million to \$200 million per annum is an appropriate sustainable level of U.S. support at the conclusion of a multiyear transition. This approach makes sense given the worsening U.S. budgetary situation. Likewise, it will be critical to expedite cultivating bipartisan support within the U.S. Congress for such a long-term vision.

Have an effective communications strategy. U.S. and South African leaders need to engage with and better communicate to key audiences in both countries why and how this transition will unfold and what the critical shared goals are. For example, those goals will include supporting South African leadership and ownership of its HIV/AIDS and other health objectives; continuing and expanding services, and overall strengthening the health system; and conducting an orderly and successful transition. In the absence of an effective communications strategy, the transition risks being sidetracked or overwhelmed by tension and noise. The United States and South Africa must be seen as active partners in this transition with shared, consistent core messages.

Make even clearer that prevention is a strategic long-term priority in the U.S. health approach. There is good reason for making such an overt, forceful case. Despite promising movement on male medical circumcision and prevention of mother-to-child transmission of HIV, prevention continues to lag in South Africa. The United States has a considerable foundation of prevention programs on which to build; as it remains engaged in the epicenter of the HIV and TB epidemic over the long term, prevention will be essential to addressing the many areas of South Africa still facing a dire HIV and TB emergency. It is possible, with a robust long-term prevention strategy, to make the credible argument to skeptics in the United States that sustained U.S. investments over the long term can contribute to changing the arc of the epidemic in South Africa.

Why South Africa and Why Now?

Since its launch in 2009, the CSIS Global Health Policy Center has emphasized the need for a U.S. strategic outlook in global health. This work began with the CSIS Commission on Smart Global Health Policy (2009–2010) and has carried forward subsequently through country-specific examinations of what U.S. global health investments are achieving on the ground, how they have evolved since the advent of the Obama administration's Global Health Initiative (GHI), and what the five-to-ten-year vision for those investments is, as agreed on between the United States and its largest development partners.²

2. The center published its first analysis in this series in March 2011, with an in-depth look at how the GHI is evolving on the ground in Kenya: Suzanne C. Brundage, Lisa Carty, Christopher J. Elias et al., *On the Ground with the Global Health Initiative: Examining Progress and Challenges in Kenya* (Washington, D.C.:

Of the major partners, none has been more significant to the United States than South Africa. South Africa is the single-largest U.S. bilateral health account, with \$3.1 billion invested since 2004. South Africa and the United States also have considerable, enduring mutual interests aside from health. For these reasons alone, U.S. health investments in South Africa merit an in-depth examination. Moreover, the increased U.S. reliance on a partnership to catalyze greater investments by partner governments like South Africa raises the question of how the transition is unfolding, and what sort of multiyear plan is envisioned. Another important development is the onset in the past three years of an age of austerity during which the United States and other donor countries face historic debt and deficit challenges in the midst of a protracted economic recession. An eventual compromise within the United States on long-term spending cuts and revenue enhancement will constrain foreign aid budgets considerably in the near and medium term, and until economic growth resumes. Pressures on Capitol Hill and elsewhere will rise to define the long-term endgame strategy for U.S. investments in major partner countries such as South Africa.

Given these factors, a diverse delegation³ organized by CSIS traveled to South Africa to examine how the United States and South Africa are negotiating the next phase in the battle against HIV/AIDS, one that fully recognizes South Africa as a strategic partner capable of assuming greater responsibility for its health programs. How PEPFAR can better link with family planning and reproductive health services to improve women's health and save lives in South Africa is the subject of a companion report published by CSIS in October 2011.⁴ The delegation also explored questions around how the United States relates to South Africa as an emerging economy with growing international influence and interest in shaping the global health and development agenda. These latter questions will be treated in a separate paper to be published by CSIS in December 2011.

Between August 9 and 15, 2011, the delegation conducted focused interviews in Pretoria, Johannesburg, and KwaZulu-Natal with U.S. embassy officials, including representatives from the Department of State, U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC); South African officials in the Ministry of Health and deputy president's office; provincial and district health officials; local nongovernmental organizations; and independent observers of South African politics.⁵ The delegation is thankful to both the U.S. embassy and South African Ministry of Health for their candor and cooperation. Embassy officials supported the CSIS mission and were forthcoming about the opportunities and difficulties associated with elevating the U.S.–South Africa relationship to a new level. Particular gratitude is owed to Ambassador Donald Gips, who pulled together an embassy-wide meeting for the delegation and joined the group for a public session on the U.S.–South Africa relationship at the South African Institute of International Affairs. The CSIS delegation benefited significantly from high levels of engagement with senior Ministry of Health officials and the deputy president's office. These meetings would not have been possible without the support of Dr. Nomonde Xundu, then health attaché at the South African embassy in Washington, D.C. Both governments are grappling

CSIS, March 2011), <http://csis.org/publication/ground-global-health-initiative>. Similar work on Ethiopia will appear in January 2012.

