Partnership Framework Implementation Plan in Support of South Africa's National HIV, STI & TB Response

2012/13 – 2016/17

between

The Government of the Republic of South Africa

and

The Government of the United States of America

CONTENTS

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ACRONYMS

ACSM	Advocacy Communication and Social Mobilization
AEF	Aid Effectiveness Framework
AIDS	Acquired Immune Deficiency Syndrome
APT	Annual Planning Tool
ART	Antiretroviral Treatment
ARV	Antiretroviral Drug
AZT	Zidovudine or Azido-Thymidine
ASSA	Actuarial Society of South Africa
BAS	Basic Accounting System
BCG	Bacille Calmette Guerin
CAPS	Curriculum Assessment Policy Statements
CBO	Community-Based Organization
CCE	Community Capacity Enhancement
CFR	Case Fatality Rate
CHAI	Clinton Health Access Initiative
CTX	Cotrimoxazole
DAC	District AIDS Council
DBE	Department of Basic Education
DCS	Department of Correctional Services
DHET	Department of Higher Education and Training
DOH	Department of Health
DOJCD	Department of Justice and Constitutional Development
DPSA	Department of Public Service and Administration
DSD	Department of Social Development
DSP	District Strategic Plan
DWCYPD	Department for Women, Children, Youth and Persons with Disabilities
DHIS	District Health Information System
DMT	District Management Team
DSP	District Support Partner
EPP	Estimation and Projection Package
EU	European Union
eTR.Net	Electronic TB Register
FBO	Faith Based Organization
FET	Further Education and Training
GBV	Gender Based Violence
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GHI	Global Health Initiative
GIPA	Greater Involvement of People with HIV and AIDS and TB
GP	General Practitioner
HCBC	Home and Community Based Care
HCT	HIV Counseling and Testing
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HRD	Human Resource Development
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSS	Health System Strengthening
I- ACT	Integrated Access to Care & and Treatment
IDP	Integrated Development Plan
IEC	Information, Education, Communication
ILO	International Labour Organization

IPT	Isoniazid Preventive Therapy
LAC	Local AIDS Council
MARP	Most at Risk Population
MC	Management Committee
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MDR-TB	Multi-drug Resistant TB
MMC	Medical Male Circumcision
MSM	Men who have Sex with Men
MTSF	Medium-Term Strategic Framework
MTCT	Mother to Child Transmission
NACOSA	Networking AIDS Community of South Africa
NCS	National Core Standards
NDoH	National Department of Health
NGO	Non-Governmental Organization
NIDS	National Indicator Data Set
NIMART	Nurse Initiated Management of Anti Retroviral Therapy
NHI	National Health Insurance
NSDA	Negotiated Service Delivery Agreement
NSP	National Strategic Plan on HIV, STIs, and TB, 2012-2016
NRASD	National Religious Association for Social Development
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PETS	Public Expenditure Tracking Survey
PF	Partnership Framework
PFIP	Partnership Framework Implementation Plan
PICT	Provider Initiated Counseling and Testing
PIMS	PEPFAR Monitoring Information System
PLHIV	People Living with HIV and AIDS
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
PrEP	Pre-Exposure Prophylaxis
PSP	Provincial Strategic Plan
PwP	Prevention with Positives
QC	Quality Control
QI	Quality Improvement
RCC	Rolling Continuation Channel (Global Fund)
RCT	Right to Care
SAG	Government of the Republic of South Africa
SAMHS	South African Military Health Services
SANDF	South Africa National Defence Force
SANAC	South African National AIDS Council
SBCC	Social and Behavior Change Communication
SC	Steering Committee
SI	Strategic Information
SRH	Sexual and Reproductive Health
SSF	Single Stream Funding (Global Fund)
STI	Sexually Transmitted Infection
TAMS	Tiered ART Monitoring System
TB	Tuberculosis
UNAIDS	United Nations AIDS Organization
UNDP	United Nations Development Program

UNICEF	United Nations International Children's Emergency Fund
USG	Government of the United States
VMMC	Voluntary Medical Male Circumcision
WCDOH	Western Cape Department of Health
WHO	World Health Organization
XDR-TB	Extremely Drug Resistant Tuberculosis

1. INTRODUCTION

The *Partnership Framework in Support of South Africa's National HIV and AIDS and TB Response (2012/13 – 2016/17) (PF)* between the Government of the Republic of South Africa (SAG) and the Government of the United States (USG) was signed by the South African Minister of International Relations and Cooperation and the United States Secretary of State on December 10, 2010. The PF commits the SAG and USG to the following principles: South African leadership; alignment; sustainability; innovation and responsiveness to the epidemics; mutual accountability; multi-sectoral engagement and participation; gender sensitivity; financial commitments and transparency; and finally, fostering a collaborative and not contractual partnership.

The PF Implementation Plan (PFIP) forms the roadmap for the implementation of these principles and is guided by the South Africa National Strategic Plan for HIV, STIs and TB 2012 – 2016 (NSP), which was launched on December 1, 2011. The NSP extends over the same five-year period as the Partnership Framework. The NSP is a multi-sector national plan that lies at the heart of the development agenda of the South Africa Government. It calls on all government departments and civil society sectors to work together to achieve the national goals and targets for the HIV, STI, and TB epidemics. The President's Emergency Plan for AIDS Relief (PEPFAR) supports this multi-sector approach, and this PFIP outlines how PEPFAR is to implement programs in support of the NSP.

SAG continues to lead and increase funding for the HIV and TB national response and is increasing efficiency and impact by coordinating all development partner activities under the NSP. The shared objectives for strengthening collaboration made in this PFIP are expected to be translated into action through further discussions at provincial and local levels as both the SAG and USG have committed to supporting a country owned, well managed, and properly executed HIV and TB response.

In order to support the ambitious goals of the NSP, the USG and SAG have mutually decided that PEPFAR's investments in South Africa should gradually transition from support of direct clinical care and treatment services toward support for system strengthening, prevention, orphans and vulnerable children, and health services innovation. As the SAG commits greater resources for the HIV and TB response and PEPFAR funding declines, the transition is expected to be implemented in a manner that puts the wellbeing of patients and vulnerable and affected populations at the center of all interventions. While the SAG continues to increase the number of patients on treatment through the public health system, PEPFAR intends to keep long-term sustainability and health and social systems strengthening as priorities that lead to increased efficiency in implementation of the national response.

2. COUNTRY CONTEXT

2.1. HIV and AIDS and TB in South Africa

South Africa has the largest HIV epidemic in the world with approximately 5.7 million people living with HIV. It also ranks third in the world in terms of TB burden according to World Health Organization (WHO) estimates, with an incidence of 948 new infections per 100,000 population in 2010, which is compounded by high levels of multidrug-resistant tuberculosis (MDR-TB). The estimated number of confirmed MDR-TB cases among new pulmonary TB

cases in 2010 was 7,386.[1] The high rates of co-infection (approximately 60% of TB patients are co-infected with HIV) lead to further expansion of the epidemics and complicate treatment and care of patients.

HIV and its related opportunistic infections (TB, certain forms of cancer, diarrheal disease) contribute significantly to maternal mortality (50%) and mortality under five years of age (35%). This is reflected in the challenge South Africa is experiencing in making progress to achieve Millennium Development Goals (MDGs) 4 and 5, relating to child and maternal mortality. Child mortality initially increased from the MDG baseline in 1990 of 60 deaths under the age of 5 years per 1,000 live births, peaked at 82 deaths/1,000 births in 2003, and decreased to 56 deaths/1,000 births in 2009. The maternal mortality ratio is an estimated 310 maternal deaths per 100,000 live births (2008 data)[2].

In 2010 the South African National AIDS Council (SANAC) conducted a "Know Your Epidemic" survey in all provinces. The report identified key biological, behavioral, social, and structural determinants of the HIV epidemic. The report also identified key populations and geographic areas where HIV prevalence is concentrated. The South Africa HIV epidemic is heterogeneous within provinces, districts, and sub-districts. Thus, an effective response should be very localized and sharply targeted. The table below highlights the geographic nature of HIV infection. [3]

Table 1: The annual rate, estimated number, and percentage of new HIV infections by province, 2010

Province	Estimated Annual HIV Incidence Rate	Estimated New HIV infections	Percentage of Total New Infections
KwaZulu-Natal	2.3%	100 787	29.4%
Gauteng	1.4%	68 618	20.0%
Eastern Cape	1.6%	47 464	13.8%
Limpopo	1.1%	29 599	8.6%
North West	1.7%	29 106	8.5%
Mpumalanga	2.0%	28 809	8.4%
Free State	1.7%	23 104	6.7%
Western Cape	0.5%	12 585	3.7%
Northern Cape	0.7%	3 177	0.9%
Total Annual HIV Infections	**1.2%**	**343 249**	

2.2. South Africa's National Strategy and Key Policies in Response to HIV and TB

SAG has significantly expanded HIV prevention, care, and treatment programs since 2008 and has set ambitious targets as indicated in the NSP. The successes include but are not limited to: the national HIV Counseling and Testing Campaign, with 20 million tests conducted since the start of the campaign in April 2010;; the launch of the Accelerated PMTCT Plan that has resulted in universal access to PMTCT services across the country and a decrease to 2.7% of early transmission; significant scale-up of voluntary medical male circumcision with 500,000 conducted in the 2011; a rapid increase in access to antiretroviral treatment (ART) with an estimated 1.7 million people on treatment in 2012 making it the

[1] WHO Global TB Control Report, 2010
[2] Source: 2012 Health Data Advisory and Coordination Committee (HDACC) Report
[3] KYE/KYR Summary Report 2011

world's largest ART program; and improvement in the TB cure rate to 73%. To build on these successes the new NSP has once again set ambitious targets to be achieved by 2016/17 that include: 30 million people tested for HIV and screened for TB; 1.6 million men circumcised; 80% of people who need ART to receive it, and >85% TB cure rate for new smear positive cases. This has been supported by a rapid increase in SAG spending for HIV from just under ZAR 5 billion (US$576 million) in 2008 to around ZAR 11 billion (US$1.25 billion) in 2012, with intentions for further growth in the coming years.

The NSP is driven by South Africa's long-term 20 year vision (2010-2030) of "Zero new HIV and TB infections, Zero new infections due to vertical transmission of HIV, Zero preventable deaths associated with HIV and TB, and Zero discrimination associated with HIV, STIs, and TB." Four strategic objectives include:

- Addressing social and structural barriers to HIV, STI, and TB prevention, care, and impact;
- Preventing new HIV, STI, and TB infections;
- Sustaining health and wellness; and
- Increasing the protection of human rights and improving access to justice.

The NSP also sets the following broad goals, which are supported by PEPFAR:

- Reduce new HIV infections by at least 50%, using combination prevention approaches;
- Initiate at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation;
- Reduce the number of new TB infections, as well as the number of TB deaths, by 50%;
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP; and
- Reduce the self-reported stigma and discrimination related to HIV and TB by 50% by 2016.

The NSP has also identified key strategic enablers that are to determine the success of implementation of the interventions of the strategic objectives: governance and institutional arrangements; effective communication; monitoring and evaluation (M&E); and research.

In addition to the NSP, there are also several other key policy documents that define the SAG development agenda and have a bearing on the SAG and USG activities. These include:

National Development Plan 2030 (http://www.npconline.co.za/pebble.asp?relid=25): This plan identifies 20-year developmental goals for economic, social, educational, health, and social systems to eliminate poverty and reduce inequality by 2030. The health pillar aims to provide "quality health care for all" by increasing ART to all people who need it; speed up training of community specialists in medicine; recruit, train, and deploy between 700,000 and 1.3 million community health workers; set minimum qualifications for hospital managers; implement the national health insurance in a phased manner; promote active lifestyles and balanced diets, control alcohol abuse, and promote health awareness to reduce non-communicable diseases.

Medium-Term Strategic Plan Framework (MTSF) 2009-2014 (http://www.thepresidency.gov.za/docs/pcsa/planning/mtsf_july09.pdf): The MTSF outlines SAG's framework to improve the conditions of life of South Africans over the next five years.

Of particular relevance is Strategic Priority 5: **Improve the health profile of all South Africans.** Elements of the strategy include phasing in a National Health Insurance (NHI) system; increasing institutional capacities to deliver health system functions and initiate major structural reforms to improve the management of health services at all levels of health care delivery, but particularly hospitals; strengthening treatment of TB, particularly drug-resistant TB; implementing the Comprehensive Plan for the Treatment, Management, and Care of HIV and AIDS; enhancing public health services to respond to a range of non-communicable diseases, injuries, and trauma; and introducing new child vaccines to reduce cases of diarrhea and pneumonia, which are significant causes of child morbidity and mortality.

Department of Basic Education: Integrated Strategy on HIV and AIDS, 2012 – 2016 (http://www.info.gov.za/view/DownloadFileAction?id=164847): Within the Department of Basic Education (DBE), this integrated strategy is in accordance with the NSP and with new thinking globally on rolling back HIV and AIDS. The strategy relies on the framework of the NSP with prevention, treatment, care and support, and research/monitoring arms together with efforts to mainstream and strengthen a systemic response to HIV and AIDS. It also defines interventions beyond the Life Skills Program to respond more comprehensively to the epidemic. There are four major intended impacts of this strategy:

- Improved learner and educator retention within the education system through HIV related interventions.
- A contribution toward decreased HIV incidence among 15 – 19 year olds and among educators, school support staff, and officials.
- Improved sexual and reproductive health among learners, educators, school support staff, and officials.
- Increased physical and psychological safety in all South African schools.

