Counting the Cost of South Africa’s Health Burden

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Acknowledgments

This report is based on a series of interviews conducted in Pretoria, Johannesburg, Cape Town, and Durban in May 2015. Researchers met with officials at the U.S. embassy in Pretoria, representatives of the South African government past and present, senior officials from South Africa’s Department of Health and National AIDS Council, representatives from organizations implementing health programs in South Africa, civil society leaders, medical researchers, representatives from the private sector, and one former head of state. In addition, the research team visited facilities in Durban and Cape Town where treatment and research is carried out into HIV/AIDS and tuberculosis. The South Africa visit was supplemented by extensive discussions in the United States with current and former U.S. government health officials along with health policy experts, staff from the U.S. Congress, and representatives from U.S., international, and multilateral global health organizations. The CSIS team is grateful to everyone who shared his or her time and insights. The views expressed here are solely those of the authors. This work was made possible by the generous support of the Bill & Melinda Gates Foundation.
Executive Summary

South Africa’s health system is approaching a make-or-break moment. Can it complete a set of complex organizational reforms and place itself on a sustainable financial footing that will enable it to deliver first-rate healthcare services to patients? Or will a stalled political process, economic stagnation, and the country’s daunting—and expanding—health burden torpedo the reform effort and cause the system to grind to a halt, with dire consequences for the nation’s health? The next decade will go a long way toward answering these questions.

Since the end of the apartheid era, South Africa has faced the challenge of correcting the imbalances of a two-tier health system, whereby a well-financed private network of clinics and hospitals delivers high-quality services to the few (predominantly whites and a small black elite) while an under-resourced public system struggles to deliver the most basic services to the majority black population. Further layers of inequality lead to big variations in health outcomes from province to province and between rural and urban areas. A massive restructuring effort is under way, beginning at the Primary Health Care (PHC) level, to smooth away these inequalities in favor of a unitary system that will ultimately provide healthcare to everyone under a national health insurance (NHI) scheme. This important initiative has made slow progress because of the sheer size of the undertaking and big questions over the ability of the South African government to finance the effort.

An exception to this two-tier health landscape is the system put in place for treating the 6.4 million South Africans who have HIV/AIDS. The United States played the lead role in setting up this structure, bypassing a South African government that under former President Thabo Mbeki was reluctant to help its own people. The President’s Emergency Plan for AIDS Relief (PEPFAR) was the vehicle for delivering this ambitious objective, and millions of lives were saved as a result. Today, the United States and South Africa work together in managing the program and South Africa has largely assumed the financial burden for sustaining its highly successful treatment services. Health stands at the very center of the bilateral relationship, reflecting the fact that South Africa is at the epicenter of the global HIV/AIDS pandemic.

What PEPFAR has largely failed to do, however, is deliver benefits to the broader South African health system. This was never the original intention of a program set up to deal with a pressing emergency, but now that PEPFAR is officially committed to Health System Strengthening (HSS) and is looking to scale back its frontline activities, there is a pressing need to find ways to establish sustainable, sector-wide healthcare solutions.
This task is urgent because South Africa, despite its middle-income status, suffers abysmal health outcomes. The fight against HIV has meant that insufficient attention and resources have been directed toward other infectious diseases. Tuberculosis is now the leading cause of death in South Africa and the high TB-HIV coinfection rate means that one disease cannot possibly be tackled in isolation from the other, a reality that historically disconnected treatment programs have been slow to grasp. South Africa’s women and girls suffer particularly poor health outcomes. While catastrophically high rates of new HIV infections among adolescent girls offer a partial explanation, too many avoidable deaths occur during childbirth and in the few days afterwards. Rising rates of noncommunicable disease and endemic violence, including alarmingly high rates of gender-based violence, add more weight to South Africa’s health burden. High levels of poverty among the general population exacerbate many of these health problems and complicate efforts to deal with them.

The United States will continue to be a strong partner to South Africa on health but its role is changing, particularly as significant cuts to the PEPFAR budget come into effect and a more strategic approach is pursued. As belts tighten, assistance is being targeted at the worst HIV “hotspots” in an effort to maximize impact. The scientific argument underpinning this strategy—known as PEPFAR 3.0—is sound but it has caused inevitable tensions with the host country, which is facing acute financial pressures and increasingly angry demands from its citizens for better public services. The next year will be critical as the new approach unfolds. If PEPFAR 3.0 can be successfully implemented it could open the way for accelerated progress against HIV/AIDS and enhance South Africa’s leadership of the disease response. But the new strategy also carries significant risks, and close coordination and planning will be required to ensure that service gaps do not appear and negative political reactions can be contained.

As it considers its future health relationship with South Africa and ponders ways to strengthen the PEPFAR partnership, the United States should:

- Make more effort to understand the complexity of South Africa and the set of political, economic, and social difficulties it currently faces, that make it a more fragile place than is commonly acknowledged. Understand how these constraints apply to the health system and think strategically about how to work around them.

- Build flexibility into the PEPFAR 3.0 rollout to take account of the sensitivities of its partners, the complexity of the changes, and the dangers of making mistakes that could lead to service delivery gaps.

- Make HIV prevention the lead message in the run-up to, and during, the International AIDS Conference to take place in July 2016 in Durban.
Understand that NHI is the key to a sustainable health system in South Africa and invest appropriate attention, funding, and technical assistance in working with South Africa on funding and delivery options.
Counting the Cost of South Africa’s Health Burden

Richard Downie and Sahil Angelo

Putting South Africa’s Health Challenges in Context

South Africans have faced many challenges in gaining access to quality healthcare during the first two decades of multiracial democracy. The apartheid system that apportioned health resources according to race left black South Africans at the bottom of the heap, forced to endure substandard healthcare in overcrowded, underfunded, and understaffed facilities. Its effects are still felt today in poorer health outcomes for black South Africans and a public healthcare system that groans under the weight of the demands placed upon it. The situation further deteriorated under the presidency of Thabo Mbeki (1999–2008), whose denial of the link between HIV and AIDS had a devastating impact on the nation’s health. This period of inactivity in the face of a health emergency of unprecedented proportions cost the lives of millions.1 The impacts of these two legacies—apartheid and AIDS denialism—help explain the extreme variations in the burden of disease across populations. Statistics show that in 2012, the HIV prevalence rate as a percentage of the population stood at 15 percent for blacks, 3 percent for coloreds, and less than 1 percent for whites and Indians.2

Table 1: Demographic Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2009</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (millions)⁴</td>
<td>51.8 (2011 census)</td>
<td>53.7</td>
</tr>
<tr>
<td>Life expectancy (total)⁴</td>
<td>57.1</td>
<td>62.2</td>
</tr>
<tr>
<td>Life expectancy (male)⁴</td>
<td>54.6</td>
<td>59.4</td>
</tr>
<tr>
<td>Life expectancy (female)⁴</td>
<td>59.7</td>
<td>65.1</td>
</tr>
<tr>
<td>Median age⁵</td>
<td>N/A</td>
<td>25.5</td>
</tr>
</tbody>
</table>


While the damage inflicted by these political choices is still felt to this day, South Africa has entered a more enlightened era of health policymaking and the government has made significant efforts to deliver on its constitutional mandate to

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ensure the progressive realization of the right to health. Many of these improvements have been made possible by broader efforts to improve living standards for large numbers of South Africans through a social grants program that provides the poorest families with additional state support. By 2010, for example, 82 percent of households had electricity, 89 percent had access to piped water, and 93 percent had a toilet.3

The current health minister, Aaron Motsoaledi, and the senior officials around him have provided energetic leadership. Ambitious targets have been set to prevent, detect, and treat HIV/AIDS and other infectious diseases such as TB. On HIV, South Africa has in a fairly short time taken on the financial and managerial responsibility for sustaining approximately three million patients on antiretroviral therapy (ART), the largest such program in the world. While dealing with the HIV crisis, South Africa has shown flexibility and creativity, for example, by relaxing guidelines in order to allow nurses to administer antiretroviral (ARV) drugs and establishing the framework for an electronic HIV registry.4 Attempts are being made to reduce mortality rates among key populations—particularly mothers, young children, and babies, whose poor health outcomes must be addressed if South Africa is to meet its Millennium Development Goals (MDGs).5 Comprehensive programs for the Prevention of Mother-to-Child Transmission (PMTCT) of HIV have achieved remarkable success.