3. Delegation members: Ms. Sally Canfield, Office of Senator Marco Rubio (R-FL); Dr. Peter Lamptey, Family Health International; Ambassador Mark Bellamy, African Center for Strategic Studies; Dr. J. Stephen Morrison, CSIS; Dr. Katherine Bliss, CSIS; Ms. Jennifer Cooke, CSIS; Ms. Margaret Reeves, CSIS; Ms. Suzanne Brundage, CSIS.

4. Janet Fleischman, *Improving Women's Health in South Africa: Opportunities for PEPFAR* (Washington, D.C.: CSIS, October 2011).

5. The trip itinerary appears in Appendix A.

with how to smoothly transition the PEPFAR program. Their willingness to speak candidly about their experiences greatly assisted us in formulating the following recommendations, which represent a consensus of the delegation. We hope our analysis will be viewed by all sides as constructive and fair.

The Bilateral Relationship

The United States and South Africa have strong mutual interests. The two countries share a healthy trade relationship, with the United States as South Africa's third-largest trading partner, accounting for 8.5 percent of all South African trade, eclipsed only by the European Union (accounting for 30 percent of all South African trade) and China (10 percent of trade). Through the end of 2012 both governments will sit on the UN Security Council, voting on vital security issues. South Africa has recently become a more active partner in negotiating for fair and peaceful elections in Zimbabwe, and has been an important voice in global nuclear nonproliferation since its transition to democracy in 1994. Perhaps even more significantly, shared values and common historical struggles with racially based injustices have built strong people-to-people bonds, most recently evinced by the popular reception of First Lady Michelle Obama's July 2011 speech at Regina Mundi church in Soweto.

The two countries also have inevitable enduring tensions, from a variety of roots: historical grievances over the United States' unwillingness to align itself with the African National Congress (ANC) during the antiapartheid struggle; predictable frictions between regional and global powers; and a realignment of alliances as emerging powers seek new partnerships. Also, significant longstanding foreign policy disagreements over Iraq, Iran, Libya, and the Israeli-Palestinian conflict require careful management. An anti-American sentiment endures in some political circles.

Multiple ups and downs have marked the U.S.–South Africa relationship since the 1994 transition to post-apartheid rule, but special mechanisms have been created to mitigate tensions and normalize relations. The first of these efforts was the Mbeki-Gore Commission, founded at the beginning of ANC rule and led by then–Vice Presidents Thabo Mbeki and Al Gore. The commission addressed the issues emerging around the democratic transition, and served as a forum to resolve disagreements on sensitive topics such as intellectual property rights and pharmaceuticals. A close relationship between the two vice presidents grew out of the commission's activities.

During the administrations of Presidents George W. Bush and Thabo Mbeki, the relationship cooled significantly, tied to differences over the U.S. invasion of Iraq in March 2003 and its aftermath. Disagreements over Zimbabwe and President Mbeki's misguided HIV policies were also significant sources of tension. However, relationships between U.S. and South African NGOs, advocacy groups, and research organizations did flourish during this period. The United States' huge PEPFAR investment in South Africa has not generated corresponding levels of goodwill among all levels of the South African political class. That notwithstanding, many opinion leaders and the 1.2 million people directly benefiting from U.S. programs and their families and communities deeply appreciate America's commitments on HIV/AIDS.

Government-to-government relations began to improve in 2009, as a change in leadership in both countries ushered in a new era and a second formal effort to renew the strategic partnership. The U.S.–South Africa Strategic Dialogue, launched in early 2010 and led by U.S. Secretary of State Hillary Rodham Clinton and South African Foreign Minister Maite Nkoana-Mashaban, reflects

the multitude of common interests on defense cooperation, trade and investment, and HIV/AIDS. A robust technical working relationship crosses almost all areas of work covered by U.S. and South African agencies. On the health front, the Strategic Dialogue has been a significant tool for intensifying and deepening cooperation between the two countries.