Department of Social Development's Strategic Plan, 2012 – 2015 (http://www.info.gov.za/view/DownloadFileAction?id=164902): This strategic plan aims to ensure the provision of comprehensive social services, which protect the poor and vulnerable within the framework of the South African Constitution and subsequent legislation; create an enabling environment for sustainable development; and deliver integrated, sustainable, and quality services in partnership with all those committed to building a caring society. Specifically, the Plan aims to: reduce new HIV and AIDS infections through social and behavioral change; mitigate the psychosocial and economic impact of HIV and AIDS as well as TB and other chronic illnesses; and strengthen community capacity and systems.

Ministerial Performance Agreements, previously referred to as the Health Negotiated Service Delivery Agreement (NSDA) (http://www.info.gov.za/view/DownloadFileAction?id=135747): The performance agreements between Ministers and the President are a charter that reflects the commitment of key sectoral and intersectoral partners linked to the delivery of identified outputs for specific sectors of government. The Government has agreed on 12 key outcomes as the key indicators for its program of action for the period 2010-2014. For the health sector, the priority is improving the health status of the entire population to contribute to the SAG vision of "A long and health life for all South Africans". Four strategic outputs are identified:

- Output 1: Increasing life expectancy
- Output 2: Decreasing maternal and child mortality
- Output 3: Combating HIV and AIDS and decreasing the burden of disease from tuberculosis
- Output 4: Strengthening health system effectiveness

Primary Health Care Re-engineering (http://www.phasa.org.za/wp-content/uploads/2011/11/Pillay-The-implementation-of-PHC.pdf): The re-engineered approach to providing primary health care (PHC) services proposes a population based approach for the delivery of PHC outreach service to the uninsured population of South Africa of 41,992,831 people (84% of the total population). Each province will develop a plan to roll out the three streams of the PHC Re-engineering including clinical specialist teams, school health, and ward-based PHC outreach teams. This approach aims to strengthen the district health system and to do the basics better and is built upon the World Health Organization's health systems strengthening building blocks.

National Health Insurance (NHI) (http://www.doh.gov.za/docs/publicity/2011/nhi_english.pdf): This policy aims to ensure the provision of universal health care to the entire population of South Africa. NHI is a system that is to ensure all citizens of South Africa (and legal long-term residents) are provided with essential healthcare, regardless of their employment and socio-economic status. Quality is expected to be ensured through three mechanisms: improving the quality of services in the public health facilities; ensuring that, in every facility, certain basic core standards are complied with; and implementing a radical change to health care management within the public healthcare system in line with the 10-Point Plan of the Department of Health: "Overhauling the health care system and improve its management".

Human Resources for Health (HRH) Strategy for the Health Sector 2012/13 – 2016/17: A vision to improve access to healthcare for all and health outcomes makes it necessary to develop and employ new professionals and cadres to meet policy and health needs, increase workforce flexibility to achieve this objective, improve ways of working and the productivity of the existing workforce, improve retention, increase productivity, and revitalize aspects of education, training, and research. This strategy address three primary challenges in human resources for health (HRH) in South Africa, namely:

- The supply of health professionals and equity of access
- Education, training, and research
- The working environment of the health workforce

3. PEPFAR'S SUPPORT TO SOUTH AFRICA

PEPFAR was established to respond rapidly to the global HIV epidemic by addressing needs for HIV prevention, care, and treatment in high burden countries around the world. PEPFAR efforts began in South Africa in 2004, and since then, have scaled up rapidly; to date the USG has contributed more than 3.7 billion US dollars (ZAR 29.7 billion[4]).

Table 2: PEPFAR Bilateral Funding for South Africa 2004 – 2011 (US$ in millions)

FY[5] 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2009 – 2010 ARVs	TOTAL FY 2004-2011
$89.3	$143.3	$221.6	$397.8	$590.9	$561.3	$560.4	$548.7	$483.7	$120.0	**$3,717.0**

PEPFAR funding for South Africa is implemented by several USG agencies, including the U.S. Centers for Disease Control and Prevention, the U.S. Agency for International

[4] For the purposes of this document, the exchange rate used is $1 = ZAR 8
[5] The US fiscal year is from October to September

Development, Peace Corps, National Institutes for Health, State Department, Health Resources and Services Administration, and the U.S. Department of Defense.

PEPFAR enhances the multi-sectoral response of SAG by working with key departments at the national level and in all provinces. These include the Departments of Health; Social Development; Basic Education; Higher Education and Training; Correctional Services; Defence; Public Service and Administration; Women, Children and People with Disabilities; National Prosecuting Authority; National Treasury, and the South African Police Service. In addition, PEPFAR engages with SANAC (which has civil society representation) and the private sector.

PEPFAR has direct funding agreements with more than 120 prime implementing partners, including SAG, parastatals, non-governmental organizations, unions, private entities, and universities. Approximately 10% of PEPFAR's budget directly funds and provides technical assistance to several national departments and parastatals.

PEPFAR funding has significantly strengthened the role of indigenous South African NGOs, leveraging the technical expertise and capacity that exists in South Africa. The majority of funds for NGOs (approximately 80%) are for South African NGOs rather than international NGOs. These NGOs have been able to provide technical assistance and capacity building to support SAG's efforts to meet prevention, care and treatment targets.

In the re-authorization of PEPFAR in 2008, the scope of the U.S. program shifted from an emergency response to that of building and sustaining health outcomes and systems through a closer alignment with host country priorities. In May 2009 President Obama launched the Global Health Initiative (GHI), which guided USG investments in global health to support host country partners to plan, oversee, manage, and deliver health programs that are responsive to the needs of their people. Hence, the PF aims to support improvements in the effectiveness, efficiency, and sustainability of the South African national response to HIV and TB and its goals and related objectives. The PFIP Management Structure outlines the strategy for implementing PEPFAR programs in support of collaborative, transparent, and country owned response.

4. PFIP MANAGEMENT STRUCTURE

Major political and policy shifts have occurred in South Africa since 2008. Political commitment, vision, and leadership is at an unprecedented level across a wide range of stakeholders thus presenting South Africa with a unique opportunity to scale up its programs and continue to reverse the tide of new HIV infections. Two initiatives in particular have guided the management structures of the PFIP, namely the Aid Effectiveness Framework and the recommended governance structure for SANAC, which oversees the implementation of the NSP.

The Aid Effectiveness Framework launched by the Minister of Health outlines the framework to coordinate all development assistance for health. The National Department of Health (NDOH) assumes the leadership role in this process, by taking ownership of strategies, action plans, and review mechanisms. In collaboration with development partners, the NDOH focuses on results, links activities to outputs, ensures clear and unambiguous expectations, and facilitates the process of alignment and coordination. This framework ensures that development partner resources are used more efficiently and effectively, fulfilling resource gaps.

The current NSP, which focuses on prevention of new infections and a more integrated approach to responding to the TB and HIV epidemics, needs a stronger and more multi-

sectoral approach than the previous NSP. The new SANAC governance structures reflect stronger engagement and coordination with various government sectors, civil society, and provinces. The SANAC Plenary is to continue to be chaired by the Deputy President, with a senior leader from civil society serving as deputy. The SANAC Plenary is to have the nine provincial Members of the Executive Council for Health and a civil society counterpart representing each of the provinces. Lastly, the role of the Provincial and District Councils on AIDS and the Secretariats at national, provincial, district, and local levels should be strengthened in a way that facilitates the work of implementing the NSP in a coordinated and sustainable manner.

The transition of PEPFAR programs to the SAG as outlined in the PF is only be possible if the USG and SAG work more closely together. The Steering and Management committees that manage the implementation of the PF intend to build on the multi-sectoral approach, strong leadership within SAG national departments, and improved coordination with provincial and district AIDS councils including provincial governments. These management structures mark a major change in the way that the PEPFAR program in South Africa is coordinated including timely and transparent sharing of information between the USG and SAG.

4.1. Steering Committee

The Steering Committee (SC) is expected to provide strategic direction and oversight for the implementation of the PF/PFIP at the highest political level and ensures mutual accountability. It is to be represented by key government departments that implement HIV activities, the National AIDS Council (which includes civil society), and provincial representation. It is to be co-chaired by a member of the USG and SAG and should include:

- The US Ambassador to South Africa [Co-Chair]
- Minister of Health [SAG Co-Chair]
- Representatives from the USG delegated by the US Ambassador including the CDC Director, USAID Director, and Health Attache
- Ministers or a senior delegate from the following ministries: Health; Basic Education; Social Development; Correctional Services; Defense; Higher Education and Training; Women, Children, and People with Disabilities; Treasury; International Relations and Cooperation; and Public Service and Administration
- Representative from the Office of the Deputy President
- The SANAC Chief Executive Officer
- One representative from each of the nine provinces as delegated by the Premiers' Offices.

The SC is to meet twice per annum with the timing of the meetings tentatively scheduled for February and August in order to align with SAG planning and budgeting processes, as well as provide direction to the Management Committee in the development of the annual PEPFAR Country Operational Plan (COP) and then present the COP to the SC prior to submission to the Office of the Global AIDS Coordinator (OGAC).

The objectives of the SC meetings are to:

1. Discuss updates to South African and PEPFAR TB and HIV programmatic and geographic priorities;
2. Review results of programs as they relate to the strategic objectives of the NSP including those of the SAG, PEPFAR, and other contributors;

3. Review progress on joint management and coordination of PEPFAR at national and provincial levels; and
4. Review expected funding commitments from the SAG, PEPFAR, and other external resources in the HIV and TB response.

4.2. Management Committee

The Management Committee (MC) is expected to carry out the directives of the Steering Committee. It is responsible for operationalizing, implementing, and monitoring the PEPFAR transition. It intends to meet every other month to allow for sufficient time to deliver on the objectives outlined below. It is to be represented by national-level representatives, but should also regularly liaise with provincial coordination structures. Similar to the SC, the MC is also to be co-chaired by the USG and SAG.

- PEPFAR Coordinator [Co-Chair]
- Senior Advisor to the Office of the Deputy President [Co-Chair]
- Senior technical managers delegated by the Ministries that form part of the Steering Committee
- Senior technical managers delegated by the US Ambassador to South Africa
- Membership from the SANAC Secretariat

The MC is to be tasked with four key deliverables:

1. As part of the Country Operational Plan: a) discuss programmatic priorities and budgets and provide technical input; b) assess programmatic performance; c) ensure that geographic priorities are reflected in the COP based on epidemiology and resource gaps; and d) review COP targets.
2. Review regular progress on support to the NSP[6] by the SAG and PEPFAR and on the transition of PEPFAR-supported activities as outlined in the PFIP M&E framework.
3. Review new funding opportunities for PEPFAR funds. Based on recommendations from the Steering Committee and USG technical working groups, there may be a need to develop new funding opportunities. As SAG funding increases and PEPFAR funding declines over the course of the next five years, new funding opportunities should be carefully scrutinized. They should only be considered if they are in line with the PF, meet NSP gaps, and have clear plans for sustainability. Since funding opportunities are procurement sensitive, members of the Management Committee are expected to sign USG confidentiality agreements. Provincial governments are to be consulted as needed. As per the request of provincial governments, the USG has decided that, prior to funding new agreements, the USG is to request letters of support from provincial and district governments.
4. Review SAG and PEPFAR HIV/TB expenditures to fully understand how PEPFAR resources are being directed not only by category such as human resources, equipment, etc., but also by province. Beginning in September 2012, all PEPFAR implementing partners are to expected to report expenditures in a standardized format. These data are essential for informing the South African government budgeting process.

[6] See illustrative baseline (June 2012) summary of current SAG and PEPFAR support to the NSP Strategic Goals, Appendix II.

As the membership of the MC includes representation from various sectors of the SAG and SANAC, the MC is to identify task teams or sub-committees to focus on specific issues as needs arise, and the teams may be dissolved as deliverables are met. For example, recent discussions have identified the need to review the transition of clinical services; the PEPFAR prevention strategy and vision for the next five years; and the transition of OVC services.

Transitional Task Team for Clinical Services

The transition task team (TTT) for clinical services was established in June 2012, primarily because many current five year funding agreements are scheduled to end between June and October 2012, and many new ones with similar scopes are beginning in September/October 2012. Although this group is expected to meet quite frequently during the next few months, once the new agreements are signed, the TTT is to meet on a monthly basis.

In early July 2012, the TTT conducted an initial review of treatment partners by province to ensure that plans are in place to maintain the continuum and quality of care for persons on ART. It was determined that patients would only be transitioned to public sector facilities where it has been carefully planned and coordinated and that transition plans should be consistent with the district and provincial planning processes. In many cases, partner ART transition plans had already been carefully planned at the provincial and district levels, but those plans had not been reviewed comprehensively at the national level. The summary of this review and next steps are included in *Workstream 1 of PF Goal 2: Transition of PEPFAR Care and Treatment Program Support.*

These initial strategic discussions were needed at national level but similar discussions are needed at the provincial level and are expected to take place between August and September 2012. The TTT mutually decided that USG and SAG members of the TTT would meet with relevant Department of Health representatives within each of the provinces to discuss clinical services transition plans and needs for priority service delivery and health systems strengthening as the new agreements are signed in the next few months.

The TTT has also engaged with PEPFAR implementing partners to better understand the realities and challenges to implementation, to address issues as they arise, and to highlight successes of the transition. These meetings are to be held regularly throughout the five year transition of the care and treatment program.

Although this TTT was initially established to address the immediate issue of ensuring continuum of care with agreements ending and new ones beginning, the TTT serves to oversee the broader transition of clinical services. This includes providing strategic direction to the transition of direct service delivery to health systems strengthening, and monitoring DOH's efforts to assume direct service delivery currently provided by PEPFAR.

The TTT has identified the immediate need to develop a joint communication strategy to ensure that stakeholders are informed about the USG and SAG joint vision for transition of clinical services.