In addition, work is under way to overhaul the health system, improve health facilities, strengthen medical supply chains, ramp up the collection and application of data, and make better use of the few health workers at its disposal. These activities are centered on the Primary Health Care (PHC) system, where since 2009 a so-called reengineering process in the public health sector has been trying to make clinics more welcoming, standardizing and improving the quality of services they provide, and buttressing their staff with additional support from clinical specialist teams and community health workers. Plans are also being formulated to achieve universal health care through the introduction of a national health insurance (NHI) scheme. The PHC reforms are intended to reorient the health system around preventative care rather than more costly, less efficient curative interventions.

Preventive health is a constant theme of Minister Motsoaledi’s public pronouncements. His 2015 budget speech referred to the importance of hand washing as a guard against infection and highlighted an expansion of the childhood immunization program to include the pneumococcal conjugate and rotavirus

4 The system, called Tier.net, is managing a staged transition from paper to electronic records.
5 South Africa looks likely to miss MDG goals 4 and 5 on reducing child mortality and improving maternal health according to Mayosi et al., Health in South Africa.
The Department of Health has not shied away from making robust policy interventions. In 2013, for example, South Africa became the first country in the world to pass legislation placing mandatory limits on the amount of salt that food producers can put in certain foodstuffs. The government has also adopted an enlightened approach to family planning; it has expanded the contraceptive method mix and is considering proposals to make contraceptives available to students at school.

Translating all these policies into reality is a perennial challenge and progress has been patchy. South Africa's decentralized system of government adds an additional layer of complexity, making it more difficult for national-level policymakers to impose their will on the country's nine highly autonomous provinces and the 52 districts beneath them. Nevertheless, many South Africans interviewed agreed that the nation enjoyed strong national-level leadership on health and was beginning to chip away at some of its most pressing health challenges.

The U.S. Contribution to Health in South Africa

In its efforts to tackle HIV/AIDS in particular, South Africa has received significant support from external sources. The United States has played a particularly important role that began in earnest with the introduction of the President’s Emergency Plan for AIDS Relief (PEPFAR) in 2003, an effort that South Africans herald as a turning point in the fight against the epidemic. For much of the Mbeki presidency, the United States circumvented the government, setting up what amounted to a parallel health system that administered life-saving treatment through nongovernmental organizations and scaled up operations throughout the country. Between 2004 and 2014, the United States invested more than $4.6 billion in HIV/AIDS and TB in South Africa, by far the largest PEPFAR commitment in any country.

When President Mbeki stood down in 2008, the engagement shifted to one of partnership with South Africa, which gradually assumed greater responsibility and ultimately the lead role in paying for and administering treatment, hiring health workers formerly employed directly by the United States and placing them within its public health system. It was a monumental U.S. investment rarely acknowledged in public by a South African government strongly protective of its sovereignty and reluctant to embrace the United States. However, conversations with health officials from both countries convey a genuine feeling of partnership in the fight against HIV. This partnership is not without its difficulties, in particular a long and delicate

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handover from U.S.-led to South African-led programing, accompanied by a drop-off in PEPFAR funding that is set to accelerate as early as October 2016. The emergency nature of the initial intervention in South Africa combined with the attitude of the host government at the time meant that PEPFAR’s approach was by necessity a top-down, externally driven one. The very different present-day circumstances demand a more integrated, horizontal set of programs that look to pass off primary responsibility for the HIV/AIDS response to South Africa and deliver sustainable benefits to the broader health system. The task of managing this handover in an orderly fashion has been a complicated and at times fraught process that has yet to be completed. In addition, new leadership at the Office of U.S. Global AIDS Coordinator (OGAC) in Washington and a new policy direction that adopts a much more targeted approach to tackling the epidemic have triggered a controversial, potentially destabilizing round of program changes still reverberating in South Africa.

Health Challenges

In considering South Africa’s health situation and the evolving role of the United States as a health partner, the horizon is clouded by two main sets of problems:

- Concerns over South Africa’s ability to service its population’s growing health needs in a period of political and economic uncertainty;
- Problems and sensitivities emerging from the new U.S. PEPFAR 3.0 strategy including how it was introduced, how it will be implemented, and whether it can ultimately succeed in the way envisaged. These problems complicate the already formidable set of health challenges and policy choices South Africa faces.

1. Assessing South Africa’s Ability to Meet Its Health Needs

South Africa is a large, diverse, and complex nation that presents health policymakers with a set of contradictions and challenges. On the one hand, it is a middle-income country richly endowed with natural resources, boasting a diverse economy and a solid, though underperforming, manufacturing base. South Africa is therefore able to allocate a fairly respectable 8.7 percent of the country’s GDP toward health and in absolute terms spends more on health than any other African country. Furthermore, it has a well-functioning government with impressive technocratic capacity at the senior level and pockets of high performance at the provincial and district levels. Its infrastructure is excellent by African standards. It has medical expertise and research capacity that far surpasses that of any other African country. It has a large, diverse

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Civil society that makes an important contribution to health service delivery and has performed an effective advocacy role on health for many years, particularly on HIV/AIDS. Finally, South Africa has an engaged private sector including companies that have shown global leadership in taking care of the health needs of their workforce.

At the same time, good health leadership, good policies, and reasonable levels of spending on health have failed to translate into good health outcomes. Life expectancy remains low—62 years in 2013—below the level of much poorer African countries such as Ethiopia and Senegal. South Africa is one of only 12 countries where life expectancy for the under-fives has declined since 1990. There are several explanations for this but they can be broken down into demand-side and supply-side problems. In terms of demand, the sheer size of South Africa’s disease burden, which includes illnesses common to both developing and developed nations, threatens to overwhelm the country. The disease burden is aggravated by inequalities in South African society that inhibit the ability of the poorest citizens to look after their health and access quality healthcare. On the supply side, South Africa’s public health system is ill-equipped to cope with the country’s enormous health needs. The physical infrastructure is poor, health staff are overstretched, and medical supplies are lacking. Even where services are available, the quality of the healthcare they provide is often substandard, with long waiting times, dirty clinics, and—in too many cases—rude and unprofessional staff.

**Demand Side Problems**

*A large—and expanding—set of health burdens*

South Africa’s health burden is commonly broken down into four components: An alarmingly high rate of infectious disease; a slew of health challenges affecting women and girls, young children, and babies; a growing problem of noncommunicable disease; and a high toll caused by violence and accidents, sustained by deep-rooted social problems linked to the apartheid legacy.

**Infectious diseases:** South Africa accounts for 17 percent of the global burden of HIV, with 6.4 million people living with the disease. Since 2009, major gains have been made in providing treatment: the government has the largest ARV treatment program in the world. It currently provides 3.1 million people with antiretroviral drugs, a

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10 South Africa Department of Health Strategic Plan 2015/16–2019/20, 15.
11 Mayosi et al., *Health in South Africa*. South African health officials are confident that updated figures yet to be released will show a big improvement.
number that is expected to rise to 4.6 million by 2016. These figures represent a big success story for South Africa yet the financial challenge of sustaining an expensive ARV treatment program is enormous and places huge strain on the health system. There are additional concerns about ensuring patients adhere to their drug regimens; failure to do so can lead to poorer health outcomes, increase the risk of new infections, and raise the risk that patients might develop drug resistant HIV.