HIV/AIDS

With a budget many times larger than all other forms of U.S. assistance to South Africa combined, PEPFAR is the star exhibit of the bilateral relationship. Secretary of State Clinton set in place the first major accomplishment of the Strategic Dialogue in December 2010 when she signed a five-year PEPFAR Partnership Framework. The framework emphasizes the centrality of the South African government in decisionmaking and planning, the alignment of PEPFAR operations with the national health system, and the shift of U.S. government-supported staff to the aegis of the South African government. The framework also acknowledges a “likely decline” (deadline) in U.S. financial contributions as South African investments increase, but does not elaborate on how or when this transition will take place. Some details are expected to be included in the PEPFAR Partnership Framework Implementation Plan.

PEPFAR began investing health dollars in South Africa in 2004. During this period President Mbeki refused to acknowledge the link between HIV and AIDS and opposed lifesaving antiretroviral (ARV) therapy. As a result, PEPFAR had to launch its programs *in spite of* an uncooperative national government. It channeled money through nongovernmental organizations, on an emergency basis. In time PEPFAR built up a strong, prominently civil society network initially largely independent of the national department of health. Over \$3.1 billion was invested between FY 2004 and FY 2011. These investments built up new capacity in civil society, empowered local NGOs, fostered innovation and research, and contributed to providing ARVs to 1.2 million of the 1.7 million South Africans on treatment. South African NGOs in particular rose to the challenge and became vital implementing partners.

As President Jacob Zuma assumed office in May 2009, he and Health Minister Aaron Motsoaledi put in place new, revised health policies that were met with widespread optimism and support. Together they launched initiatives to control the HIV/AIDS epidemic, including an ambitious testing and counseling campaign that reached 14.7 million South Africans in one year; an additional initial budgetary allocation of R1.7 billion for HIV programs; the adoption of new World Health Organization treatment guidelines; the scale-up of male medical circumcision, an effective prevention intervention; a new focus on the gender dimension of the epidemic; a plan for reengineering the health system to primary care; and a commitment to carry most costs.

From 2009 forward, the United States and South Africa intensified their high-level exchanges around health cooperation and the transition to South African leadership and full ownership. On three occasions, these exchanges involved the direct engagement by South African President Zuma. They also involved extensive engagement by Secretary of State Clinton, Dr. Eric Goosby, head of the Office of the Global AIDS Coordinator, Health Minister Aaron Motsoaledi, and Foreign Minister Maite Nkoana-Mashabane, among others. A strong consensus emerged: that a transition is both warranted and inevitable, in which U.S. resources draw down and convert from direct service delivery to technical assistance, aligned with South African priorities. At the same time, South Africa expands its political and financial contributions as it enlarges its lead in delivering quality HIV/AIDS and related services.

Since 2009, the United States has expanded its direct technical support to the Ministry of Health to build the analytic and policy capacities essential to estimate future costs, staffing requirements, and policy modifications at different levels of the government. The United States also provided a \$120 million facility to underwrite a bulk purchase of ARVs to meet demand at the start of South Africa's mass testing campaign. The facility was provided on an urgent basis, when antiretroviral medications were at serious risk of disruption. It included \$10 million for technical assistance. This onetime investment was also used to leverage a shift by the South African government to use generic drugs, which enabled it to double its ARV supply and adopt the WHO 2009 guidelines of putting patients on treatment earlier, at a CD4 white-blood-cell count of 350 instead of 200.

The Transition: Enormous Opportunity with Risks

A shift of this magnitude contains complex logistical, managerial, and leadership challenges. Much progress has been made in the past two years as the United States has worked with South Africa to create the data, analytic, and institutional foundations for a successful transition. Effectively negotiating present and future challenges in the medium term will require continued high-level leadership, a clear vision and benchmarks, and the development of a hybrid model that blends nongovernmental organizations and the health ministry into new service arrangements. All nine provinces will be affected, with implications for more than 30,000 South African health professionals who receive their wages and salaries from PEPFAR, 1.7 million AIDS patients on life-sustaining treatment, and 386,000 orphans and vulnerable children receiving care. At the highest levels of government, on both the U.S. and South African sides, a baseline consensus agrees that this colossal challenge must be undertaken. It is at the very center of the U.S.–South Africa relationship. The current question before each government is not *whether* the transition should take place, but rather how to ensure its success and mitigate risks.