4.3. PEPFAR Coordination at the Provincial Level

In South Africa, the national government sets policy and the NSP lays out the strategic objectives to be achieved by 2016. However, each of the nine provinces develops targeted plans informed by the epidemiology of the province, and the provincial government is responsible for implementation of policies set at the national level. Each province submits

annual business plans that outline the budget for the HIV conditional grant funding. Because such planning and budgeting processes happen at the provincial level, there is an imperative to strengthen coordination of PEPFAR at that level.

Currently, PEPFAR-funded programs are not thoroughly reflected in SAG's provincial and district plans. As PEPFAR funding decreases over the next five years, PEPFAR activities are to be integrated into SAG planning processes to ensure that PEPFAR activities are aligned and are meeting resource gaps. Provinces are expected to budget for PEPFAR-funded activities that they deem to be necessary to continue funding including human resources, equipment, training, etc. The annual PEPFAR expenditure analysis is to assist in this effort, but systems need to be in place in order to ensure that the provinces and districts have the timely information needed about PEPFAR programs to have fully informed planning. The USG should work closely over the next several months with the SAG to recommend steps for how this process would work. Deliverables from their analysis are expected by the end of October 2012.

In addition to integrating budgeting and expenditure information into provincial planning, discussion about standardized district and provincial workplans for PEPFAR partners have begun but are not yet been finalized. These workplan templates are expected to be finalized by the December 2012.

Although this PFIP lays out the plan for PEPFAR implementation over the next five years, it is necessary to have more tailored plans for each of the nine provinces with guidance from the Management Committee. It may not be necessary for each province to develop individual PFIPs as such, but PEPFAR support should be clearly articulated in SAG provincial and district plans along with long-term plans to continue funding programs and staff that they deem to be necessary.

In terms of clinical services, provincial and district DOH have already been working closely with PEPFAR implementing partners to transition patients to the public sector and absorb staff posts that were deemed critical to maintain patient care. For example, the Western Cape has drafted terms of reference for the transition of clinical services so that it is clear how the transition is expected to take place, and the timeline is defined. They have an inventory of all clinical posts supported by PEPFAR and have identified which ones they plan to absorb and which ones are not going to be absorbed by the province. (Note though that currently this absorption is limited to clinical positions, and does not include the vast cadre of community health workers).

Provincial management structures for the implementation of the PF are expected to leverage Provincial AIDS Councils and other existing structures to ensure an integrated approach rather than setting up additional structures. Provincial coordination of the PF and recommendations for moving forward are to be discussed at the first Steering Committee meeting of the PFIP tentatively scheduled for October 2012.

In 2010, the USG identified the need to improve provincial coordination of PEPFAR and assigned PEPFAR Provincial Liaisons (PPL) in each of the nine provinces. The role of the PPL is to communicate information about PEPFAR to the relevant departments within the province and to PEPFAR implementing partners in addition to communicating priorities and challenges emerging from the province and implementing partners back to USG in Pretoria. The PPLs are expected to play a critical role in the implementation of the PF at the provincial level.

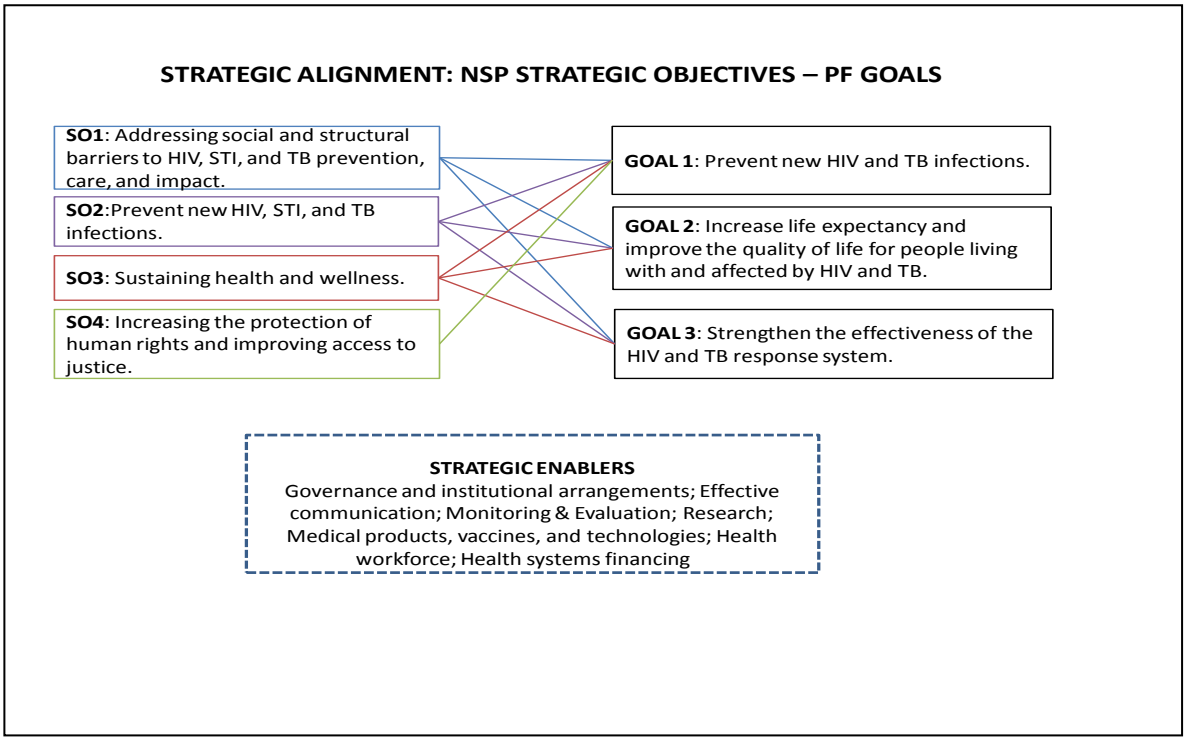
5. FIVE YEAR SAG-USG STRATEGIC FOCUS

The PFIP is a plan to leverage and harness past, current, and future PEPFAR investment in South Africa. There has been tremendous investment in developing human capacity; monitoring and evaluating programs; rapidly scaling-up combination prevention, treatment, care and support programs, and strengthening community-based organizations (CBOs).

The transition of the PEPFAR program within the broader development agenda of the SAG is expected to need support from both the USG and SAG to ensure that the South African system is adequately prepared to absorb the programmatic elements that PEPFAR built up over the years, particularly the clinical services, without compromising patient access to care and treatment, quality of services and continuum of care. In addition, PEPFAR is to maintain its strategic focus on prevention to address critical areas of intervention. It is critical therefore that the strategic focus is built around the themes of the NSP, which are embedded in the development agenda of government.

The strategic alignment between the NSP's Strategic Objectives and the SAG/USG Partnership Framework is illustrated below:

Figure 1: Strategic Alignment: NSP Strategic Objectives – PF Goals



Within the context of the three original goals of the PF, the PFIP identifies four workstreams to outline PEPFAR's support to the NSP. USG and SAG teams have or should be formed to focus on these four areas. Their role is to develop short-term and long-term strategies to carry out the vision of the PF/PFIP.

PF Goal 1: Prevent new HIV and TB infections
PF Objectives: • Expand biomedical and behavioral prevention interventions that address the various drivers of the epidemics; • Reduce vulnerability to HIV and tuberculosis (TB) infection, focusing on key

populations (e.g. female sex workers, people living in informal settlements, prisons); and • Increase the number of people who know their HIV and TB status and link them to appropriate services. **Workstream:** • Strategically Focus Prevention Interventions
PF Goal 2: Increase life expectancy and improve the quality of life for people living with and affected by HIV and TB
PF Objectives: • Expand integrated treatment, care, and support services; • Decrease infant, child, and maternal mortality due to HIV and TB; and • Mitigate the impact of HIV and TB on individuals, families, and communities, especially orphans and vulnerable children. **Workstream:** • Transition PEPFAR Care and Treatment Program Support • Mitigate the Impact of HIV on OVC
PF Goal 3: Strengthen the effectiveness of the HIV and TB response system
PF Objectives: • Strengthen and improve access to institutions and services, especially primary institutions; • Strengthen the use of quality epidemiological and program information to inform planning, policy, and decision making; • Improve planning and management of human resources to meet the changing needs of the epidemics; and • Improve health care and appropriate financing of prevention. **Workstream:** • Strengthen Health and Community Systems

Workstream 1: Strategically Focus Prevention Interventions

The prevention of new HIV and TB infections is the number one priority of the South African national response across all governmental departments and all partners. PEPFAR has been a critical ally and advocate of this multi-sectoral, multi-faceted approach since 2004, supporting a range of evidence based biomedical, social, and structural interventions in various government departments driving the prevention agenda (Health, Basic Education, Defence, Public Service and Administration, Social Development, National Prosecuting Authority, and Women, Children and People with Disabilities) as well as the various NGOs. Continued PEPFAR support is needed to strengthen the national prevention strategy and its integration into provincial plans and to expand coverage of quality combination HIV prevention interventions, in particular innovative and proven models targeting key populations. During the PFIP implementation, PEPFAR's prevention strategic focus is to:

a) Align its activities with the NSP and integrate them into provincial plans;
b) Support SAG's combination prevention strategy focusing on particular key populations (i.e. populations most at risk of acquiring new HIV infections and populations where new infection rates are high);
c) Identify capacity and service delivery gaps for prioritizing PEPFAR support;
d) Consolidate the portfolio for greater epidemiologic, demographic, and geographic efficiency and impact; and
e) Participate in cross-sectoral, multi-partner prevention planning, coordination, and implementation efforts.

PEPFAR's evidence based comprehensive prevention portfolio provides technical support to the key government and non-governmental actors and direct service delivery to approximately 4 million people in 35 selected areas. Important programmatic elements of PEPFAR's approach in support of the NSP includes both TB and HIV counseling and testing (HCT), especially for key populations (e.g. migrant and mobile populations, people living in informal settlements, in- and out-of-school youth); prevention of gender-based violence, prevention of mother to child transmission (PMTCT); voluntary medical male circumcision (VMMC); integrated gender equity and HIV prevention in school-based curricula; comprehensive prevention interventions for people living with HIV and those affected by it (e.g. orphans and vulnerable children); technical assistance to improve the systems and programs of departments driving the prevention agenda; sexual prevention including male and female condom promotion and use of multi-media communication channels; strengthening data management and use for prevention; and especially community-based demand creation and social norm and behavior change interventions. Support should also be provided to strengthen the ability of provinces and districts to successfully map the epidemiology of HIV in local areas, identify the specific prevention interventions needed, and identify the resources needed to respond to the local epidemic(s). Given the strong scientific evidence of some prevention interventions, USG support should target and potentially assist to scale-up these interventions (e.g., VMMC) to support SAG's ambitious targets outlined in the NSP.

The social and structural factors driving HIV and TB infection are a major challenge for the national response. Thus another key USG support area to the PFIP is to strengthen community systems to address HIV prevention and social and gender norms. This may include both proven interventions and innovation in program implementation. For example, operational research may be able to identify "best practices" in gender equity or reducing gender-based violence program implementation. As new science emerges, PEPFAR support may be needed in the introduction of new prevention interventions as they become cost-effective and part of international best practice (e.g. oral pre-exposure prophylaxis [PrEP] and microbicides). Decisions concerning support for innovative approaches are to be jointly taken by SAG and the USG through the Management Committee, especially when support for innovative projects is expected to have a significant financial implication for the SAG further down the line (e.g., pilot projects for 'test and treat,' or 'treatment as prevention').

Based on further discussions of the Management Committee, USG interventions in support of NSP objectives may also include capacity building in supply chain management of key prevention commodities (e.g. condoms, test kits, MMC kits, TB drugs); support for SAG efforts to integrate sexual HIV prevention and family planning services; support for intensified TB/HIV co-infection case finding and infection control in priority TB districts; support to SAG to develop policies and tools such as point-of-care technology to improve prevention linkages to care and treatment services; capacity strengthening of targeted communities and AIDS Councils to deliver comprehensive prevention programs; and improving monitoring and evaluation of prevention interventions.

Workstream 2: Transition PEPFAR Care and Treatment Program Support

Over the past five years SAG has made unprecedented efforts to rapidly establish an HIV care and treatment program larger than any other in the world, with an estimated 1.7 million people on ART in 2012. PEPFAR has been critical in the scale-up of this program over the years; from its inception, around 50% of PEPFAR funding has gone towards support for HIV and TB care and treatment services.

In order to meet the overwhelming number of persons in need of ART, several models have been implemented by PEPFAR:

1. The General Practitioner (GP) model: South Africa has extensive GP capacity in the private sector. PEPFAR has funded GP networks to initiate and maintain patients on ART to reduce the burden on the public sector and to provide access to services for patients that typically didn't access public services but did not have medical aid to pay for private sector ART (e.g. some teachers). GPs would typically provide clinical reviews, access to lab tests, ART, and treatment of easy to manage opportunistic infections and minor side effects.
2. Support for non-public facilities: PEPFAR engaged with a number of NGOs, many of which were faith-based organizations (FBOs) with already existing health infrastructure (hospitals, clinics, programs) that were well placed to rapidly roll out ART services. Using their infrastructure, personnel, and other resources, fully functioning ART clinics were established to provide ART services in rural areas where limited services were available and complement public ART services that were at the time insufficient to respond to the need. Many of these partners have been able to negotiate lab and drug costs with provincial governments.
3. Support for the public sector: PEPFAR support has largely focused on strengthening public sector facilities to increase access to ART. PEPFAR implementing partners provide direct technical and financial support for clinical service delivery (e.g. human resources, equipment, supplies, training, mentoring, community programs, and monitoring and evaluation). PEPFAR partners provide various levels of support across all 52 districts in the country, reaching an estimated 1.3 million patients.