Table 2: Number of People Living with HIV and Access to Antiretroviral Therapy (ART)

<table>
<thead>
<tr>
<th></th>
<th>Estimated Number of People Living with HIV</th>
<th>Estimated Number of People on ART</th>
<th>Proportion of People Living with HIV on ART (%)</th>
<th>HIV/AIDS-Related Deaths in 2013</th>
<th>Proportion of Total Deaths Due to HIV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2,531,000</td>
<td>651,000</td>
<td>25.7</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Female</td>
<td>3,873,000</td>
<td>1,344,000</td>
<td>34.7</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>0–14</td>
<td>369,000</td>
<td>166,000</td>
<td>45.1</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>15–24</td>
<td>720,000</td>
<td>103,000</td>
<td>14.3</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>25–49</td>
<td>4,706,000</td>
<td>1,466,000</td>
<td>31.2</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>50+</td>
<td>610,000</td>
<td>260,000</td>
<td>42.7</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>15–49</td>
<td>5,426,000</td>
<td>1,569,000</td>
<td>28.9</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Black African</td>
<td>6,232,000</td>
<td>1,924,000</td>
<td>30.9</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Other</td>
<td>172,000</td>
<td>71,000</td>
<td>41.3</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,422,000</strong></td>
<td><strong>2,002,000</strong></td>
<td><strong>31.2</strong></td>
<td><strong>23,203</strong></td>
<td><strong>5.1</strong></td>
</tr>
</tbody>
</table>


The government has responded to these concerns in part by renewing its focus on prevention. Impressive efforts have been made in areas like condom distribution, conducting voluntary medical male circumcisions, and PMTCT. However, HIV infection rates remain stubbornly high, particularly among certain key populations. For example, 1,700 new infections are recorded each week among young women and adolescent girls. South Africa’s epidemic remains a dangerous emergency. Comprehensive prevention programs that go beyond biomedical solutions are required to shift these figures. However, they involve changing political, social, and

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14 Interview with senior official in the Department of Health, Pretoria, May 12, 2015.
15 In 2012, 48.1 percent of all men in South Africa were reported circumcised; more than 501,000 condoms were distributed, and the mother-to-child transmission rate was less than 2.4 percent. See Day and Gray, “Health and Health Related Indicators.”
cultural norms, as well as legal practices and economic realities, which will require multisectoral approaches and longer-term investments.

### Table 3: HIV Prevalence, New Infections, and Incidence

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Prevalence (% of total population)</th>
<th>Estimated Number of New Infections</th>
<th>Incidence (% of total population)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Total Male</td>
<td>Female</td>
</tr>
<tr>
<td>0–14</td>
<td>2.4</td>
<td>29,000</td>
<td>N/A</td>
</tr>
<tr>
<td>15–24</td>
<td>7.1</td>
<td>139,000</td>
<td>26,000</td>
</tr>
<tr>
<td>25+</td>
<td>19.9</td>
<td>300,000</td>
<td>125,000</td>
</tr>
<tr>
<td>All ages</td>
<td>12.2</td>
<td>469,000</td>
<td>151,000</td>
</tr>
</tbody>
</table>


TB is another grave problem that has emerged from under the shadow of HIV to become the leading cause of death in South Africa. After adjusting for population size, South Africa has the highest incidence and prevalence of TB among all high-burden countries.\(^{17}\) Almost 300,000 new cases were reported in 2013.\(^{18}\) Furthermore, South Africa reports the second-largest caseload of multidrug-resistant (MDR)-TB, and the largest number of extensively drug-resistant (XDR)-TB cases in the world. Screening and diagnosis of TB has improved due in large part to South Africa’s aggressive uptake of GeneXpert technology. However, the TB response has struggled to keep pace with the increased caseload; it is complicated and costly for governments and involves a long and arduous treatment process that patients struggle to adhere to, particularly in drug-resistant cases. While treatment success rates have improved, there is a long way to go. In 2011, 79 percent of cases were successfully treated, while in 6 percent of cases patients defaulted on their treatment.\(^{19}\) TB in South Africa has largely been driven by the spread of HIV. TB/HIV coinfection rates are as high as 70 percent, requiring close integration of services.

The South African government has made the fight against TB a top health priority. Minister Motsoaledi has recently applied to TB the so-called 90/90/90 targets set by the United Nations Program on HIV/AIDS (UNAIDS)\(^{20}\) and in his 2015 budget speech,

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\(^{18}\) Department of Health *Strategic Plan 2015/16–2019/20*, 17.

\(^{19}\) Ibid., 18.

\(^{20}\) The UNAIDS target sets a deadline of 2020 for 90 percent of people with HIV to know their status, 90 percent of people diagnosed with HIV to receive antiretroviral therapy, and 90 percent of people on antiretroviral therapy to have achieved viral suppression.
announced a massive program to screen and treat populations vulnerable to TB, such as prisoners and mine workers.

**Table 4: South Africa TB Indicators, 2014**

<table>
<thead>
<tr>
<th></th>
<th>Mortality Rate (per 100,000)</th>
<th>Prevalence Rate (per 100,000)</th>
<th>Incidence Rate (includes HIV+TB)</th>
<th>HIV Prevalence in Incident TB Cases (%)</th>
<th>Total Number of People with TB</th>
<th>Case Detection Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All TB</td>
<td>48</td>
<td>715</td>
<td>860</td>
<td>61</td>
<td>380,000</td>
<td>69</td>
</tr>
</tbody>
</table>


**Table 5: Drug-Resistant TB in South Africa**

<table>
<thead>
<tr>
<th></th>
<th>Estimate of Notified Cases</th>
<th>Cases enrolled in MDR Treatment (%)</th>
<th>Treatment Outcomes Evaluated (%)</th>
<th>Treatment Success (%)</th>
<th>Deaths (%)</th>
<th>Loss To Follow up (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDR-TB</td>
<td>6,900</td>
<td>41</td>
<td>65</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>XDR-TB</td>
<td>612</td>
<td>N/A</td>
<td>59</td>
<td>15</td>
<td>40</td>
<td>36</td>
</tr>
</tbody>
</table>


**Table 6: TB-HIV Coinfection in South Africa**

<table>
<thead>
<tr>
<th></th>
<th>TB Patients with Known HIV Status</th>
<th>HIV+TB patients</th>
<th>Incidence Rate of HIV-TB (per 100,000)</th>
<th>Mortality Rate (per 100,000)</th>
<th>TB Patients Started on ART</th>
<th>HIV Patients Started on Isoniazid Preventive Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB/HIV Coinfection</td>
<td>294,504 (90%)</td>
<td>181,783 (62%)</td>
<td>520</td>
<td>121</td>
<td>38,754 (88%)</td>
<td>373,000 in 2012^c</td>
</tr>
</tbody>
</table>


*Maternal, neonatal, and child health:* South Africa has prioritized efforts to reduce the number of deaths among these three groups and appears to be making some progress, albeit from a dismal starting position. The biggest successes are attributable to improvements in HIV treatment and prevention. PMTCT is the area where most progress has been made. This is largely due to an aggressive program of HIV testing during pregnancy, the prompt initiation of treatment for women who test HIV positive, and high levels of antiretroviral prophylaxis. MTCT dropped from 3.8 percent

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in 2010 to 2.6 percent in 2012, and, according to preliminary laboratory data, has now dipped below 2 percent. However, non-HIV-related indicators for maternal and child health remain stubbornly high.

Mothers and children are target groups of the PHC reengineering program. The objective of this strategy is that every district will eventually have a Clinical Specialist Team comprising an obstetrician and gynecologist; a midwife, a pediatrician, an anesthetist, a family doctor, a pediatric nurse, and a PHC nurse. Implementing this policy will be challenging, especially given the dearth of human resources for health and the difficulties of incentivizing specialists to practice in rural areas. As of April 2014, only two districts in the entire country had appointed the full seven-member team.