Despite the gains achieved in the past two years in terms of intensified political dialogue and accelerated programmatic collaborations, three potentially problematic scenarios need to be considered:

1. A disruption of life-sustaining treatment and other HIV services in South Africa. Both the South African and U.S. governments have made clear their determination to avoid any disruption of life-sustaining HIV/AIDS services. That said, given the scale of services in South Africa, and the complexity of the transition, the transition might elevate the inherent risk of managerial shortfalls. The CSIS delegation heard this anxiety firsthand across multiple conversations with U.S. and South African experts, both official and nonofficial.
2. Criticism of the U.S. government by a few vocal NGOs (predominantly South African, as they are the major service providers) and critics who play to an enduring anti-U.S. government sentiment. As the transition advances, conceivably more frequent accusations will arise that the United States is “abandoning” South Africa and putting the health of South Africans at risk. Although most advocacy and implementing NGOs will support the transition and recognize that the United States remains committed over the long term, the United States should still anticipate vocal dissent that could negatively affect opinion and require a special effort to rebut.
3. Strains in the U.S.–South Africa relationship, fed by frustration and resentment. The U.S.–South Africa relationship has improved significantly in the past two years but remains prickly.

The relationship is complicated, fragile, and prone to misunderstandings and breakdown. While the health partnership is one of the strongest and most secure elements of the bilateral relationship, the CSIS delegation witnessed that talk of a PEPFAR transition has generated considerable anxiety among some South African officials. After years of not being fully engaged by PEPFAR, the South African government is sensitive to any hint of condescension or lack of full transparency. The mounting pressures of implementation negotiations could strain basic trust and communications.

The U.S. embassy team in Pretoria is grappling with these critical issues. It deserves credit for winning consensus around the basic tenets of a transition, and for developing over the past seven years robust technical partnerships with South African counterparts. One high-ranking South African official cited a recent example of the United States undertaking a five-year review of PEPFAR programs, at the South African government's request, as evidence that the United States is sincere about abiding by priorities set by the Ministry of Health. The embassy has also taken steps to reduce redundancies and inefficiencies, appointing one U.S.-supported implementing partner per district to provide services, under a strategy called "alignment," and appointing a PEPFAR liaison to each province in order to improve communications with local health officials.

Nonetheless, the embassy has some significant shortcomings. The June 2011 U.S. Department of State inspector general report stated:

The PEPFAR program receives weak executive oversight. The PEPFAR coordinator serves primarily as a staff resource and does not effectively coordinate the activities of USAID and CDC. The agencies, in turn, seek to bypass the coordinator. In one case, CDC and USAID staff members were explicitly directed by their supervisors not to discuss their findings with the coordinator. The Department's Office of the Global Aids Coordinator in Washington is reexamining the terms of reference for PEPFAR coordinators in the field, which is a potentially important step that could clarify the coordinator's role. Lack of oversight and poor communication have taken a toll on important initiatives.

Competition and programmatic duplication across U.S. agencies, interagency rivalries (particularly between USAID and CDC) are apparent to South African officials, and the management structure is unsuited to mitigating these tensions. The U.S. ambassador to South Africa, Donald Gips, receives high marks from the inspector general, and has stated he is committed to sorting out these challenges with a "whole of government" approach. In addition, a few U.S. government-supported NGOs have already criticized the United States for suggesting a drawdown in funding—an early sign that criticisms during the transition could be fierce. With a program of this magnitude, the U.S. embassy struggles to relay to its South African partners the granular details of U.S. spending, including the finer costs of personnel, operational support, subcontracts and consultants, and procurement.

On the South African side, the government has made unprecedented new financial commitments and political statements in support of the fight against HIV/AIDS. The Zuma administration is committed to delivering better health outcomes to its population and has proven its ability to dramatically scale up interventions such as male medical circumcision, HIV testing and counseling, and prevention of mother-to-child transmission.⁶ South Africa has a well of private-

6. South African Medical Research Council, "SA PMTCT Evaluation shows that virtual elimination of paediatric HIV is possible with intensified effort," June 9, 2011, <http://www.mrc.ac.za/pressreleases/2011/10press2011.htm>.

sector talent that can be tapped to make even more dramatic gains. Beneath these remarkable assets, however, lie serious and fundamental challenges. Professional skills, particularly in public-sector finance and data management, remain inadequate. Funds are often mismanaged. Rigid and formalistic hiring practices have prevented the health ministry from bringing in new talent, and morale is low. Steps have been taken to overcome many of these challenges, but it will take several years to correct the health system's structural weaknesses. The South African government does not have a strong history of partnering with nongovernmental groups in health, and will have to figure out what kinds of partnerships it desires and how to make them work.

A managed, successful transition will require both the U.S. and South African governments to build upon the gains achieved between 2009 and 2011, acknowledge their respective shortcomings, plan accordingly and in partnership, and invest significant leadership and resources in ensuring that the transition runs smoothly. The following recommendations represent early steps the United States can take to facilitate planning, but ultimately the transition belongs to South Africa. As a sovereign country, it will own the plan, the process, and the success.