Currently, the majority of PEPFAR support (>97%) is in the public sector in order to support the South African government's efforts to increase access to ART for the majority of the South African population. PEPFAR is supporting the SAG implementation of PHC re-engineering and the number and capacity of public health facilities providing ART is increasing.

At this point, GP network models are phasing out and are expected to be fully phased out by the end of 2012. Patients have either been transferred to public facilities or are to find other means to finance their health care in the private sector. As public health clinics are capacitated, PEPFAR and the SAG intend to ensure patients currently treated in NGO sites under PEPFAR funding are transitioned to other non-PEPFAR models of support (whether nearby public health facilities or NGO facilities with other sources of funding).

Since 2010 there has been an extensive effort to ensure that PEPFAR-support (through all models of care) was provided in a more synergistic manner by working closely with province, district and sub-district management to direct support to areas of greatest need. In order to reduce duplication and improve efficiencies, one PEPFAR partner was designated to work in a district or sub-district, covering all 52 districts.

One primary aim of the PFIP is to shift the focus of PEPFAR support from providing clinical services to strengthening service delivery platforms, especially in the public sector. This support is to assist the SAG in scaling-up treatment to reach the target set in the NSP (initiate 80% of eligible people on ART) and focus PEPFAR investments on health system strengthening that should drive efficiencies in implementation of the national response. This includes integration of HIV services, referral systems, training, mentorship, supervision, quality improvement, health planning/budgeting, human resource management, supply chain management, information management, and monitoring and evaluation.

The PEPFAR transition of service delivery for care and treatment includes: 1) patients transferring from GP and non-public sector sites to public sector facilities, and 2) reduced support for direct services within public sector sites. Several principles were jointly decided upon between USG and SAG to ensure this successful transition:

- Transition should not compromise the quality and continuum of care. Beneficiaries of current services (e.g. a patient on ART) should not be detrimentally affected by the transition of services.
- Transition of patients to public health facilities is to happen only when carefully planned and coordinated.
- Adjustment of support to public health facilities (e.g. reduction of supplemental staff) is intended to be gradual and consistent with district and provincial planning.
- All new awards for further PEPFAR care and treatment support are to be made based on joint planning and decision-making, in line with a broader transition plan (see below).
- Timely and transparent sharing of information between USG and SAG is intended to ensure a united approach to the transition of the care and treatment program and joint communication to stakeholders.

The Transition Task Team (TTT) is in the process of developing a comprehensive transition plan and is to be responsible for the monitoring of its implementation. The transition plan is expected to clearly define the necessary steps for a smooth and successful transition and inform the provincial business plans for the HIV conditional grants to ensure complete integration. The transition plan includes:

- PEPFAR is to ensure that no interruptions in support occur as a result of transition from one PEPFAR funded organization to another as agreements come to an end and new ones are initiated.
- Effective planning is to be done in partnership with provincial and district leadership to transition PEPFAR supported patients through GP and NGO sites into the public sector.
- Within the first year of the PFIP, the TTT plans to oversee the mapping of PEPFAR supported human resources in the public sector and carefully plan their transition. Where the provinces and districts determine PEPFAR-funded positions to be essential, there is to be coordinated absorption of those positions. For positions that are determined to be non-essential, arrangements are to be negotiated for those to be gradually phased out. This process has already begun to take place in provinces such as the Western Cape and Gauteng. Lessons learned from these experiences are to be applied to planning in other provinces.

The following are issues/challenges that have been already identified for the TTT to carefully consider:

- A review of the extensive experience with GP models is to be conducted to better understand success, efficiencies, and proper placement, keeping in consideration the upcoming National Health Insurance (NHI).
- As the PEFPAR GP model is phased out, one possibility for retaining the expertise of the well-trained and experienced GPs is for the Department of Health (DOH) to engage them part-time to support the provision of care and treatment at public facilities through clinical consultation, training, mentoring and supervision, etc.
- Several PEPFAR implementing partners have developed very strong community-based components to their care and treatment programs and employ many Community Health Workers (CHWs). The strategy for integrating current PEPFAR

supported CHWs to ensure retention of their positive impact in the national response is to be developed by the TTT. In addition, community-based programs have to be reviewed for their value and lessons learned. Their continuation (where deemed necessary) has to be discussed and planned.

- Several PEPFAR partners support care and treatment programs that cater for special populations (i.e. very remote populations, undocumented foreigners, men who have sex with men (MSM), and other marginalized or key population groups). Proper assessment and planning is needed so that the programs' added value is leveraged and treatment continues to be made available to the most vulnerable population groups.
- It may be beneficial to continue to retain the services of some highly specialized NGOs, leveraging their expertise in complex care, management of children, and implementation of medical male circumcision, while continuing to provide capacity building in these areas in the public sector.
- Transferring patients from GPs or non-public sector facilities that are not on 1st or 2nd line therapies are to be considered as special cases, and PEPFAR support may continue to be needed to support their ARVs.
- The TTT is to establish a communication structure to frequently consult with provinces and districts about priorities and transition issues.

The transition plan is to describe a phased process with independent timelines in each province and district, and clearly defined steps that are to be monitored to ensure a smooth and successful transition.

Workstream 3: Mitigate the Impact of HIV on Orphans and Vulnerable Populations

The NSP includes key goals and objectives aimed at mitigating the effects of HIV and AIDS on orphans and vulnerable children (OVC) and youth. The plan recognizes OVC as a key population for whom specific interventions are to be implemented as primary prevention for HIV, as well as mitigating impact and breaking the cycle of ongoing vulnerability. The Department of Social Development (DSD) "National Action Plan for Orphans and and Other Children Made Vulnerable by HIV and AIDS" (NAPOVC) defines the unique value-adding role of various stakeholders in addressing the social impact of HIV and AIDS. It creates and promotes a supportive environment in which orphans and other children made vulnerable by HIV and AIDS are adequately cared for; supported; and protected physically, psychologically, materially, socially, morally, spiritually, and legally to grow and develop to their full potential. It is based on the principle that no single sector can successfully address the impact of the HIV and AIDS epidemic on individuals, families, and communities and emphasizes a multi-sector response. Investing in programs that are family orientated is expected to have long-term and sustainable benefits in mitigating the HIV response. Research shows that families are the primary sources of behavioral patterns, and interventions involving the entire family may positively influence risk reduction and health-seeking behaviors, and may help to overcome disparities in access to treatment and healthcare observed between men and women.

PEPFAR has a very extensive portfolio that supports OVC in South Africa. In the current PEPFAR legislation, at least 10% of PEPFAR prevention, treatment, and care and support funding is earmarked for OVC. From September 2010 to October 2011, the South Africa OVC portfolio provided direct services to approximately 393,261 OVC. OVC-related interventions include child protection, clinical nutritional support, general healthcare referral, health care support for access to antiretroviral treatment, HIV prevention education, psychological care, educational support, and household economic strengthening. The OVC

portfolio is implemented in close collaboration with the Departments of Social Development, Basic Education, and Health to improve service delivery systems for OVC as well as promote linkages, referrals, and coordination to mitigate the social impact of HIV on OVC in sub-districts and districts with high HIV prevalence, high maternal mortality, and high numbers of OVC.

Future PEPFAR activities are to be aligned with the DSD's Policy Framework on OVC, the NSP, and other government responses related to meeting the needs of children affected by HIV and AIDS. For example, activities are closely aligned with DSD's Strategic Plan's objective of mitigating the impact of HIV and AIDS by facilitating the implementation of the NAPOVC. Proposed activities also support government's efforts to develop policies, strategies, and programs on integrating services for OVC. Promising community-led behavioral change best practices are to be identified and scaled up by providing communities with resources to help them manage their self-identified/designed HIV and TB responses, including those addressing sexual violence & unequal gender relations as well assistance to mobilize and strengthen community-based responses for the care, support, and protection of OVC and youth.

Future support to DSD is to focus on integration and coordination activities to achieve the following three objectives:

- Improve timely availability of reliable data on program performance monitoring and evaluation (M&E) and research of the social effects of HIV and AIDS on OVC;
- Strengthen coordination, management, and oversight of local structures that protect and care for the most vulnerable children and the families that care for them; and
- Strengthen inter-sector integration and coordination with other Departments such as Health and Education and build a supportive multi-sector environment for vulnerable children through health and social system strengthening at the national and provincial level.

Key components of the impact mitigation workstream include support to strengthen health and social welfare system coordination and integration; support of social and individual behavior change activities to prevent HIV infection for children under 18 years; and support to strengthen the management of the social welfare workforce.

Workstream 4: Strengthen Health and Community Systems

Strengthening government systems to expand its capacity to absorb the programmatic elements of the PEPFAR program is essential. The magnitude of the HIV and TB epidemics in South Africa has placed a tremendous strain on the district health system. The shortage of critical human resources, especially doctors and pharmacists, has led the SAG to adopt a nurse-based model of treatment, care, and support that incorporates community-based services to ensure equitable access of quality HIV and TB services. As the PEPFAR program transitions from direct service provision, the focus is to be on strengthening the capacity at provincial and district level along the WHO six building blocks. This section also describes PEPFAR support to the strategic enablers outlined in the NSP: governance and institutional arrangements; effective communication; monitoring and evaluation (M&E); and research.

Strengthening governance at district and sub-district level and in particular leadership skills to coordinate, manage, implement, and monitor, and at the same time scale up these programs in the face of the change in funding and support provided is vital. PEPFAR district

support partners and other implementing partners are to assist in training and mentoring in this regard.

In addition, as per the SANAC governance structures, PEPFAR implementing partners are also to work with district and provincial AIDS councils to strengthen their role in the multi-sectoral response. Coordination, leadership, and management skills are needed to mobilize all sectors around a common vision that takes into account the nature of the epidemics in their locality. Evidence-based planning, identifying key populations and high-risk areas, and developing targeted programs are also needed.

Human resource development is needed to scale up HIV and TB prevention, treatment, care, and support services at the PHC and community level as outlined in the South African HRH Strategy document. The SAG has trained primary care nurses to initiate and manage patients on ART, but there is need to strengthen their capacity through a system of mentorship. The shortage of doctors, especially in rural areas, has been a challenge in mentoring nurses to build up their competencies and confidence to initiate and manage patients on ART. This is compounded by the high HIV and TB co-infection rates. Support is needed to strengthen the integration and clinical governance of TB and HIV services to reduce related morbidity and mortality rates. The SAG is in the process of re-engineering the PHC services, introducing such concepts as multi-disciplinary teams, ward-based (community outreach) teams, and a chronic care model to increase the absorption capacity and access to quality services at primary care level. These efforts, however, need the support of the PEPFAR program.

PEPFAR is assisting the Department of Health (DoH) to implement a Human Resource Information System (HRIS) to provide management with the information needed to better plan and manage HRH provision in the country over the next three years and support may extend through the last two years in areas that need more capacity building. Continued support is to be provided for multi-sectoral pre-service training activities (e.g. training of Clinical Associates and doctors, curriculum development for the training of community health workers, training of laboratory and pharmacy technicians, epidemiologists, nurses, pharmacists, parasocial workers, teachers and data capturers), as well as in-service training, and mentoring support. At the request of SAG and in coordination with regional training centers, in-service training support and mentoring may also be provided by PEPFAR. This support is not just limited to clinical and programmatic staff, including social workers and other community workers, but also district and provincial management staff of the relevant government departments.

Supply chain management for pharmaceuticals and commodities needs capacity building from the facility to the district and provincial levels, to ensure continuous supply of medicines such as ARVs, OI medicines, TB prophylaxis and treatment, and commodities such as condoms and test kits. Adequate supply chain management is critical to ensure patients have sufficient drugs to adhere to strict regiments. PEPFAR partners that work at facility, district, provincial, and national levels are to work to support efforts such as improved drug forecasting and quality control of stock.

Health financing: In response to increasing SAG expenditure to scale up much needed HIV and TB services, there is need to strengthen capacity at provincial and district level for financial management to increase efficiency and effectiveness of resources. This is an area of increasing responsibility for the provincial and district leadership as they seek to further integrate a multi-sectoral HIV and TB response more broadly. The PEPFAR expenditure analysis should help identify PEPFAR financial inputs by program and geographic area to facilitate transparency of the PEPFAR budget and joint planning of future activities. This

exercise should provide the necessary information per district for the National AIDS Spending Assessment.

Improving the availability and use of strategic information is critical to generating quality information needed to inform policy development and program implementation. PEPFAR implementing partners have extensive skills in the collection and validation of data and use of strategic information for decision-making. PEPFAR implementing partners are expected to work closely with SAG counterparts at service delivery, district, provincial, and national levels to improve the use of data and to monitor the implementation of the NSP.

PEPFAR is to more closely align its indicators to that of the national indicator data set (NIDS) and reduce the reporting burden especially at the service delivery level. PEPFAR is expected also to work to strengthen the use of the district health information system (DHIS) and reduce the need for parallel reporting systems to the extent possible.

PEPFAR is to continue to invest in the implementation of the 3-tiered information system that is expected to provide the information needed on the number of persons on ART and a minimum dataset to measure health outcomes for persons on ART. The 3-tiered approach ensures that all facilities that manage patients on ART either have a standard paper-based register, an electronic register, or a patient-based electronic management system.

In addition to the DOH 3-tiered system, PEPFAR is supporting the ETR.net (which is the TB surveillance system). Integration of TB and HIV information systems and data use is important for monitoring the dual epidemics and improving health outcomes.