Table 7: Maternal and Child Health

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>2009</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio (per 100,000)</td>
<td>310</td>
<td>269</td>
</tr>
<tr>
<td>Infant mortality ratio (per 100,000)</td>
<td>40</td>
<td>29</td>
</tr>
<tr>
<td>Under-five mortality ratio (per 100,000)</td>
<td>56</td>
<td>41</td>
</tr>
<tr>
<td>Fertility rate* (births per 1,000 women)</td>
<td>2.7</td>
<td>2.3</td>
</tr>
<tr>
<td>Adolescent fertility rate* (births per 1,000 women ages 15–19)</td>
<td>56</td>
<td>49</td>
</tr>
</tbody>
</table>


Noncommunicable diseases (NCDs): In addition to its high infectious disease burden, South Africa must also tackle the rising prevalence of NCDs often associated with upper-middle-income countries. It is estimated that the major NCDs, including cardiovascular diseases, cancer, respiratory diseases (such as asthma and pneumonia), and diabetes, account for 40 percent of all deaths in South Africa. Surveillance of these illnesses is poor, particularly when it comes to distinguishing comorbidities with infectious diseases. The Department of Health has developed a national strategy to tackle NCDs that will set up a disease surveillance system and follow-up legislation on salt content with similar initiatives to target alcohol, sugar, and tobacco consumption.

Violence and Accidents: South Africa’s rates of general violence, injuries, and accidents are declining (except for gender-based violence), but remain at very high levels. Nearly half of all nonfatal injuries in South Africa are due to violence and the injury

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22 Interview with senior official from Department of Health, Pretoria, May 12, 2015.
25 For example, people with diabetes are three times more likely to acquire active TB.
death rate is twice the global average. Male homicide in South Africa is estimated to be eight times the global average, with the rates highest among men aged 15–29 years. Violence against women is particularly severe: Female deaths from intimate partner violence in 2009 were six times the global rate, and total female homicide was five times the estimated global rate. The rates of reported rape increased by about 20 percent from 1994/95 to 2010/11.

High rates of violence stem in part from the harmful legacy of the apartheid system, which sustained itself through the use of physical and mental abuse and traumatized those who experienced it. This shared trauma appears to have been passed down a generation; high rates of violent behavior are found among South Africans born after 1994, whose lives are often blighted by unemployment, poverty, and family breakdown. Catalytic factors include drug and alcohol abuse, poor mental health support, and weak or predatory law enforcement. These desperate conditions provide a partial explanation for the frequent explosion of collective acts of violence in South Africa, such as the almost daily service delivery protests or the episodes of xenophobic rioting that occurred in 2008 and early 2015.

Efforts by the South African government to tackle violence have been undermined by the fact that solutions require coordinated efforts by multiple agencies. Too little progress has been made in reducing the risk of violence faced by women and girls, and official policies come into conflict with gender norms and cultural practices among some groups that believe women are subordinate and that men must vigorously assert their masculinity. Furthermore, measuring rates of violence, especially gender-based violence, is notoriously difficult, and it is likely that the true numbers of victims may far exceed reported cases.

**Aggravating Factors**

South Africa’s challenges in tackling its heavy health caseload are compounded by a broader set of problems.

Perhaps the most important is rampant inequality in society. South Africa’s most intractable health problems are tied to the socioeconomic challenges of poverty, injustice, and gender discrimination that can only be addressed by concurrent efforts to strengthen the country’s supporting infrastructure of health and wellbeing, which includes water and sanitation, education, housing conditions, roads, and access to

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28 Ibid.
jobs, as well as legal protection. While progress has been made in some areas—particularly in improving access to water and power in the poorest households—it has been static in others, such as unemployment, which ranges from 25 to 37 percent, depending on one’s definition. As a result, the gap between rich and poor has widened in the post-apartheid era. According to the Gini coefficient, which measures income distribution, South Africa is the most unequal country in the world. Inequality affects all aspects of life, from the two-tier health system (see below) to the drastically different health outcomes experienced by racial and economic groups. The legacy of the racially segregated education system continues to be felt to this day, resulting in a poorly educated stratum of society that does not take proactive measures to improve its own health and therefore increases demands on expensive curative services. These complex societal problems cannot be overcome in 20 years of multiracial democracy.

A different problem—one that is beginning to hamper efforts to tackle infectious disease in South Africa, particularly HIV/AIDS—is complacency. Health professionals note that the rapid expansion of the ARV program has led people to view the disease as a treatable problem. As a result, there are worrying signs that some people are letting down their guard. According to the South African National HIV Prevalence, Incidence and Behavior Survey, released in 2014, the number of people reporting condom use during their last sexual encounter decreased from 45 percent in 2008 to 36 percent in 2012. The biannual International AIDS Conference taking place in Durban in July 2016 provides an excellent opportunity for the global AIDS community to refocus on prevention and discuss proactive measures to tackle the complacency problem.

In relation to TB, activists and medical professionals accuse the country’s health leadership of sleep walking its way over the course of many years toward a major epidemic that has now become the nation’s number one killer. Only in the last two or three years has the current government acknowledged the scale of the problem and rolled out a comprehensive strategy to deal with it. But a lot of ground has been lost in the process. A senior official in the Department of Health admitted that “because HIV overwhelmed us, it has taken attention away from other health issues, TB in particular.” These shortcomings apply not only to the South African government but to donors as well, who have focused their efforts on the HIV emergency—albeit for good reason—without sufficiently acknowledging the reality that the two diseases have a symbiotic relationship in South Africa.

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30 Day and Gray, “Health and Related Indicators,” 211.
31 According to World Bank statistics from 2011, complete for 45 countries, South Africa had the highest inequality ranking with a score of 0.65 (where 0 equals absolute equality and 1 equals absolute inequality), http://data.worldbank.org/indicator/SI.POV.GINI?order=wbapi_data_value_2011+wbapi_data_value&sort=asc.
33 Interview with senior official from South Africa Department of Health, Pretoria, May 3, 2015
A final point to consider is that South Africa’s health problems are intrinsically linked with those of the broader southern Africa region, further complicating efforts to deal with them effectively. South Africa is the economic and transportation hub for the entire region and hence is a magnet for migrants wishing to find work—particularly in the mining sector—or flee political instability and hardship in places like Zimbabwe. These residents often bring their health problems with them and the conditions in which they live and work—and the hostility they sometimes encounter from the local population—place them at higher risk of illness and disease. When it comes to accessing health services, migrants have an uncertain status; some facilities demand to see identity cards while others do not. What is certain is that they represent an unquantified extra burden on an already overwhelmed health system. Furthermore, this highly mobile population poses headaches in terms of disease surveillance because many migrants begin taking ARVs or TB drugs only to disappear part way through their treatment. Understanding the vectors of the HIV and TB epidemics involves tracking movements and social interactions through a vast region where tools for effective disease surveillance are limited. Other diseases like malaria are a cause of concern in parts of northern provinces like Limpopo and Mpumalanga in part because of the limited success of neighboring states like Malawi and Mozambique to tackle the disease within their own borders. Regional cooperation on health issues remains at a fairly limited level despite efforts by organizations like UNAIDS and the Southern African Development Community, whose health ministers meet twice a year to discuss shared concerns.