In the delegation's judgment, five steps should be priorities for the U.S. government:

1. *Get the facts out.* Across multiple conversations, the CSIS delegation heard a considerable amount of frustration by South African officials. At times edging toward resentment, this frustration emanates from a perceived lack of transparency by the United States in accounting for its total PEPFAR investment and how monies are spent. South African officials repeatedly called for an increase in data, transparency, and predictability in order to plan for the transition. These sentiments are real and undeniable, albeit perhaps surprising given the multiple advancements made under the high-level strategic dialogue in sharing data and building the South African government's policy, analytic, and planning capabilities. To be fair, it is important to acknowledge that the United States has invested heavily in recent years in strengthening the South African government's data-gathering capacities.

The annual Country Operational Plan provides a basis for cooperative planning and data sharing, but more effort is needed. One important step in ameliorating frustration is to provide a more clear and comprehensive map of U.S. government funding flows. This map should clearly identify which NGOs receive funding from PEPFAR, the operational costs of those programs, and the salary ranges for U.S. government-supported staff. No less important will be to accelerate the dialogue over what the Global Fund to Fight AIDS, TB and Malaria is supporting. During the transition the South African government will need to absorb thousands of skilled health workers, many of whom are paid at significantly higher rates than those in the public health service. Calculating the cost of absorbing those salaries and reengineering the salary structure to retain skilled workers will take considerable work. Anxieties will ease and transition planning will become much easier when this immediate step is taken. To the extent possible, the PEPFAR budget, managed by USAID and CDC, should also be reworked so line items are consistent with the South African government's line items. This will provide the South African treasury with essential information as it develops annual budgets for HIV programs.

2. *Build highly qualified negotiating and planning teams.* Much progress has been made in the past two years in building the U.S.–South Africa dialogue. It is now common for senior government officials to discuss the status of South Africa's HIV/AIDS programs. Despite these advancements, the quality and reliability of the negotiations needs to be upgraded. Both the United

States and the South African government need more coherent and better-equipped senior-level teams empowered to drive forward a well-planned, negotiated transition. That process should be accelerated at both the national and provincial levels, with direct regular government-to-government communications.

At the U.S. embassy, either the ambassador or the incoming deputy chief of mission should formally assume responsibility for ensuring the transition's success. A high-level official from Washington should be embedded within the embassy with the singular purpose of negotiating with the South African government and leading the U.S. planning team. Qualified teams also need to be built at the provincial levels, where the nuts-and-bolts of forming the new hybrid service delivery arrangements will take place. Currently one PEPFAR liaison exists within each province. Each liaison needs to be told clearly what his or her responsibilities are for managing the on-the-ground transition. Either the liaisons should be given staff support to negotiate provincial transition plans, or PEPFAR teams should be dispatched from Pretoria for several weeks at a time to focus on province-specific issues. District and provincial health authorities must also be empowered to provide input into national planning and develop their own transition plans that will fit local needs and capabilities.

3. *Rapidly produce a roadmap.* A broad framework that sets concrete milestones for the next several years is needed in order to align expectations, eliminate uncertainty, and minimize speculation and misunderstanding. The roadmap should set a notional figure for a scale-down of U.S. funding over five years to a lower sustainable level, with this new level of funding extending beyond 2016. This mutually agreed figure should be based on realistic assessments of the South African government's needs and result from consultations.

The framework should include a clear upfront policy statement that the ultimate goal is not to terminate U.S. support; indeed, the U.S. intention is to remain committed, well beyond 2016, to support prevention efforts and critical technical and training needs. To that end, the United States should systematically and proactively define the endgame and quickly set forth concrete budgetary guideposts. The CSIS delegation believes it is important to get a figure (or range) on the table soon in order to guide planning and shape expectations, in both South Africa and the United States. It would not, for instance, be unreasonable to argue that \$100 million to \$200 million per annum is an appropriate sustainable level of U.S. support at the conclusion of a multiyear transition. This approach makes sense given the worsening U.S. budgetary situation. Likewise, it will be critical to expedite cultivating bipartisan support within the U.S. Congress for such a long-term vision.

The roadmap should provide an initial framework for developing new hybrid service delivery arrangements between South African and U.S. NGOs and South African government agencies, working directly and increasingly together as the United States phases down its involvement in treatment and care. NGOs offer efficiencies and expertise crucial to addressing South Africa's complex HIV/AIDS epidemic and need to remain in the fold, albeit in a different relationship with the South African Ministry of Health.