PEPFAR is to support DSD's information system that provides information about OVC service delivery and community-based care.

In addition to routine data, support for surveillance systems is expected to provide the information needed to monitor trends in the HIV and TB epidemics. PEPFAR is to continue to support laboratory-based surveillance activities for opportunistic infections (OIs), TB and TB drug resistance, and ARV drug resistance.

Health service delivery innovation: Continued support is needed in setting a national research agenda to inform service delivery models and new prevention and treatment guidelines. Support is needed in areas of research, innovation, surveillance, and program evaluations to improve health outcomes including HIV and TB outcomes and prevent new infections. At the district level, the focus tends to remain on input, process and output with insufficient attention to service delivery outcomes and population level impact for program planning and implementation. An outcomes-based planning model is necessary to make progress in curbing the epidemics.

Laboratory Strengthening: PEPFAR has focused on strengthening the overarching public health laboratory system and services in South Africa as identified by the NDOH and the National Health Laboratory Services (NHLS). PEPFAR, in collaboration with the NHLS, is involved in several activities that should facilitate the successful implementation of public health laboratory programs. These activities are aimed at supporting the national ART rollout and the National TB Strategic Plan and include extensive training of laboratory personnel in all laboratory aspects of HIV and TB, strengthening of Internal Quality Control (IQC) and External Quality Assurance (EQA) systems as well as re-enforcing the importance of good laboratory practices.

Laboratory infrastructure improvement activities, key to increased diagnostic capacity, are also being supported. These include: acquisition and rollout of new diagnostic technologies

such as the GeneXpert machines for improved TB diagnosis and results turnaround times; improvement and implementation of specimen tracking systems and cold chain to facilitate specimen and results movement between facilities; and improvement of the electronic delivery of and access to laboratory results through the implementation of netbook and/or mobile devices at designated facilities, thus significantly reducing the turnaround time for laboratory results.

Community Systems Strengthening: PEPFAR is to build capacity of community structures and leadership to coordinate with relevant SAG departments to improve and sustain the HIV/TB response by actively linking the community to HIV/TB services. Community systems' strengthening includes addressing social, cultural, and gender norms that underpin the epidemic. It is the community systems and structures that are the first line of defense. It is in the community and in the household that people decide to go for testing and counseling or seek health or social services. The community can create an enabling environment strengthens the capacity of communities to own responses to HIV and TB, and promotes and helps people to get into treatment.

6. MONITORING AND EVALUATION

The SAG has developed a Monitoring and Evaluation (M&E) framework to track the implementation of the NSP and progress towards achieving national HIV, STI and TB targets. The PFIP M&E framework is to mirror that of the NSP, and results are to be reported by PEPFAR to SAG. USG is to continue monitoring PEPFAR-funded programs through internationally standardized indicators and mechanisms, aligned whenever possible with SAG facility-based reporting systems and other routine reporting tools. (See Appendix I: NSP impact indicators aligned with PEPFAR process indicators). The PFIP is expected to also promote an environment of data transparency and sharing between PEPFAR and SAG in order to maximize data use and streamline reporting, including the development of a joint data sharing agreement.

Impact Monitoring

PEPFAR is expects to support the national HIV, STI and TB response and in monitoring the impact of the overall national effort. The PFIP is to adopt the SAG national impact targets (Table 3) and employ routine monitoring and reporting to quantify PEPFAR contribution to changes in these indicators.

Table 3: NSP and PFIP Impact Indicators

NSP Indicator	Baseline (2012)	Target (2016)
HIV prevalence among women and men aged 15-24	8.7%	50% reduction
HIV prevalence among key populations	No data	50% reduction
HIV incidence	0.94%	50% reduction (0.47%)
TB prevalence	795/100,000	397/100,000
TB incidence	981/100,000	490/100,000
TB mortality	50/100,000	25/100,000
Infants born to HIV positive mothers who are HIV positive at 6 weeks and 18 months post-partum	3.5% @ 6 weeks	< 5% @ 18 months
Adult mortality due to HIV and	43.6%	50% reduction (21.8%)

NSP Indicator	Baseline (2012)	Target (2016)
TB		
Stigma index	To be determined	To be determined
People initiating ARV alive and on treatment @ 5 years	No data	70%

PEPFAR expects to continue to provide technical and financial assistance to implement the national monitoring, evaluation, and surveillance systems needed to collect this impact data, with a particular emphasis on capacity building of local agencies and organizations. In collaboration with SAG and other in-country partners, PEPFAR expects to contribute to monitor national targets for impact and outcome indicators including the following:

- **Reduce new HIV infections by at least 50% using combination prevention approaches**

Reductions in HIV incidence are to be estimated through modeling and laboratory-based methods with data derived from ANC surveillance (yearly), general population surveillance (every 3 years), surveillance of high-risk populations including sex worker, truck drivers, injecting drug users (IDU) and MSM (periodicity to be determined), and PMTCT surveillance (periodicity to be determined). PEPFAR expects to continue to support key aspects of this monitoring system as well as providing technical assistance to strengthening overall HIV surveillance systems and implementing additional surveys that answer key data gaps.

- **Initiate at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation**

Monitoring patients newly initiated on ART and patients retained in care is to be conducted using the DHIS and 3-Tiered ART Monitoring System platforms. Rollout of paper-based registers (Tier 1) and the stand-alone electronic ART registry (Tier 2) is scheduled to be completed in 2013. Over the lifetime of the PFIP, SAG expects to also roll out the Tier 3 SmARTer system. These systems provide information on the number of patients newly initiated on ART and ART patients alive and on treatment at 6, 12, 24, 36, 48, and 60 months post-initiation. PEPFAR expects to continue to support these efforts to strengthen reporting, including implementation of the Tier 2 and 3 systems.

In addition, PEPFAR intends to support the rollout of adult HIV drug resistance surveillance and pharmacovigilance surveillance as well as strengthening the national infant and maternal mortality surveillance system.

- **Reduce the number of new TB infections, as well as the number of TB deaths by 50%**

PEPFAR expects to support the NDOH in the development and rollout the national TB prevalence survey every 2-3 years. In addition, TB case reporting in South Africa is collected through an electronic tuberculosis register (eTR.Net). Incidence estimates are to be based on WHO modeling that includes parameters derived from local data. PEPFAR also expects to assist in improved quality of data in eTR.Net as well as increased use of the database by relevant managers, and work with SAG in increasing integration of TB and ART monitoring systems.

- **Reduce reported stigma and discrimination related to HIV and TB by 50%**

In order to monitor a reduction in self-reported stigma and discrimination, PEPFAR is expected to support SAG in developing a stigma mitigation framework and Stigma Index every 2-3 years. Data from general and high-risk population surveillance systems is to also inform progress toward reducing stigma and discrimination.

PEPFAR also expects to continue to work collaboratively with the SAG to develop a national research and surveillance agenda that should inform new and existing policies, provide information national guidelines as well as providing data to evaluate the NSP.

Implementation Monitoring

PFIP implementation monitoring indicators are expected to be aligned with those NSP priority indicators captured in the DHIS and other routine reporting structures as well as through current PEPFAR reporting systems. PFIP monitoring should quantify and track both direct service delivery and technical assistance indicators based on the NSP indicators and targets. The tables below detail the NSP indicators, national 5 year targets, USG expected contribution to SAG in achieving these targets in Year 1, and designate whether support with be provided through direct service delivery, technical assistance, and capacity building or a combination of models.

Targets for inputs and outputs of USG programs are to be set each year through the COP process and achievements towards reaching these goals are to be reported to SAG in a timely manner so they can be reflected in national status reports.

In addition to reporting service delivery indicators, PEPFAR intends to develop a standardized tool to quantify its technical assistance and capacity building contribution to the following illustrative areas:

- Supply chain logistics and procurement
- Human resources for health including salaries
- Management, training, and supervision
- Infrastructure
- Quality improvement and assurance
- Monitoring and evaluation and data quality
- Frequency of PEPFAR involvement
- Level of PEPFAR support (patient, facility, community, district, province)
- HIV expenditure tracking
- Financial modeling and policy development
- Impact on patient care

A final technical assistance and capacity building monitoring system is expected to be developed by PEPFAR in consultation with SAG and partners, which should leverage in-country and headquarters PEPFAR support and be completed by the end of 2012. This system is expected to enable PEPFAR to quantify its contribution to NSP targets through technical assistance activities.

Table 4: Baselines and National and PEPFAR targets (2012 and 2016)

Partnership Framework Goal 1: Prevent new HIV and TB infections

	National		**PEPFAR**		
	Baseline (2012)	**Target (2016)**	**Target (2012)**	**Service Delivery**	**Technical assistance**

Men and women 15-49 counseled and tested for HIV	13 million (62% ever tested, 37% tested in last 12 months)	30 million (80% ever tested)	4 million	✓	✓
TB patients tested for HIV	54%	90%		✓	✓
Male condom distribution	492 million	1 billion		✓	
Female condom distribution	5.1 million	25 million		✓	
Men medically circumcised	143,000	1.6 million	191,000	✓	✓

Partnership Framework Goal 2: Increase life expectancy and improve the quality of life for people living with and affected by HIV and TB

	National		PEPFAR		
	Baseline (2012)	**Target (2016)**	**Target (2012)**	**Service Delivery**	**Technical assistance**
OVC aged over 17 whose household receive free basic external support in caring for the child	75%	90%	90%	✓	✓
People screened for TB	8 million	30 million	2,524,500	✓	✓
Newly diagnosed HIV positive people started on IPT	53%	85%		✓	✓
ART eligible who receive treatment	58%	80%	2,500,000	✓	✓
TB/HIV co-infected and on ART	No data	100%	280,500	✓	✓

Partnership Framework Goal 3: Strengthen the effectiveness of the HIV and TB response system

	National		PEPFAR		
	Baseline (2012)	**Target (2016)**	**Target (2012)**	**Service Delivery**	**Technical assistance**
Domestic and international HIV spending	ZAR 13 billion				✓
Government departments and sectors with operational plans with HIV, TB and related gender and rights-based dimensions integrated	To be determined	100%	100%		✓

PEPFAR is currently undergoing a process of reviewing and aligning its indicators to those of the National Indicators Data Set (NIDS), which primarily provides facility-level health data. While PEPFAR partner reporting to satisfy all US Congressional and programmatic

implementation requirements is to continue, PEPFAR systems should not pose any added burden to national reporting systems. PEPFAR also expects to continue to provide technical support to strengthening the routine national systems that monitor program implementation and HIV-related outcomes. Data quality assurance for PEPFAR as well as SAG systems are to be a high priority, and routinized data quality assessments should be built into PEPFAR data capturing and reporting structures.

Transition Monitoring

PEPFAR and SAG intend to develop a longer-term transition plan that details a smooth and sustainable conversion of programmatic, financial and human resources, and investment from the USG to the SAG public sector, beginning with the treatment program. PFIP monitoring is expected to quantify and track both direct service delivery and technical assistance indicators that support the transition plan, and a detailed monitoring system is to be developed once the transition plan has been completed.

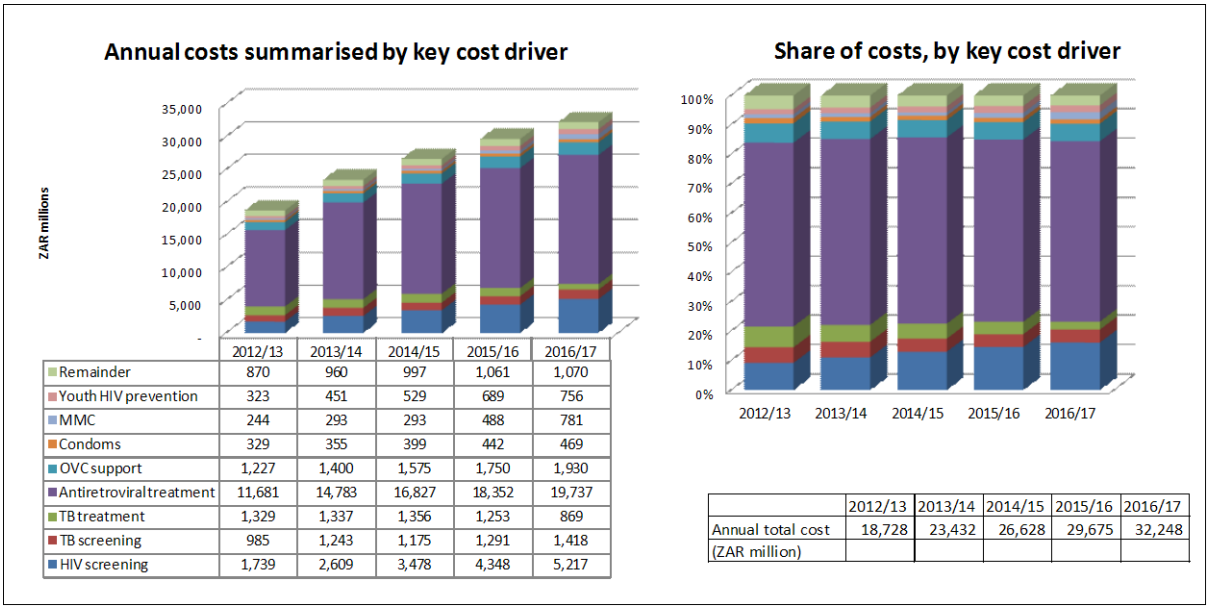
7. OVERALL FUNDING REQUIREMENTS FOR THE NATIONAL HIV AND TB PROGRAM

In late 2011, SAG released its new NSP[7]. The NSP contains a high-level costing, which is to be complemented by more detailed "bottom up" costs from each of the nine provinces, in the form of the provincial strategic plans (PSP). The PSPs are to be completed later this year, possibly during the third quarter of 2012.