Supply Side Problems

Weak Health System

Serious capacity deficits and structural problems weaken the ability of the South African health system and its staff to meet the high demands of the public. It is important to consider two sets of structural constraints. First is the decentralized system of government in South Africa, which hands responsibility for most policymaking and budget decisions to the National Department of Health (NDoH) but places the onus for healthcare delivery on the nine provincial governments and the 52 districts below them. The ability of national officials to influence events at the subnational level is very limited. As a result, the degree to which policies are applied and the way they are interpreted differs dramatically across the country. For example, a national effort to standardize the role of ward-based community health workers and put them on the payroll has been interpreted differently by the nine provinces, which have each set up different contractual arrangements, salary levels, and job descriptions, achieving very different results in the process.34 One province,

Western Cape, has ignored the national policy entirely, choosing to set up its own structure run through nonprofit organizations. The quality of management at the provincial level is extremely variable. In 2009, for example, the health systems of several provinces came close to collapse due to the basic failure of provincial health teams to manage budgets and the failure of NDoH officials to hold them to account.\(^\text{35}\) More recently, the media and civil society organizations have blamed incompetent health service managers in Free State and Eastern Cape provinces for putting patients’ lives at risk.\(^\text{36}\) Meanwhile, the failure of Gauteng and KwaZulu-Natal provinces to settle unpaid bills to the National Health Laboratory Service has brought the country’s premier diagnostic testing facility to the edge of bankruptcy.\(^\text{37}\)

A second structural issue is the presence in South Africa of a two-tier health system where a minority of the population pay to use a first-rate private system while the majority have to muddle their way through an underfunded, overcrowded public health system. In the 2010/11 fiscal year, 50.4 percent of health expenditure occurred in a private sector that is exclusively used by only 16 percent of the population.\(^\text{38}\) According to Section27, a South African advocacy organization promoting constitutional rights, 1,200 students graduate from medical school each year. Of this number, 600 leave the country to practice abroad. Of the 600 who stay, only 150 end up in the public sector. Within the public sector an urban-rural divide emerges, with many medical practitioners reluctant to serve outlying communities.\(^\text{39}\)

The government’s NHI plan is an ambitious attempt to iron out some of these inequalities and during its preparatory phase a big push is underway to improve public facilities, scale up services, and invest in skills training for staff. The hope is that these disparities will ultimately level out in favor of a unitary system that will take care of patients’ needs through a package of quality services provided free at the point of access by both private and public healthcare providers, paid for by a government fund partly financed by taxpayer contributions. The NHI was officially launched in 2009 and has been repeatedly declared a flagship priority for the NDoH but it has yet to move beyond the concept phase and there have been repeated delays in publishing proposals for financing it. Pilot projects have been established in 11


districts, where efforts to entice private doctors to contribute spare time to public facilities have received a lukewarm response.40

Table 8: Inequality between Public and Private Health Sectors

<table>
<thead>
<tr>
<th></th>
<th>Public Sector</th>
<th>Private Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population served</td>
<td>43,866,003</td>
<td>8,567,693</td>
</tr>
<tr>
<td>Public expenditure of GDP (percent)</td>
<td>3.91</td>
<td>5</td>
</tr>
<tr>
<td>Medical specialists</td>
<td>4,414</td>
<td>6,171</td>
</tr>
<tr>
<td>Medical practitioners</td>
<td>12,470</td>
<td>7,673</td>
</tr>
<tr>
<td>Destination of medical graduates (percent)</td>
<td>12.5</td>
<td>37.5</td>
</tr>
<tr>
<td>Users who are black (percent)</td>
<td>68</td>
<td>32</td>
</tr>
<tr>
<td>Users who are white (percent)</td>
<td>16</td>
<td>84</td>
</tr>
</tbody>
</table>

Source: SECTION27, 2012-2013 Review.

Structural constraints play out in multiple, damaging ways in South Africa’s health system. A basic shortage of healthcare staff is a chronic problem. An assessment conducted in 2011 projected a deficit of more than 66,000 healthcare professionals by 2015.41 The report noted that training programs were failing to keep up with demand and observed high attrition rates among staff due to poor conditions in public health facilities and the attraction of working in the private sector or overseas. Medical supplies, particularly medicines, are also subject to shortages. Some of these problems are beyond the control of the NDoH, which is reliant upon the availability of global pharmaceutical supplies.42 Efforts have been made to strengthen pharmaceutical supply chains and substantial progress has been made but stock-outs of essential medicines like ARVs and TB drugs continue to occur with regularity in provinces such as Mpumalanga, Limpopo, and Free State, leading one pessimistic civil society observer to conclude that “the ARV program is not far off collapse.”43

Beyond basic supply deficits, there are serious problems with the quality of services provided within the South African health system. Many South Africans have had firsthand exposure to unprofessional, uncaring, and domineering healthcare staff. The stigma experienced by patients with HIV extends to the healthcare facilities in which they receive treatment; so much so that some patients report being too scared to pick up their ARV drugs for fear of being abused by clinic staff. Hoosen Coovadia notes that “one of the challenges of the democratic era has been to improve relationships between nurses and patients, since rudeness, arbitrary acts of

unkindness, physical assault, and neglect by nurses have been widely reported.”44 South Africa’s media routinely shares the harrowing stories of patients whose lives were lost through poor treatment, neglect, or staff shortages. In one example, a woman whose husband was admitted to a Free State hospital—and subsequently died of pneumonia—explained that when she pleaded with a nurse to help, “She threw his hospital file to the side and told me I was in the way.”45 Beyond the frontline staff, management is of a low standard, particularly at the provincial and district level, where health executives, hospital managers, and health budget teams lack the necessary skills.

Toxic Politics

Some of the problems faced by South Africa’s health system—particularly in the area of managerial competence and service quality—reflect broader issues affecting politics in the country. South Africa is currently experiencing a period of political disillusion, drift, and malaise. While the African National Congress (ANC) remains dominant, falling turnout at national elections suggest that it is losing its appeal to voters. The main opposition party, the Democratic Alliance (DA), has recorded steady gains over each election cycle at the national level and has established a record of governance at the provincial level, where it controls Western Cape province and the city of Cape Town. It is confident of winning control of other cities in the 2016 municipal elections, and has set its sights on Pretoria, Johannesburg, and Port Elizabeth.

The Economic Freedom Fighters (EFF), led by the firebrand former ANC Youth League president, Julius Malema, pose a different challenge. The party sprang from nowhere to win more than 6 percent of the vote in the 2014 national elections. Its populist message resonates strongly with young people and its 25 members in the National Assembly have shaken up proceedings with their loud and persistent allegations of corruption within the ruling party. Meanwhile, the ANC alliance itself is fracturing, in particular its labor movement, the Congress of South African Trade Unions (COSATU), which is in the midst of a bitter battle over leadership and political direction. This combination of growing external pressure and internal division has unsettled the ANC, which has adopted a defensive, inward-looking posture at a time when a host of national problems demand strong leadership.

The ANC faces a demographic challenge in that the majority of South Africans have no personal experience of its liberation struggle, and impatience and frustration are setting in at the slow pace of efforts to deliver improvements to their lives. This so-

called Born Free generation is not instinctively loyal to the ANC and while it is politically active, it feels disconnected from formal politics. Instead, these young people prefer to test their political credentials in the street, mobilizing over issues as diverse as poor service delivery or demands to remove colonial-era statues from college campuses.

The malaise within formal politics is personified by President Jacob Zuma, whose personal probity continues to come under sustained attack but whose canny political management ensures he is at no immediate risk of being unseated. President Zuma himself has come to symbolize, in the minds of many, the faction of the ANC elite that has prioritized wealth accumulation in the era of multiracial democracy, often through preferential access to lucrative public contracts. This manner of enrichment has become so endemic that a new word has been coined to describe those who master it: “tenderpreneur.” Public perceptions of corruption and nepotism have increased sharply during President Zuma’s time in office. These broader problems manifest themselves in the health sector through policy stagnation, a broken tender process, and the selection of health managers based on loyalty to the party rather than competence.

Particular problems have emerged at the provincial leadership level, where the most senior health official, the health Member of the Executive Council (MEC), is a political appointee. In the most notorious current example, the Free State health system has been brought to the brink of collapse by poor leadership and financial mismanagement, yet the MEC for health—who in early 2015 appeared in court on corruption charges dating back to a previous job—has retained his post. This, according to journalists and civil society activists, is because his boss, the premier of Free State, is a senior ANC figure considered “untouchable.” Furthermore, South Africa’s constitution prevents the health minister from giving direct orders to health MECs. As one health journalist put it: “[Minister of Health] Motsoaledi can’t touch him because he’s scared of the premier.” She added: “Motsoaledi is a sincere person, he just wants to fix the health system, but he’s realized it’s not possible to do that alone, you have to play the political game.”