Interim plans will be necessary to ensure full coverage of services during the transition, such as mentoring of new service providers and mapping that clearly demarcates how patients will be transferred from one treatment system to another. Also, long-term plans will be necessary

to create new hybrid structures that become the permanent means for delivering essential services. Ensuring effective linkages between HIV and preventing mother-to-child transmission (PMTCT) and family planning and reproductive health services should be a part of this process. The planning will test the adaptability of all players, as the development of new salary structures, hiring practices, and service arrangements will require complex negotiations at local, provincial, and national levels. While the roadmap should be flexible, it needs to have sufficient detail to lower the level of anxiety and uncertainty in the South African government and focus the negotiating teams on achieving key targets.

4. *Develop a communications plan.* Clearly and proactively communicating with key audiences in the United States and South Africa on why and how the transition will unfold, and what the critical shared goals are, will be crucial. Criticisms of the transition, including accusations that the United States is walking away from commitments, should be anticipated. These risks can be proactively countered by engaging lawmakers, media, and NGOs (both American and South African) early on the vision for the transition and how it will unfold. Importantly, the South African government should make clear in multiple forums that it desires the transition, and that at its core the transition is about the South African government taking lead responsibility for its HIV/AIDS programs—not the United States shirking its obligations.
5. *Make even clearer that prevention is a long-term strategic priority in the U.S. health approach.* The United States has a considerable foundation of prevention programs, and a good case can be made for continuing and building upon these activities. Despite promising movement on male medical circumcision and prevention of mother-to-child transmission of HIV, prevention still lags behind in South Africa. South Africa has yet to turn the corner on breaking the epidemic in terms of new infections, and remains the epicenter for HIV and TB coinfections. In scaling up effective HIV prevention programs, it will also be essential to meet the needs of women and girls, including through expanded U.S.-supported linkages between HIV and PMTCT programs with family planning, reproductive health, and maternal child health services. Prevention will need to combine behavioral-change interventions as well as biomedical interventions, including treatment for prevention. Improving prevention will require exceptional effort, but this is where the United States and South Africa have a solid preexisting partnership, with the South African government continuing to lead but with supplementary technical support from the United States. The United States brings important capacities, including programmatic and applied research expertise, and significant logistical support. Breaking HIV transmission in South Africa would have global implications over the long term, and it is on those grounds that the United States should remain engaged.

Conclusion

The United States and South Africa are entering uncharted territory, a period where they will move through difficult decisions on how to redefine their HIV/AIDS relationship. Both countries agree that a shift in financial and managerial responsibilities is inevitable, in large part due to the dramatic gains that have unfolded since 2009. Fundamental questions remain, however, of how the transition will unfold. Five components—data, a planning roadmap, skilled negotiators, a communications strategy, and the guarantee of long-term U.S. engagement focused on prevention—are essential for moving the transition forward.

The United States and South Africa are on a path to an exemplary outcome. Although at times planning and implementation may falter, much is riding on the transition being successful. For the 1.7 million South Africans receiving life-sustaining antiretroviral drugs, it means relying less and less on a parallel health system dependent on foreign support. For the South African government, the transition is a promising opportunity to create an effective, comprehensive health system capable of responding to multiple disease burdens—defining the path forward for the African continent. For the global HIV/AIDS community, the transition is a chance to transfer treatment and care to a willing and able partner government, freeing up resources to bring under control the HIV and TB pandemics at their epicenter. For the United States government, the story of U.S. engagement in South Africa is already one of strategic choice, sustained commitment, and significant human impact. That story can also be one of dramatic foreign assistance success. The opportunity is enormous.



APPENDIX A DELEGATION AGENDA

Control Officers

For Pretoria and Johannesburg meetings:

Mr. Paul Pavwoski

Economics Officer, U.S. Embassy Pretoria

For Durban meetings:

Ms. Chalone Sevant

PEPFAR Liaison, KwaZulu-Natal

Tuesday, August 9: Johannesburg

Dinner with prominent South African opinion leaders to discuss South Africa's political landscape

Wednesday, August 10: Pretoria

Initial delegation health briefing led by U.S. health attaché Dr. Mary Fanning and CDC Country Director Dr. Thurma Goldman

Working lunch with Mr. Terrence Pflaumer

Meeting with U.S. Ambassador Donald Gips

Country team meeting with senior U.S. embassy officials, led by U.S. Ambassador Donald Gips