The NSP estimates that total resources needed for South Africa to fight HIV and TB amount to ZAR 18.7 billion (US$ 2.2 billion) in 2012, rising to ZAR 32.3 billion (US$3.8 billion) by 2017. Over the five-year period, the total is ZAR 130.7 billion (US$ 15.6 billion). This represents a huge investment in efforts to prevent new infections, prolong and improve the lives of those living with HIV, and deal with the social and economic consequences of the epidemic, including assisting orphans and vulnerable children.

[7] Government of South Africa, *National Strategic Plan on HIV, STIs, and TB, 2012-16*. December 2011.

Figure 2: Categorized annual costs (ZAR millions in 2011 prices)



	2012/13	2013/14	2014/15	2015/16	2016/17
Remainder	870	960	997	1,061	1,070
Youth HIV prevention	323	451	529	689	756
MMC	244	293	293	488	781
Condoms	329	355	399	442	469
OVC support	1,227	1,400	1,575	1,750	1,930
Antiretroviral treatment	11,681	14,783	16,827	18,352	19,737
TB treatment	1,329	1,337	1,356	1,253	869
TB screening	985	1,243	1,175	1,291	1,418
HIV screening	1,739	2,609	3,478	4,348	5,217

	2012/13	2013/14	2014/15	2015/16	2016/17
Annual total cost (ZAR million)	18,728	23,432	26,628	29,675	32,248

7.1. Review of HIV and AIDS Expenditures in South Africa

Despite some gaps in the data, it is clear that spending on HIV and TB has been rising rapidly in South Africa in recent years. Financing of HIV and TB interventions has grown significantly in the last 8 years, driven by an expansion of services to meet the need for treatment, prevention, and care for orphans and vulnerable children.

This rapid rise in financial outlays reflects the strong political commitments to reversing the spread of HIV and attenuating its negative effects by SAG, PEPFAR, and other external and domestic partners. As reported earlier in this document, the positive impact of this expanded national effort is large and impressive – though much more still needs to be done.

Even though the overall financing of the HIV response in SA cannot be accurately quantified, the general pattern of recent HIV and TB spending is clear. Overall expenditures have risen very fast. SAG has increased its own spending rapidly, at an annual unadjusted rate of around 12% over the past four years, according to the National Treasury. Domestic public spending accounts for about three quarters of all HIV and AIDS spending in South Africa. PEPFAR covers most of the remainder. In addition, South Africa receives Global Fund support and has been designated a “High Impact” country – meaning that Global Fund investments can be expected to continue beyond the scope of the current grants and based on successful applications for ongoing funding in the future.

7.2. Aligning Aid Assistance

While the NSP is not a health department strategy, the majority of the directly attributable costs are incurred within this sector. Sustainable financing of the NSP therefore includes the need to ensure sustainable financing of health care. South Africa’s health system includes both public and private financing and delivery.

In January 2011, the Minister of Health launched the Aid Effectiveness Framework (AEF). The AEF seeks alignment of development partner assistance with departmental processes, so as to make planning and implementation more efficient, reduce the administrative burden,

and minimize transaction costs, while at the same time recognizing the need to strengthen the internal capacity and procedures.

The AEF is expected to be updated annually to incorporate the needs and progress on the NSP implementation. The AEF also mandates the use of an Annual Planning Tool (APT) to ensure access to high quality data and analysis to inform decisions. The APT is to collect and consolidate expenditures and forward-looking budget information across levels of government (e.g. national and province), government departments (e.g. Health, Social Development, Education), and development partners including the Global Fund. This APT tool is included in the NSP as the mechanism for looking at consolidated information on HIV and TB (though the APT as a tool within the Health Department would look at health spending beyond HIV and TB). The National Treasury is a key driver of this process.

The APT, launched in the second half of 2012, is to be used to collect expenditure information according to a uniform set of reporting categories for all funding and implementing bodies to track both the resources available and the spending patterns.

In addition to the APT, the Department of Public Service and Administration, with support from the World Bank, are implementing two tools that would ensure a more comprehensive picture of spending. The Public Expenditure Tracking Survey (PETS) seeks to track public resources from the treasuries (national, provincial) to health facilities. The Qualitative Service Delivery Assessment is also done at the same time with the PETS study to provide a comprehensive picture of health facility expenditure. This work has started in KwaZulu-Natal and is being rolled out to other provinces.

7.3. Financial Prospects for the PFIP Period

On the external financing side, PEPFAR spending in South Africa is projected to decline over the next five years of the PFIP (see below). At the same time, several other development partners such as the UK and Netherlands have reduced or cut their HIV and AIDS contributions to South Africa, and the Global Fund is in the midst of a restructuring that has led to a temporary pause in new grants to South Africa and other countries. This uncertain external financing picture is expected to without doubt put the main funding burden for HIV and AIDS squarely on the Government of South Africa.

Since the start of the ART program, the SAG has covered a large portion of costs related to HIV and TB interventions. However, given the very large burden of HIV and TB in South Africa compared to other countries, there is also a justification for continued external financial support to fill gaps and help catalyze innovative solutions in treatment and care, prevention, and other areas of the national response. In addition, South Africa faces growing burden of diseases, driven by non-communicable diseases (including AIDS-related cancers and cardiovascular disease) and trauma/violence, which remain underfunded.

Improving efficiency and effectiveness of HIV and health spending

While South Africa continues to attempt to mobilize adequate funds for its HIV program, the country is also identifying ways to use existing resources more efficiently, thereby reaching more people with HIV and TB services with the same amount of money. Some examples include:

1. The NDOH has recently been successful in negotiating a 53% reduction in ARV prices and a 36% reduction in the price of TB medicines.

2. The establishment of the Central Procurement Unit is expected to see further savings on the procurement of medicines in 2012.
3. An analysis of HIV treatment costs, undertaken on behalf of the NDOH, shows that improved efficiency relating to staffing utilization, laboratory testing, and drug utilization can further contribute to utilization of existing financial resources.

Additional measures to enhance efficiency need to be pursued during the next five years of the PFIP.

7.4. PEPFAR Funding for the PFIP

The Partnership Framework states that to improve the financing of the HIV and TB response, the PF is to work to improve the cost efficiency of all HIV and TB interventions. Several SAG and USG initiatives are already underway to effectively cost their respective operations and identify areas where savings can be achieved. Chief among these are commodity procurement and human resource management.

The PFIP is expected to support strengthening SAG capacity at national, provincial, and district levels to budget, allocate, and manage committed financial resources efficiently so as to achieve desired results. The SAG is to also continuously increase its financial commitment and diversify its funding base through greater engagement with the private sector and other development partners.

Since PEPFAR allocations to South Africa and all recipient countries depend on annually voted appropriations by the U.S. Congress, it is not possible to project PEPFAR spending over the next five years with certainty. However, based on the overall current authorization from the Congress, the gradual transition of PEPFAR's directly supported clinical services to SAG, and on financial planning analysis by the Office of the Global AIDS Coordinator and the PEPFAR South Africa team, the scenario below has been developed for the period of the PFIP.

In order to sustain the gains made in South Africa, the transition in PEPFAR funding should be approached with caution and in a phased manner. As such, the current funding is expected to remain constant through FY 2014 and then decline in a phased manner over the remaining years of the PFIP to $250 million by 2017.

As a major contributor to the Global Fund, the USG is working closely with the Global Fund to increase coordination between PEPFAR and Global Fund programs. To facilitate this effort in SA, PEPFAR has received a Global Fund (GF) Collaboration award to increase coordination between PEPFAR and Global Fund funded programs through programmatic collaboration and coordination assisted by establishing a shared PEPFAR – GF – Country Coordinating Mechanism (CCM) electronic platform for data sharing and to enhance program performance for Global Fund supported activities by strengthening the financial management and monitoring and evaluation capacity of Primary Recipients (PR)s and their sub-recipients and assisting the CCM to provide oversight for program implementation through membership on the CCM and active participation and assistance as needed.

7.5. South African Global Fund AIDS and Tuberculosis Grants

The current status of the South African Global Fund AIDS, Tuberculosis, and Malaria (GFATM) grants is demonstrated in the tables below. There are 5 active grants. The grant to the Western Cape Department of Health (WCDOH) supports ART, peer education, palliative and step down care, and community-based responses in the Western Cape. The

National Religious Association for Social Development (NRASD) supports behavior change communication, HCT, home and community-based care, OVC, and institutional capacity building. The Networking AIDS Community of South Africa (NACOSA) grant funds community-based prevention interventions, community demand creation, OVC support and institutional strengthening for community organizational strengthening. The NDOH grant supports HIV and TB case finding, expansion of ART and Isoniazid Prophylaxis Therapy (IPT) with a focus on ARV and drug procurement, and strengthening government and civil society human resources and building their HIV and TB response capacity. The Right to Care (RTC) grant supports HIV and TB case finding, MMC, and HIV drug resistance monitoring.

Table 5: GFATM Grant Status in South Africa

Principal Recipient	Grant Number	Total Signed Amount (USD)	Status	Start Date	End Date
National Department of Health	SAF-202-G05-00	24,400,220	Phase II in closure	January 2006	December 2010
Western Cape Department of Health	SAF-304-G04-H	38,470,422	RCC 1	July 2010	30 June 2013
National Religious Association for Social Development	SAF-9010-G09-H	13,701,694	R9 Phase I	October 2012	30 September 2012: recently extended to 30 March 2013
National Department of Health	SAF-H-NDOH	100,270,275	SSF Phase I	July 2011	30 March 2013
Networking AIDS Community of South Africa	SAF-H-NACOSA	19,516,564	SSF Phase I	July 2011	30 March 2013
Right to Care	SAF-H-RTC	16,169,384	SSF Phase I	January 2012	30 September 2013
*NOTE: Grants signed with First Commitment and Supplementary First Commitment amounts, which are released as per disbursement requests					

7.5. Overall NSP Financing Plan

By combining the different sources containing the most reliable information on recent past, current, and projected HIV needs and commitments a composite financing table of expected contributions covering the NSP/PFIP timeframe can be constructed. See Table 5 below. The National Treasury and the Department of Health are currently collaborating to collect information, using the APT, which would further inform the table below. As this is a work in progress and is still incomplete, the NSP financing table should be finalized during the first six months following the signing of the PFIP, so that it can then be used as part of the joint monitoring and accountability to be followed by both governments, including regular reviews of actual spending and revised estimates for the coming year(s).

Table 6: NSP Financing Plan, 2012 – 2017 (ZAR and USD Millions)

		2012	2013	2014	2015	2016	2017
Government of South Africa	R	9,574	11,378	13,130	13,787	14,476	15,200
	$	1,197	1,422	1,641	1,723	1,810	1,900

		2012	2013	2014	2015	2016	2017
PEPFAR*	R	3,872	3,872	3,672	3,304	2,800	2,000
	$	484	484	459	413	350	250
Subtotal	**R**	**13,446**	**15,250**	**16,872**	**17,091**	**17,276**	**17,200**
	$	**1,681**	**1,906**	**2,100**	**2,163**	**2,160**	**2,150**
Government as %		71%	75%	80%	80%	84%	88%
PEPFAR as %		29%	25%	20%	20%	16%	12%
Global Fund	R	656	88				
	$	82	11				
European Union	R $	Information collected through APT; not yet available					
United Kingdom	R $	Information collected through APT; not yet available					
Other Bilateral	R $	Information collected through APT; not yet available					
Grand Total (Incomplete)	**R**	**14,102**	**15,338**	**16,872**	**17,091**	**17,276**	**17,200**
	$	**1,763**	**1,917**	**2,100**	**2,163**	**2,160**	**2,150**
Total Need	R	18,278	23,432	26,628	29,675	32,248	35,473
	$	2,285	2,929	3,329	3,709	4,031	4,434

*PEPFAR allocation is notional and subject to Congressional appropriation and approval by the Global AIDS Coordinator.

Note that for the SAG and Global Fund amounts, the timeframe is April 1 to March 30 (2012/13 funding), and for USG figures the timeframe is from October 1 to September 30 e.g., FY 2012 funding should arrive in country October 1, 2012. In addition, because the Global Fund grants are to be renewed in 2013, the amounts post June 2013 are not available. The SAG conditional grant amounts for 2015-2017 are indicative only.

In broad terms, the PFIP Financing Plan above shows PEPFAR planned spending declines from ZAR 4.1 billion in 2012 to ZAR 2.9 billion in 2016, and to R2.1 billion in 2017 in line with stated intentions of the USG.

As part of the first year of implementation of the PFIP, therefore, a series of steps need to be taken to make joint financial planning, budgeting, and expenditure monitoring fully functional:

- Develop financing plans at the national level for each major program area and for the overall, integrated HIV and TB response at provincial level;

- Confirm that the government's basic accounting system (BAS) can generate timely reports on Government spending for HIV and TB at the national and provincial levels and that the PEPFAR Expenditure Analysis can do the same for USG expenditures;
- Design and test the "cross walk" between SAG and PEPFAR expenditure categories so that the two funding streams can be aligned and monitored; and
- Establish the annual timetable for generating reports and analysis on national and provincial spending to inform planning and budgeting for the Steering and Management Committees. The first reviews should be held in the 1st or 2nd quarters of 2013, at the latest.