A Stagnant Economy

In tandem with its political problems, South Africa is facing a prolonged economic downturn that places enormous pressure on funding for public services, including health. Figures released in June 2015 showed that South Africa recorded GDP growth of just 1.3 percent in the first quarter of the year. The Treasury, meanwhile,

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47 Interview with senior health journalist, Johannesburg, May 6, 2015.
estimates that annual growth of 3 percent is required in order to maintain social grants at current levels. The gloomy economic picture carries serious political risks for a government already under pressure from citizens unhappy about the slow pace of social reform and the quality of public services they receive. A mixture of internal and external factors suggests the economic picture is unlikely to improve in the short-run. International commodity prices remain low for the raw materials that drive South Africa’s export economy. Meanwhile, the failure of successive governments to make sufficient investments in the country’s infrastructure or reform struggling parastatal companies is draining productivity. This is particularly apparent in the power sector, where years of underinvestment in the state-owned provider, Eskom, means the country is no longer able to meet its energy needs. The government has been forced to institute a rolling program of power cuts, known as load-shedding, which in its initial phase is thought to be costing the economy approximately 20 billion rand (USD$1.6 billion) per month in lost productivity. South Africa’s economic problems are exacerbated by an extended period of labor unrest in key industries, such as platinum mining and auto manufacturing, which COSATU in its current weakened state is less able to mediate.

Further compounding the economic pressure is the downward trajectory of external donor assistance. While the donor contribution to the overall health budget is relatively modest, at approximately 4 percent, it is an important one, particularly in relation to HIV/AIDS. Donors provide roughly 25 percent of the overall response to HIV/AIDS, with the United States the most important contributor, followed by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Annual U.S. funding under the PEPFAR program is scheduled to fall from $484 million in 2013 to $260 million by 2017. South Africa has long been aware of this funding decline but advance notice does not make the task of filling the financial shortfall any easier.

These economic trends become even more troubling in the face of the country’s growing health burden and the pressure of the government to meet it. Health Minister Motsoaledi has unveiled a string of ambitious public health targets to meet the public clamor for better services and fast-track progress on tackling infectious diseases like HIV and TB. Yet the cost implications of meeting these commitments are staggering. A government-chaired study that projected the cost of various responses to HIV up to the year 2035 found that none of the current approaches were financially sustainable. It estimated, for example, that the ARV program would need a 70 percent increase in

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49 Interview with South African economic and political analyst, Washington, D.C., April 22, 2015.
52 Ibid., with FY 2017 figure from interview with senior health official, Washington, D.C., April 20, 2015.
funding. It is unclear how this yawning—and expanding—gap in health funding can possibly be bridged. Efficiency savings within the health sector are possible, for example in the areas of PHC reengineering and drugs procurement, but can only realistically provide a small part of the answer. The NHI is another potential solution but is still on the drawing board and requires enormous up-front expenditure that the government is currently ill-placed to make. The private sector has an important role to play in the provision of health services and health infrastructure through public-private partnerships but the government remains ideologically reluctant to offer it an expanded role.

2. U.S. Health Engagement and the PEPFAR 3.0 Strategy

Since South Africa’s transition to multiracial democracy in 1994, the United States has stepped up assistance in a variety of areas of public health including strategic planning, health worker training, clinical guideline development, health system strengthening, disease surveillance, research support, and—in the case of HIV treatment—direct service provision. Several U.S. agencies are involved in this effort but the most important are the Centers for Disease Control and Prevention (CDC) and the United States Agency for International Development (USAID). The HIV/AIDS response has dominated the agenda in financial terms and the PEPFAR program therefore takes up the lion’s share of U.S. assistance on health, with the CDC and USAID between them administering most of the funding allocated under the program.

Despite its history of antagonism over the AIDS response during the Mbeki era, the bilateral health relationship is now close and cooperative. U.S. and South African officials describe health as the most positive component of a bilateral relationship that is often testy and frequently gets sidetracked by the two nations’ differing ideologies, world views, and global policy priorities. A senior U.S. official said that health was “the one area where we have a robust relationship, where we have what feels like an actual partnership.” This is more than mere rhetoric; it has been backed up in concrete terms by an evolution in the way the United States works with South Africa, particularly through PEPFAR. Direct service provision has largely been phased out in favor of a technical support role, although the U.S. financial commitment remains substantial. The two countries signed a Partnership Framework agreement in 2010 to manage the transition of HIV programs and policies to South Africa. It was followed

53 Unpublished study by Health Economics and Epidemiology Research Office, University of Witwatersrand.
54 For example, it is estimated that the South African government will shave USD$1.2 billion off its bill for ARVs between 2010–17 due to instituting better tendering processes and adopting smarter negotiation strategies with the pharmaceutical companies. Interview with country director of leading health organization, Pretoria, May 8, 2015.
in 2012 by a detailed Partnership Framework Implementation Plan (PFIP) for the next five years that laid out the mutual expectations and commitments of each side, explained how U.S. goals would more closely align with South Africa's national strategic plan for HIV/AIDS, and set out a roadmap for how the United States would shift from the provision of clinical services to broader efforts to strengthen the health system. In 2013, South Africa was designated a Country Health Partnership nation, signifying the enduring nature of the bilateral health relationship.

Substantial progress has been made in achieving the PFIP. That said, the past 12 months have been a difficult phase in the bilateral health relationship because of changes to the PEPFAR program that have altered the terms of engagement once more. New management at the top of OGAC and the rollout of the PEPFAR 3.0 agenda have caused uncertainties and led to difficult discussions over the likely impact of the new strategy on ongoing programs. The new approach is taking place in the context of—indeed is partly driven by—pending budget cuts to the PEPFAR program that will place more pressure on the already-constrained South African health budget. Some of the difficulties of the past year have arisen because of perceptions on the South African side that their U.S. colleagues at OGAC headquarters have been slow to communicate and consult with them, leaving them with only a short time to initiate a major reorganization of their HIV programs.

The PEPFAR 3.0 approach is led by data about where the disease is most destructive. In a resource-constrained environment, the emphasis is on making interventions when and where they are likely to have the most impact. This mantra of “Right things, right places, right time” will be applied in South Africa from October 2015 and is informed by a recently completed mapping exercise that examined HIV incidence rates by location and key population group. What this means in the South African context is that U.S. programs will be scaled back in terms of overall reach and concentrated in specific areas; PEPFAR will go from working in all 52 districts to working in 27, and will withdraw from two provinces entirely. The United States will focus on providing technical support and looking for ways to improve the efficiency and sustainability of its work through innovation and by integrating its programs more closely with other donor institutions and the private sector.

The approach has largely been welcomed by the South Africans, who have long been aware that cuts to the PEPFAR budget were on the horizon and during the course of the PFIP have already taken on a large share of the responsibility for their HIV burden. Indeed, the United States only supports 35,000 of the approximately 3 million South Africans on ARVs. A senior official in the South African government called the 3.0 agenda “a welcome wake-up call” that places a fresh onus on the host country to

drive the HIV response and think strategically about how best to contain the epidemic.\(^{59}\) Furthermore, most South African interviewees concur with the scientific justification for the approach and agree that focusing on disease hotspots is the best way of maximizing impact while providing value for money. At the same time, they expressed disquiet with the way PEPFAR 3.0 was rolled out, the lack of transparency and effective communication for long periods during the gestation process, and the short timelines they have been given to enact a major overhaul of their programs.