Meeting with USAID officials Ms. Kathy Moore and Ms. Christina Chappel

Dinner with Dr. Nono Simelela, Adviser to Deputy President Kgalema Motlanthe on HIV and AIDS, TB, and other health matters; Dr. Thobile Mbengashe, Chief Director for HIV/AIDS and Sexually Transmitted Infections; and various donor agencies

Thursday, August 11: Pretoria and Durban

Review of major developments in Africa with the Institute for Security Studies (ISS)

Briefing from ISS on South African foreign policy and the U.S.–South Africa relationship

Roundtable Event at ISS, “Exceptional Uncertainty and Stress: Understanding the Washington Political Climate”

Travel to Durban

Dinner with Dr. Salim Abdool Karim and Dr. Quarraisha Abdool Karim, Centre for the AIDS Programme of Research in South Africa

Friday, August 12: Durban and rural KwaZulu-Natal

Site visit to Prince Cyril Zulu Communicable Disease Centre (PCZCDC)

Site visit to KwaMakhutha Primary Health Clinic

Site visit to Umbumbulu Primary Health Clinic

Meeting with senior officials from the eThekweni District Health Office, including briefings from Ms. P. Dladla, Acting District Manager, and Mr. Roger Phili of the National Health Laboratory Services

Dinner with Dr. Fikile Ndlovu, General Manager, Chief Directorate for HIV/AIDS, Province of KwaZulu-Natal

Saturday, August 13: Durban and Pietermaritzburg

Briefing from the KwaZulu-Natal (KZN) Network on Violence Against Women and South African Police Services

Site visit to the Pietermaritzburg Traditional Healers Project, led by Professor Nceba Gqaleni from the University of KwaZulu-Natal

Briefing at Edendale Hospital on NIH-funded clinical trials

Travel to Johannesburg

Sunday, August 14: Johannesburg

Executive time

Monday, August 15: Johannesburg and Pretoria

CSIS and South African Institute for International Affairs (SAIIA) cohosted conference, “The United States, South Africa, and South Africa’s Global Health Agenda”

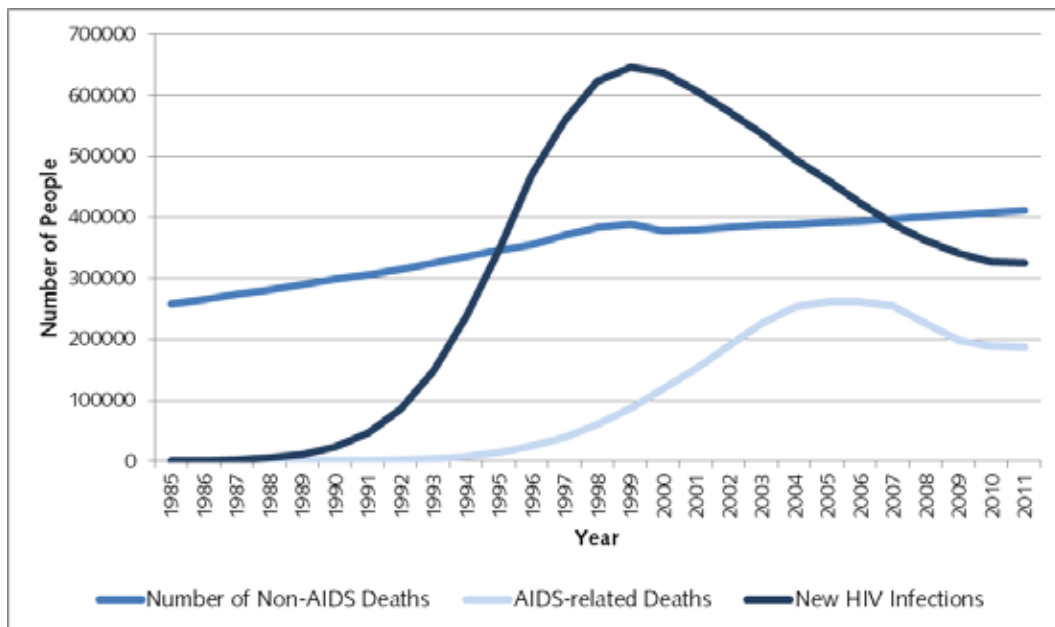
Meeting with Dr. Yogan Pillay, Deputy Director General of Strategic Health Programmes at the National Department of Health

Meeting with Ms. Malebona Precious Matsoso, Director General of the National Department of Health

APPENDIX B

DATA ON THE SOUTH AFRICAN HIV/AIDS EPIDEMIC

Number of Non-AIDS Death, AIDS-related Deaths, and New HIV Infections 1985–2011



Source: See http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/southafrica_2010_country_progress_report_en.pdf.