8. TIMELINE AND DELIVERABLES FOR YEAR ONE

Table 7: Year One Timeline and Deliverables

Timeline	Deliverables/Milestones	Responsible
July 2012	• Establish Transition Task Team (TTT) for clinical services • TTT initial review of PEPFAR treatment partners by province	Management Committee
August 2012	• Establish Steering Committee • Mutually decide on Terms of Reference for the Steering Committee to begin work in September	Management Committee providing support to Steering Committee
August 2012	• Establish Management Committee • Mutually decide on Terms of Reference for the Management Committee	Management Committee
August 2012	• Joint communication (op-ed) about the transition by MOH and US Ambassador	Management Committee providing support to co-chairs of Steering Committee
August 2012	• Finalize Terms of Reference for the Transition Task Team	Management Committee
August 2012	• Assign partners, province & other departments to the Transition Task Team	Management Committee

August 2012	• Appoint additional sub-committees of the Management Committee:
	  • Prevention Technical Task Team
	  • OVC Task Team
	  • Strategic Information Task Team
	  • Health & Community System Strengthening Task Team
		Management Committee

August 2012	• Mutually decide on Provincial Governance Structure • Assign Provincial Technical Task Teams	Management Committee

Timeline	Deliverables/Milestones	Responsible

September 2012	• Complete 5-year Transition Plan for the transition of PEPFAR supported clinical services including the transition monitoring indicators
	• Engage provinces in the following:
	  ○ In-depth discussions on the transition of clinical services
	  ○ Provincial and district Needs Assessments
	  ○ Incorporate Transition Plan into Provincial Business Plans
	  ○ Review PEPFAR expenditure by province, by partner and integrate budget and expenditure information into provincial planning
		Management Committee and Transition Task Team

November 2012	• Design and test 'cross-walk' between SAG and PEPFAR expenditure categories	Management Committee and 'System Strengthening' Task Team
December 2012	• Standardize district and provincial PEPFAR partner workplan templates	Management Committee and Transition Task Team
February 2013	• Establish annual timetable for generating reports and analysis on national and provincial spending for the Steering and Management Committees	Management Committee
March 2013	• Complete 5-year Provincial Transition Plans tailored to individual/specific provincial needs	Management Committee and Transition Task Team

9. PFIP REVIEW

Based on annual reviews on the progress of implementation and potential changes in HIV and TB epidemics and interventions, the SC may decide to make revisions to the PFIP if there are major shifts in programming.

Signature Page

Signed at Cape Town,

This 8 day of August, 2012, in duplicate, in the English language.

For the United States of America

Name: Donald H. Gips

Title: United States Ambassador to the Republic of South Africa

For the Government of the Republic of South Africa

Name: Pakishe Aaron Motsoaledi

Title: Minister of Health of the Republic of South Africa

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APPENDIX I: NSP/PFIP IMPACT INDICATORS AND PEPFAR IMPLEMENTATION INDICATORS AND TARGETS

NSP Indicator • PEPFAR Indicator	PEPFAR Target 2012	 2013
HIV prevalence among women and men aged 15-24 and HIV incidence		
• Number of individuals who received Testing and Counseling services for HIV and received their test results	4,000,000	4,000,000
• Number of pregnant women with known HIV status	990,000	995,000
• Number of males circumcised as part of the minimum package of MMC for HIV prevention services	155,000	191,000
• Number of persons provided with post-exposure prophylaxis (PEP)	68,000	13,000
• Number of People Living with HIV (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions	1,000,000	1,200,000
• Number of the targeted population reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	2,500,000	2,500,000
HIV prevalence among key populations		
• Number of MARPs reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	66,942	89,120
TB prevalence, incidence and mortality		
• Number of HIV-positive patients who were screened for TB in HIV care of treatment settings	2,295,000	2,524,500
• Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	204,000	280,500
Infants born to HIV positive mothers who are HIV positive at 6 weeks and 18 months post-partum		
• Number of pregnant women with known HIV status	990,000	995,000
• Number of HIV-infected pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission	252,450	268,650
• Number of infants born to HIV-positive women who received a HIV test within 12 months of birth	282,100	289,500
Adult mortality due to HIV and TB and People initiating ARV alive and on treatment @ 5 years		
• Number of adults and children with advanced HIV infection newly enrolled on ART	500,000	500,000
• Number of adults and children with advanced HIV infection receiving antiretroviral therapy	2,000,000	2,500,000
• Number of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	403,200	420,000
• Number of eligible adults and children provided with a minimum of one care service	3,000,000	3,300,000
• Number of HIV-positive adults and children receiving a minimum of one clinical service	2,550,000	2,805,000
• Number of HIV-positive persons receiving cotrimoxazole prophylaxis	450,000	600,000
• Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	165,000	165,000
• Number of HIV-positive patients who were screened for TB in HIV care of treatment settings	2,295,000	2,524,500
• Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	204,000	280,500
• Number of eligible clients who received food and/or other nutrition services	750,000	825,000

APPENDIX II: ILLUSTRAVE BASELINE (JUNE 2012) SUMMARY OF CURRENT SAG AND PEPFAR SUPPORT TO THE NSP STRATEGIC GOALS

NSP 2012-2016 Strategic Objective 1: Address Social and Structural Drivers of HIV and TB Prevention, Care and Impact

SAG Activities	USG Activities	Accountable Stakeholder
Sub-Objective 1.1: Mainstream HIV and TB and it's gender and rights-based dimensions into the core mandate of all government departments and all SANAC sectors		
Integrate HIV and TB into broader development agenda and civil society		SANAC
Ensure that all government departments have a departmental strategic plan for HIV and TB, which is fully aligned with the NSP 2012-2016	Support the development of departmental strategic plans	DBE, DCS, DHET, DOH, DSD, SANDF, USG[8]
Ensure that all government departments have an annual implementation plan, including guidelines, for HIV/AIDS and TB program activities	Support the development of annual and longer term implementation plans	DBE, DCS, DOH, DSD, SANDF, USG
Implement operational plans	Support DACs and LACs in developing and implementing operational plans including use of data for programming Build capacity of partners (including NGOs, HCBC, Social service professionals and Traditional Leadership) to implement	DBE, DCS, DHET, DOH, DSD, SANDF, USG
Revise the national HIV/AIDS policy for the schooling system Develop peer educator and peer mentor manuals	Support DBE policy development Support the development of peer educator and peer mentor manuals	DBE, USG
Sub-Objectives 1.2: Address social, economic and behavioral drivers of HIV, STIs and TB		
Address social & structural factors that influence HIV and TB transmission in informal settlements	Support select Local AIDS Councils and municipalities to develop and implement comprehensive prevention programs for informal settlements Support community–based interventions in select informal settlements and farming communities	DBE, DOH, DSD, USG

[8] SAG Departments of: DBE – Basic Education; DCS – Correctional Services; DHET – Higher Education and Training; DOH – Health; DSD – Social Development; SANDF – SA National Defence Force; DPSA – Public Service and Administration; DOJCD - Justice and Constitutional Development; DWCYPD – Women, Children, Youth, and People with Disabilities; SAMHS – SA Military Health Services; SAPS – SA Police Service

SAG Activities	USG Activities	Accountable Stakeholder
	Support community dialogues – action plans in select informal settlements and farming (including social mobilization) Support the development and implementation of social and behavior change programs targeting key populations	
Address social & structural factors that influence HIV &TB transmission and access to health services in rural settlements and farms	Support targeted social and behavior change interventions in select areas	DOH, DSD, USG
Develop a comprehensive package of services to address vulnerability associated with mobility and migration	Support HIV prevention systems with evidence-based HIV prevention interventions, targeting migrants in hostels, mining areas, migration centers, and high population density informal settlements Support SAG participation in regional and global efforts to address HIV and communicable diseases	DOH, DSD, SANDF, USG
Sub-Objective 1.3: Implement interventions to address gender inequities and gender-based violence as drivers of HIV and STIs		
Implement programs that integrate and strengthen gender equity, HIV and AIDS, and GBV into DBE life skills and SRHE focusing in secondary schools	Support Implementation of programs that integrate gender equity and GBV into life skills and SRHE	DBE, DCS, DHE, DOH, UNICEF, USG
Support the gender-based violence task team through implementation of integrated programs to address HIV vulnerability associated with GBV	Support implementation of community-based programs to address gender, sexual equality and GBV, in select geographic areas. Support development of targeted messages including media sensitive messages to people with disabilities e.g. Braille Support Community Capacity Enhancement (CCE). Develop capacity of CCE facilitators to develop gender lens Support the establishment of forums (at all levels of government) for men and women	DBE, DOH, DOJCD, DSD, DWCYPD, UNICEF, USG
Ensure a standardized policy and protocol for the management of gender-based violence	Support GBV surveillance system	DWCYPD, SANDF, USG
Sub-Objective 1.4: Mitigate the impact of HIV and TB on orphans, vulnerable children and youth		
Provide psychosocial services to OVC	Provide OVC services through the implementing partners	DSD, USG
Strengthen systems (e.g. capacity building, monitoring, research)	Support DSD's response system for OVC interventions (e.g. capacity building, human resource development	DSD, USG

SAG Activities	USG Activities	Accountable Stakeholder
	[HRD] systems, evidence research, children's services directory)	
Integrate behavior change interventions into strategy for social cohesion Develop and implement a comprehensive behavior change communication strategy	Build capacity to implement targeted behavior change interventions to reduce risk of HIV acquisition and transmission	DSD, USG
Prevent relative disadvantage in school attendance among orphans versus non-orphans		DSD,
Adapt and implement the regional CSTL MER Framework for SA context		DBE
Sub-Objective 1.5: Reduce the vulnerability of young people to HIV infection by retaining them in schools, as well as providing post-school education and work opportunities		
Revise the national policy on HIV for the schooling system	Support revision of policies	DBE, USG
Develop peer educator and peer mentor program	Support development of peer educator and peer mentor program	DBE, USG
Develop social mobilization and program implementation for out for school youth	Support implementation of interventions that will keep children in school and ensure school completion in select communities Support implementation of a comprehensive package of services for youth (including out of school youth) that also promotes youth leadership to mitigate the impact of HIV and TB Support social mobilization & program implementation for out of school youth	DOH, DSD, USG
Monitor and strengthen the management and implementation of the national school nutrition program in provinces, districts and schools		DBE
Sub-Objective 1.6: Reduce HIV and TB related stigma and discrimination		
Develop and implement stigma eradication programs targeting children in schools and the general population Support provinces to develop their stigma mitigation plans	Support provinces and districts with the development and planning of stigma mitigation plans	DBE, DHET, DOH, DPSA, DSD, USG
Collaborate to monitor the impact of stigma mitigation	Support stigma sentinel surveillance (stigma index) development and roll out	DOH, DSD, USG
Implement support group guidelines	Support implementation of support groups, post-test clubs, etc. at province and district level	DOH, DSD, USG
Conduct community dialogues on stigma	Support implementation of community dialogues at province and district level	DOH, DSD, USG

SAG Activities	USG Activities	Accountable Stakeholder
Support Greater Involvement of People Living with HIV and AIDS and TB (GIPA) Program	Support GIPA in HIV advisory committees and development of policy and programs	DOH, DSD, USG
Sub-Objective 1.7: Strengthening community systems and support efforts at poverty alleviation and food security programs		
Strengthen community systems and enhance impact of poverty alleviation programs including food security programs	Support strengthening of community systems in response to HIV, TB and STIs, in some selected geographical locations	DOH, DSD, USG
Sub-Objective 1.8: Reduce alcohol and substance abuse related vulnerabilities		
Reduce alcohol and substance abuse related vulnerabilities	Support implementation of mass media and community mobilization programs to reduce alcohol and substance abuse	DOH, DSD, USG
Reduce usage of illicit substances and introduce workplace programs to reduce substance abuse Enhance implementation of programs to reduce substance abuse in the workplace and the communities	Support prevention programs and workplace programs, including reduction of substance abuse	DCS, SANDF, USG

NSP 2012-2016 Strategic Objective 2: Prevent New HIV, STI and TB Infections

SAG Activities	USG Activities	Accountable Stakeholder
Sub-Objective 2.1: Maximize opportunities to ensure everyone in South Africa tests voluntarily for HIV and is screened for TB at least annually, and is subsequently enrolled in relevant wellness and treatment, care and support programs		
Scale up programs to provide universal access to HIV counseling and testing (to access ART for prevention and treatment)	Support the improvement of access and coverage	DCS, DHET, DOH, SANDF, USG
Implement PICT for HIV in all health facilities including training Implement Quality Management Systems in all HIV rapid testing sites Improve linkages to care and treatment through point of care CD4 testing; effective data management and utilization	Support integration of PICT at all health facilities Build management and leadership capacity at district and facility level Support effective linkages to care and treatment through point of care CD4 testing; effective data management and utilization	DCS, DOH, SANDF, USG
Implement couple HIV testing in all health facilities, MMC settings and mobile. Provide HCT in non-health settings to reach all populations, including inmates and survivors of sexual abuse and violence	Support the identification of discordant couples through couple HIV counseling and testing in homes, MMC setting, health facilities Support scale-up of HCT approaches focusing on key and hard to reach populations such as farm workers, migrant workers, prisoners/ offenders, commercial sex workers, men who have sex with men (MSM), and post	DCS, DOJCD, USG