One senior South African official admitted to feeling anxious that the PEPFAR 3.0 agenda would lead to services being disrupted. In order to better anticipate and preempt such problems, all of South Africa’s health districts are being asked to draw up and cost a plan for the HIV services they need, based on meeting the UNAIDS 90/90/90 target, so that resource gaps and personnel shortages can be identified and filled. One of the trickiest problems will be the allocation of health personnel under the 3.0 agenda, particularly the many South African NGOs that have been instrumental in providing HIV services and that rely on PEPFAR funding to survive. With services being scaled up in some districts and withdrawn in others, the South African government faces a major logistical challenge to match personnel accordingly and backstop areas where U.S.-funded operations are winding down.

These concerns raise several questions over the process of introducing PEPFAR 3.0 to South Africa that complicate efforts to maintain the progress South Africa has made in tackling HIV, at least in the short term:

*Does it give sufficient recognition to South Africa’s domestic constraints?* PEPFAR 3.0 is single-minded in its determination that scientific evidence should dictate its approach to tackling HIV. It is correct to do so but host countries have additional issues to consider. South Africa is constitutionally mandated to pursue equity in the way it treats its citizens. A health strategy that prioritizes some areas and populations over others would appear to go against the spirit of this commitment. In addition, the ANC is approaching a potentially difficult set of elections in 2016 that inevitably bring political calculations into the frame when decisions are made about where to allocate health resources. Finally, the size and pace of the PEPFAR budget cuts have been determined without much, if any, consideration of the acute financial pressure South Africa currently faces.

*Is it the right approach in the South African context?* As the epicenter of the global pandemic and the nation with the largest HIV caseload on the planet, South Africa is not an easy place to road test a more targeted approach. In the words of one senior health official, “Every district in this country has an area with a high prevalence. There are hotspots everywhere.”\(^{60}\) He suggested that the model for PEPFAR 3.0 had

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60 Interview with senior South African health official, Pretoria, May 7, 2015.
been overly influenced by a study from Kenya that showed that the disease was highly concentrated in specific regions but was relatively uncommon in other parts of the country.61 “But South Africa is not Kenya,” he added. “Here we have a hyper-epidemic.” Another dimension of the HIV epidemic that sets South Africa apart from other PEPFAR countries is its high TB coinfection rate. While both the United States and South Africa have elevated the importance of tackling TB, it remains a fairly small component of the PEPFAR agenda and efforts to capture data on TB through PEPFAR mechanisms such as the Partnership Information Management System are at a less advanced stage.

**Is it trying to achieve the impossible?** South Africa is being asked to accelerate progress in the fight against HIV and reach new, more ambitious targets, with fewer resources. Is this realistic? In the view of one government official, the UNAIDS 90/90/90 goals, which have been embraced by both the United States and South Africa, place the country on a more ambitious path and in response, the United States should slow down the pace of its budget cuts. In her view, “These targets change the landscape, they double the demand for services, for prevention, for treatment systems. So, if OGAC is genuinely committed to 90/90/90, as it says it is, it must review the speed of the transition.”62 An executive at the NDoH echoed this point and went further, arguing that the current timetable of reduced support from the United States risked undoing some of the progress made to date: “I don't understand the scale back of PEPFAR. The epidemic may have a resurgence. The feeling in the United States seems to be that South Africa has the resources; it’s a middle-income country. But it [the United States] doesn’t recognize the sheer weight of the problem.”63

**Could it have been managed better?** Communications problems dogged the period during which the new PEPFAR approach was conceived, announced, and sensitized. The head of an international development organization that works closely with the South African government observed a “bunker mentality” in Washington, D.C., while key decisions were made, describing it as an “introverted, internal process that left the SAG [South African Government] feeling isolated.”64 This caused resentment on the South African side so that once the 3.0 strategy was unveiled, PEPFAR had a more difficult task to win support for it. There was a feeling, according to one South Africa-based U.S. health expert, “that the U.S. makes a decision and only after that does it seek to get buy-in.”65

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63 Interview with senior South African health official, Department of Health, Pretoria, May 12, 2015.
64 Interview with country director of U.S. development organization, Pretoria, May 8, 2015.
65 Interview with South Africa country manager of leading health organization, Washington, D.C., April 20, 2015.
The PEPFAR 3.0 rollout and the strategic overhaul it entails has placed severe pressure on both its staff in South Africa and the South Africans themselves. It was not until April 2015 that the South Africans were told which districts and provinces PEPFAR would continue to work in from October 2015. In addition, the annual process whereby the PEPFAR country team draws up a Country Operational Plan (COP) for spending HIV resources and submits it to OGAC headquarters for approval is long, arduous, and fraught with tensions between staff in Pretoria and Washington. It was a particularly painful process this year, as the team had to interpret and apply a new strategy and guidelines. A senior official at the U.S. embassy in Pretoria said, “We felt DC was being a bit imperial in rushing these changes through. They needed to better understand our constraints, the need to nurture relationships here.”66 By the time approval for the COP is obtained, South Africa will have a very short time to factor the document into its own planning process. Further compounding the planning challenge is that the budget years of South Africa and PEPFAR are not aligned, with the former beginning its fiscal year in April and PEPFAR’s beginning in October. This means that when it comes to budget planning for HIV/AIDS, South Africa only has a six-month horizon of certainty when it begins its fiscal year.

Is sufficient attention being paid to gender and HIV prevention? Multiple South Africans had the same message: “We can’t treat our way out of this epidemic.” While impressive efforts have been made to establish and sustain HIV treatment programs, South Africa’s chronically high infection rates mean that there is an urgent need for, as one official put it, “a big prevention intervention. PEPFAR has the ability to kick-start that.”67 While there are no plans to launch something of the breadth and scale South Africans are calling for, the new DREAMS initiative provides an opportunity to target prevention efforts toward one of the most at-risk groups, adolescent girls and young women.68 The DREAMS initiative is a $210 million public-private partnership between PEPFAR, the Bill & Melinda Gates Foundation, and the Nike Foundation that will operate in 10 countries, including South Africa, over an initial two-year period. It will be laser-focused on just five districts, mostly in the Johannesburg and Durban areas.

South Africa has welcomed the concept as an opportunity to test multiple approaches to HIV prevention and a team of officials from across the NDoH has submitted a proposal to the U.S. government for how it would spend the funds. It is expected that the effort will try to tackle one of the main infection loops of the disease: intergenerational sex between HIV-infected older men and teenage girls. It will do so by looking at ways to strengthen the financial security of young women so that they do not feel compelled to enter into sexual encounters with so-called ‘sugar-daddies.’

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66 Interview with senior official at the U.S. Embassy, Pretoria, May 4, 2015.
68 The acronym DREAMS is derived from the goals of the program, which are to help women be Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe.
Possible ways to do this involve using cash transfers, reconfigured social grants, or even mobile phone credits as incentives for girls to adopt risk-reduction strategies, such as staying in school. While PEPFAR is not in the business of making cash transfers, it can potentially turn to other members of the DREAMS partnership who may be willing to do so. The DREAMS initiative is a promising effort but the short life of the project—initially just two years—does not match its lofty ambitions. No money had been disbursed almost six months into the initiative yet it is well-known that efforts to change social norms take many years to accomplish.

Can the goal of sustainability be achieved? The main objective of the PEPFAR transition has been to ensure that systems are in place for South Africa to manage and maintain HIV programs over the long term. A good deal of progress has been made in this area, despite the financial concerns that cloud the horizon. Health System Strengthening (HSS) is seen as the means of getting to sustainability by ensuring that PEPFAR leaves a legacy beyond HIV programming—one that generates a benefit to the health system as a whole. Again, some progress has been made in establishing robust drug supply chains, improving data capture and storage, strengthening budget planning, and laying the foundations for an electronic patient registry. But for the most part, these efforts apply only to HIV programs that under PEPFAR 3.0 are about to become even narrower in focus; few have had a positive spillover effect on the broader health system. In a telling comment, a senior South African policymaker relayed the complaint of a colleague who said that “if you are not a mother and don’t have HIV there’s nothing for you in our health system.”