Most at-Risk Populations

At-risk Population	HIV+ Prevalence Rate (%)	95% Confidence Incidence (CI)
African females 20–34	32.7	29.7–36.0
African males 25–49	23.7	20.1–27.7
Males 50+ years	6.0	4.4–8.1
Men who have sex with men	9.9	4.6–20.2
High-risk drinkers	13.9	10.4–18.2
Recreational drug users	10.8	7.2–15.8
People with disabilities	14.1	9.9–19.6

Source: South Africa National HIV Survey 2008.

HIV Prevalence by Age

	Adults 15–49 Years (2010)	Antenatal Women (2008)	Children 2–14 Years (2008)	Overall (2010)
HIV prevalence rate	17.3%	29.3%	2.5%	10.5%

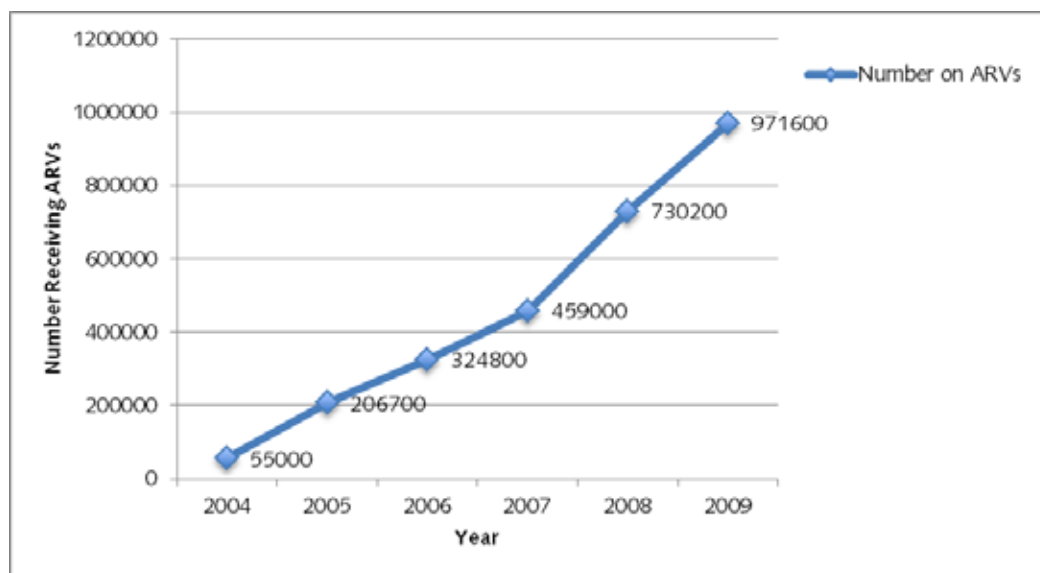
Sources: Mid-year Population Estimates 2010; South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008.

PEPFAR Bilateral Funding for South Africa in FY 2004–2011 (US\$ in millions)

2004	2005	2006	2007	2008	2009	2010	2011	Total FY
\$89.3	\$143.3	\$221.6	\$397.8	\$590.9	\$561.3	\$560.4	\$548.7	\$3113.4

Source: See <http://www.pepfar.gov/documents/organization/116231.pdf>.

Number of South Africans on Antiretrovirus (ARV) Treatment 2004–2009



Source: See <http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets/>.

U.S. Bilateral Aid to South Africa FY 2008–2011, by Objective, in Millions of Dollars

	FY 2008 Total	FY 2009 Total	FY 2010 Estimate	FY 2011 Request
TOTAL	574.937	544.890	577.560	586.350
1. Peace and security	1.615	1.608	5.150	7.465
2. Governing justly and democratically	-	-	-	2.866
3. Investing in people	567.401	534.782	560.469	560.469
3.1 Health	564.151	534.782	560.469	560.469
3.1.1 HIV/AIDS	557.200	523.282	545.969	545.969
3.1.2 Tuberculosis	5.951	10.000	13.000	13.000
3.1.3 Family planning and reproductive health	1.000	1.500	1.500	1.500
3.2 Education	3.000	-	-	-
3.2.1 Basic education	3.000			
3.3 Social and economics services and protection for vulnerable populations	0.250	-	-	-
3.3.1 Social services	0.250	-	-	-
4. Economic growth	5.250	8.500	11.941	15.550
5. Humanitarian assistance	0.671	-	TBD	TBD

Source: See http://www.usaid.gov/locations/subsaharan_africa/countries/southafrica/southafrica_fs.pdf.



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