One of the main problems is that HSS has become a mantra—something that is constantly talked about and recognized as being important but that is hard to conceptualize and even harder to apply, particularly without investing vast amounts of money over an open-ended time period. It also requires political will from the host nation, something that is open to question in some of the provinces where policies must be enacted. PEPFAR’s funders in the U.S. Congress are neither willing nor able to make the kind of commitment demanded, given their much shorter operating timeframe and demand for quick, measurable results. Yet HSS is often erroneously presented as the exit strategy for the United States in places like South Africa. Some of South Africa’s leading health experts questioned the thinking behind HSS and wondered whether it was a viable strategy. The first, a current senior official, said, “We are in a deep hole in our health system and $100 million of PEPFAR funding to do HHS—it won’t have any effect. It’s not enough.” One of the country’s former director generals of health concurred with this view, describing HSS as a “superfluous appendage,” and observing that “no-one has ever really conceptualized HSS beyond

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70 Interview with senior health official, Pretoria, May 7, 2015.
its narrow application to HIV programming. I’ve yet to see a project on HSS that is systematic.”71

Are U.S. efforts sufficiently linked up with those of other funders? The U.S. emphasis on targeting disease hotspots is echoed by other key donors such as the Global Fund and UNAIDS. But while their messages are aligned, they have not always done a good job of complementing each other’s activities. This is beginning to change, and it should. PEPFAR funding is drawing down at the same time as that of the Global Fund, while other bilateral donors such as the United Kingdom have virtually ended their health programming in South Africa. In this more austere financial climate, it will be even more important for the remaining donors to work closely together and ensure their efforts are well coordinated and complementary.

Is PEPFAR learning lessons? A big emphasis of the PEPFAR 3.0 agenda is the need to improve transparency, accountability, and efficiency in its programs. More data are being collected and made public through its country dashboards and big investments are being made in program monitoring and evaluation. But more could be done. In particular, there is still a need to improve accountability by monitoring the partners it works with. Trusted South African civil society groups could help perform that role at minimal cost, and should be empowered to do so. In addition, more time could be spent assessing what programs worked, what didn’t work, and why. In the view of one senior official in the NDoH: “All donors think their programs are the best but PEPFAR does not do enough reflection on lessons learned.”72

Recommendations for the United States

The health partnership between the United States and South Africa is strong and enduring. It has been accompanied by historic levels of U.S. funding to tackle the emergency of HIV/AIDS. More than $4 billion has been put into the effort since 2003 under PEPFAR and millions of South African lives have been saved in the process.73 This exceptional effort will continue, even as the dollar commitment reduces, and PEPFAR 3.0 provides the best means of maximizing the impact of the new, leaner budget reality. However, it is important to remember that a dangerous HIV outbreak persists in South Africa, that infection rates remain sky high, and that HIV is accompanied by a TB epidemic of astronomical proportions. For these reasons, the rollout phase of this new approach carries elevated risk.

As the United States ponders its long-term strategic direction on public health in South Africa, contemplates the difficult near-term task of implementing the PEPFAR 3.0

71 Interview with leading academic and former government health official, Cape Town, May 9, 2015.
72 Interview with South African health official, NDoH, Pretoria, May 12, 2015.
strategy, and considers how best to be a useful partner, it should consider the following policy recommendations:

Relationship Management

- **Appreciate the high stakes**: This is an important, valuable health relationship that is entering a critical phase. The United States should not jeopardize it through poorly communicated policies, dogmatic directives, precipitous withdrawals of funding, and inadequate planning.

- **Sustain the attention**: The size of South Africa’s challenges underlines the importance of the United States staying engaged at a high level. South Africa is a critical test case of whether PEPFAR can become a sustainable program managed and financed by country partners with minimal U.S. involvement. If it does not work in South Africa, it is unlikely to work anywhere. In addition to the ongoing efforts of U.S. health officials, diplomatic energy must be expended to keep progress on track, ensure the smooth implementation of PEPFAR 3.0, and impress upon the U.S. Congress the importance of South Africa to the overall success of PEPFAR.

- **Manage expectations**: The United States should understand that South Africa’s health system is fragile, that gains in infectious disease control are hard won but easily undone, that the national economy is in a parlous state, that South African politics is in an unproductive phase, that corruption and nepotism are rife at the provincial level—that in all these various ways the South African health system is ill-equipped to withstand jarring change of the kind PEPFAR 3.0 is instigating. The United States should be sensitive to these constraints, think strategically about ways to work around them, and strengthen those within the system who have the will and the ability to effect positive change.

- **Be a demanding partner**: While acknowledging these constraints, the United States should continue to keep the pressure on the South Africans to be good partners, to be proactive and solutions-driven, and to take the lead.

Managing PEPFAR 3.0

- **Communicate and plan**: The introduction of PEPFAR 3.0 has been painful and missteps made along the way, particularly in the area of communications. None of these mistakes are fatal but the next 12 months will be critical in determining the success of the new strategy. An all-out effort will be required by PEPFAR South Africa, closely coordinated with the South African government, to ensure that HIV services are maintained and alternative partners and funders are found to fill gaps. The United States must provide more advance notice of its intentions, assist health districts with budget
planning and expenditure analysis, and have contingency plans at the ready to ease the transition in ill-prepared districts and districts where PEPFAR support is being withdrawn.

- **Build flexibility into the rollout schedule:** PEPFAR must vigorously observe the 3.0 rollout to ensure that service gaps are quickly spotted and filled. A detailed district-by-district midyear review should be conducted to identify areas of concern and, based on its findings, flexibility should be built into the rollout schedule, backed by contingency funds, to slow the pace of change if necessary.

- **Empower the PEPFAR country team to drive the 3.0 rollout:** The PEPFAR South Africa team has a deep and nuanced understanding of the health landscape and the political sensitivities surrounding the bilateral health relationship and the PEPFAR 3.0 rollout. OGAC should provide constructive support to its country team, listen to its advice, and be prepared to adapt policies in line with advice from the mission.

**Strategic Direction**

- **View NHI as the acid test for HSS, and prioritize accordingly:** The United States should define more clearly and concretely how it can support Health System Strengthening and make an honest assessment of the resources that will be required to do it successfully. The top priority should be to work with South Africa on health financing solutions. The NHI is South Africa’s flagship health project, the key to achieving sustainable financing of its healthcare system, yet it is clearly at an impasse. The United States should offer technical expertise to the Treasury and NDoH in designing fiscal models for NHI, costing the various options, and providing strategic direction for the project.

- **Make a big push on HIV prevention:** No amount of success on the treatment side can offset the damage that continues to be caused by South Africa’s catastrophically high rate of new infections. PEPFAR funding earmarks should be relaxed to allow more flexibility to strike the right balance between treatment and prevention-focused efforts. The DREAMS partnership should be viewed as the opening shot in a new battle on prevention, rather than a one-off, experimental program. Channel the energy generated by the lead-up to the Durban International AIDS Conference and the event itself to renew the sense of urgency on combination prevention and challenge complacent attitudes over HIV.

- **Don’t downplay TB:** Replicate the urgency shown toward HIV and direct it at the TB epidemic. To reflect the reality that TB is now the number one killer in South Africa, PEPFAR should look for ways to elevate the disease within its programs and integrate TB and HIV programs more closely.
- Get to grips with South Africa's provinces: Policymakers in Washington need to understand that PEPFAR's success stands or falls at the subnational level in South Africa. More analysis is required to understand the enormous variations between health outcomes in South Africa's nine provinces so that creative ways can be found to overcome health governance challenges in some of the worst-performing areas. PEPFAR 3.0 has chosen to target districts where HIV incidence is highest but some of these areas are among the hardest to operate due to poor governance and capacity constraints.
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