SAG Activities	USG Activities	Accountable Stakeholder
	school youth, through targeted interventions	
Implement routine TB symptom screening of HIV infected people Promote annual TB screening for high risk populations and the public at large Develop and implement TB screening policy for high risk groups	Support implementation of routine TB activities	DCS, DOH, USG
Carry out surveillance for the management of TB and MDR/XDR TB to support TB/HIV integration	Support institutionalizing of TB drug resistance (MDR/XDR) testing	DCS, DOH, USG
Strengthen the monitoring and evaluation system on the reporting of childhood TB		DOH
Improve access of HCT and sexual and reproductive health (SRH) services to higher education institutions Scale-up the First things First Campaign to all higher education institutions, including Further Education and Training (FET) colleges. The campaign is to also focus on TB screening	Support HCT services and assist in strengthening SRH, TB screening Support the HCT campaign for post school communities including staff and students at higher education institutions	DHET, DOH, USG
Provide full package of screening in all clinical settings	Support a full package of screening within a chronic care model within the PHC context	DOH, USG
Ensure effective syndromic management of STIs in the public and private sector	Support effective syndromic management of STIs	DOH, USG
Sub-Objective 2.2: Make accessible a package of sexual and reproductive health services		
	Support development of training and mentoring materials to strengthen integration of HIV prevention in health care settings Support Implementation of comprehensive prevention services in select geographic areas	USG
Implement integrated school health program	Support implementation of integrated school health program	DOH, DBE, DWCPD, EU, USG
Develop targeted HIV prevention efforts for key populations most at risk	Support development of policies and training to address HIV prevention among key populations Support implementation of comprehensive HIV prevention services for key populations, including MSM and sex workers Support implementation of surveillance of HIV, STIs and other related risk factors among key populations	DOH, DSD, USG
Implement SRH and HIV education for 10-19 years old	Support implementation of SRH programs for youth	DBE, DOH, DSD, USG

SAG Activities	USG Activities	Accountable Stakeholder
Prevent unintended pregnancies in teenagers through appropriate sexual and reproductive health and fertility management services	Support implementation of evidence-based interventions to reduce HIV related risk among youth	
Roll-out Medical Male Circumcision (MMC)	Support national, provincial and district level on policy, guidelines, monitoring and evaluation, training, and ACSM, identify, establish, and implement high volume high efficiency sites, and demand creation in a minimum of four provinces	DOH, DCS, SAMHS, SANDF, USG
Increase effectiveness of male and female condom promotion to the general population, in particular the older age groups	Support distribution of female condom in non-traditional outlets and amongst high risk populations	DCS, DOH, USG
Conduct and monitor the implementation of PAP smear on all female inmates twice per year	Integrate women's health (breast cancer screening)	DCS
Sub-Objective 2.3: Prevent transmission of HIV to reduce MTCT to at least 2% at six weeks and to less than 5% at 18 months by 2016		
Scale up on PMTCT Coverage and improve Quality of PMTCT to reduce MTCT to less than 2%	Support overall planning and roll out M&E of PMTCT program Support QI activities Support PMTCT, NIMART training and mentorship	DCS, DOH, CHAI[9], UNAIDS, UNDP, UNICEF, USG
Facilitate integration of PMTCT into existing PHC services	Support the integration of PMTCT services at all levels	DCS, DOH, CHAI, UNAIDS, UNDP, UNICEF, USG
Increase awareness and community involvement in PMTCT	Support IEC and public awareness campaigns	DCS, DOH, CHAI, UNAIDS, UNDP, UNICEF, USG
Ensure that all children under one yr. of age are vaccinated with pneumococcal, rotavirus and measles vaccines	Support comprehensive vaccination plan	DOH, SANDF, USG
Sub-Objective 2.4: Implement a comprehensive national social and behavioral change communication strategy with particular focus on key populations (Communication cutting across all Strategic Objectives)		
Strengthen life skills programs in different settings Develop learner teacher support materials to support the implementation of the Life Skills Program	Support the life skills program	DBE, Provincial Education Departments, SANDF, SAPS, USG
Develop scripted lesson plans on sexuality education in support of Curriculum Assessment Policy Statements (CAPS) for Grades 7-9	Support development of scripted lesson plans on sexuality education in support of CAPS for Grades 7-9	DBE, USG

[9] CHAI - Clinton Health Access Initiative; UNDP – UN Development Programme; UNICEF – UN Children's Fund

SAG Activities	USG Activities	Accountable Stakeholder
Implement and strengthen the peer education programs on sexual and reproductive health Develop peer educator and peer mentor manuals	Support departments, universities and FET colleges and make training and IEC materials available	DBE, DCS, DHET, USG
Implement prevention programs to achieve high number of protected sex acts	Support implementation of a national SBCC strategy with specific focus on key populations Support community-based interventions through community dialogue and action in select communities	DBE, DOH, DSD, USG
Develop new HIV prevention strategy focusing on SBCC to preventing young people engaging in sexual activities; targeting MCP; key populations	Support development and implementation of a national SBCC strategy including specific focus on key populations	DBE, DCS, DOH, DSD, USG
Develop social behavior change program for youth out of school	Support the development and implementation of social behavioral change programs	DOH, DSD, USG
Increase reach of communications Conduct national communications survey to assess coverage/ reach of communications	Support the National Communication Survey	DBE, DOH, DSD, USG
Develop positive health, dignity and prevention interventions for PLHIV	Support the development of policies and implement training and mentoring to ensure comprehensive HIV prevention programs for PLHIV	DCS, DOH, DSD, DWCYPD, USG
Sub-Objective 2.5: Preparing for the potential implementation of future innovative, scientifically proven HIV, STI and TB prevention strategies		
Implement post-exposure prophylaxis (PEP)	Support implementation of programs to expand access to PEP for non-occupational exposure	DCS, DOH, USG
	Support the strategic planning of GeneExpert rollout	DOH, USG
Plan for new microbicide and other new prevention technologies	Support government policies, planning and research on Oral PreP, Microbicide, and vaccines	DOH, USG
Sub-Objective 2.6: Prevent TB infection and disease		
Monitor and manage of BCG disease in HIV exposed infants		DOH
Institutionalize routine contact tracing of all contacts of smear-positive TB cases	Support the rollout of routine contact tracing	DOH, USG
Reinforce implementation of IPT policy for PLHIV Provide IPT to all eligible child contacts Establish sentinel sites to monitor impact of IPT	Support the rollout of IPT and CMX preventive therapy	DCS, DOH, USG
Strengthen surveillance for adverse events for first and second line TB and ART treatment		DOH
Ensure compliance to the core quality standard for TB infection control in all health facilities	Support quality assessment and quality improvement of TB Infection control programs	DCS, DOH, USG
Sub-Objective 2.7: Address sexual abuse and improve services for survivors of sexual assault		

SAG Activities	USG Activities	Accountable Stakeholder
Address physical and sexual violence against women	Support efforts to address sexual abuse policies through HIV prevention programs and research Support programs to inform communities about available services, and raise awareness of gender-based violence to decrease stigmatization of reporting cases and seeking treatment	DOJCD, USG
Develop and implement a comprehensive package to prevent sexual abuse	Support comprehensive prevention services for gender-based violence and sexual assault	DOJCD, USG
Provide comprehensive post-sexual assault care including PEP	Support the rollout of PEP	DCS, DOJCD, DWCYPD, USG

NSP 2012-2016 Strategic Objective 3: Sustain Health and Wellness

SAG Activities	USG Activities	Accountable Stakeholder
Sub-Objective 3.1: Reduce disability and death resulting from HIV, STIs and TB through universal access to HIV and TB screening, diagnosis, care and treatment		
Provide integrated care and treatment services for HIV, STIs and TB through PHC reengineering Ensure that everyone who needs ART is started on ART Find and treat every case of TB Provide integrated management for all TB/HIV positive patients	Support onsite mentorship to health facility staff, to ensure that care delivery models allow for scale up of ART and TB services	DCS, DOH, USG
Improve access to palliative care and end of life services	Support to provide palliative care through hospice and home-based services	DOH, USG
Ensure that HIV-infected children and pregnant women are considered in all HIV, STIs and TB policies and programs	Support ART and care services for pediatrics and adolescents, pregnant women	DCS, DOH, USG
Engage people with TB/HIV and affected communities in planning, delivering and monitoring services for TB/HIV patients	Support the strengthening of linkages	DOH, USG
Implement joint TB/HIV information, education and communication activities	Support for the implementation of joint TB/HIV information, education and communication activities	DCS, DOH, USG
Develop strategies for management of HIV, STIs and TB in high-risk communities, e.g. correctional services, tertiary educational institutions, mines, refugees, police holding cells, military, orphans, homeless	Support the decentralization of HIV, TB, care and treatment services	DCS, DHET, DOH, SANDF, USG
Engage private pharmacists, private health sector, general	Support establishing of Public Private Partnership (PPP)	DOH, USG

SAG Activities	USG Activities	Accountable Stakeholder
health practitioners, traditional health practitioners, CBOs and community caregivers in TB/HIV activities		
Accelerate implementation of nutrition-related interventions within HIV and TB programs	Support rollout of nutrition programs, e.g. assessments, guidance, implementation, M&E	DOH, USG
Review of ART adult and pediatric treatment guidelines	Support the update of the National Care and Treatment guidelines	DOH, USG
Strengthen laboratory services needed to implement integrated HIV, STI and TB services	Support efforts to improve efficiency and utilization of laboratory services	DOH, USG
Screen for opportunistic and HIV related infections e.g. cryptococcal, meningitis	Support the screening for opportunistic and HIV related infections e.g. cryptococcal, meningitis	USG
Sub-Objective 3.2: Ensure that people living with HIV, STIs and TB remain within the health care system, are adherent to treatment and maintain optimal health and wellness		
Develop integrated care package for PLHIV	Support the development and implementation of HIV care package	DOH, USG
Expand I-ACT (Integrated Access to Care and Treatment) program	Support rollout of I-ACT at provincial and district level	DOH, USG
Strengthen primary health care, with a focus on provision of medication at PHC facilities and support at the household level	Support the strengthening of primary health care through the rollout of the chronic care model	DOH, USG
Ensure easy access to drugs and other required commodities	Support implementation of efficient and client friendly drug dispensing	DOH, USG, DCS
Monitor patient loss to follow-up Establish a rapid response system for primary treatment defaulters	Support programs to ensure retention in treatment of patients that are on ART	DOH, USG, DCS
Sub-Objective 3.3: Ensure that systems and services remain responsive to the needs of people living with HIV, STIs and TB		
Increase access to health care facilities within and after normal working hours (24 hour access to care)		DOH
Integrate of HIV and TB care with an efficient chronic-care delivery system	Support the integration of HIV and TB care within an efficient chronic care delivery system	DOH, USG
Investigate waiting times and design interventions to improve it	Support ongoing efforts to assess care delivery models	DOH, USG

NSP 2012-2016 Strategic Objective 4: Ensure Protection of Human Rights and Increased Access to Justice

SAG Activities	USG Activities	Accountable Stakeholder
Sub-Objective 4.1: Ensure rights are not violated when interventions are implemented and establish mechanisms for monitoring abuses and exercising rights		
Conduct annual patient satisfaction surveys		DCS
Monitor patient safety, infection control, occupational health and safety, security, medication control, etc.		DCS
Monitor and audit closely the Grievance Register with respect to HIV and AIDS status		DCS
Monitor the development of policy and programs in addressing human rights agenda		DCS
Sub-Objective 4.2: Reduce HIV and TB discrimination in the workplace		
Implement effective behavior modification programs that reduce stigma and discrimination in all facilities for both inmates and personnel		DCS
Strengthen the protection of vulnerable inmates (first offenders, youth/juvenile offenders, mentally Ill, physically challenged, sex offenders, drug and substance abusers, children accompanying their mothers**,** terminally ill (e.g. HIV, cancer), elderly and women offenders		DCS
Conduct Integrated Health Risk assessment in health and education sectors (HIV, Health and Productivity and Occupational Health Risk Assessment)	Support Integrated Health Risk assessment in health and education sectors (HIV, Health and Productivity and Occupational Health Risk Assessment)	DPSA, USG
Ensure the implementation of Workplace Programs (WPP)		DPSA
Strengthen activities addressing adults at high risk of HIV infection including support for policy development in the workplace, technical assistance to the SAG across sectors		DPSA
Align the SAG with ILO Recommendation on HIV&AIDS and World of Work, and Gender Sensitive Rights-Based HIV&AIDS Mainstreaming		DPSA
Implement UNAIDS, ILO, WHO, HIV&AIDS and TB Policy Framework for Health Care Workers		DPSA
Review compensation system for health care workers		DPSA
Revise PSCBC Resolution on HIV&AIDS for Public Servants		DPSA
Strengthen workplace programs, including coordination and working with unions, mining, and farming enterprises	Support workplace programs, including coordination and working with unions, mining, and farming enterprises	DPSA

SAG Activities	USG Activities	Accountable Stakeholder
Incorporate prevention interventions into broader service delivery efforts that include HIV testing and counseling, treatment and support		DPSA
Extend workplace programs beyond the employee to include family members, and beyond the workplace to reach out to the local community		DPSA
Include elements that influence norms, combat stigma, and foster a broader sense of community investment in public health programs		DPSA
Use peers rather than outside experts to lead interventions		
Taking the scale of the employer and the size of the workforce into account, workplace interventions may have to cater to the needs of mobile populations		
Sub-Objective 4.3: Reduce discrimination in access to services		
Conduct PLHIV discrimination workshops	Support PLHIV discrimination training/workshops at province and district level	DOH, DSD, USG
Enforce workplace PLHIV policy	Support workplace HIV/AIDS programs at implementation level	DOH, USG
Develop a joint Government and Trade Union Health Campaign against TB Stigma and Discrimination		DPSA

NSP 2012-2016 Strategic Enablers

SAG Activities	USG Activities	Accountable Stakeholder
Strategic Enabler 1: Governance and Institutional Arrangements		
Facilitate the implementation of the SANAC Governance and Accountability Framework across all provinces	Build district governance capacity	SANAC, USG
Develop a standard framework for the engagement of development partners across all levels of government	Build relationships between PEPFAR partners and provincial level governments through PEPFAR Provincial Liaisons	SAG, USG
Develop and disseminate guidelines for district level multi-sectoral engagement	Build capacity of District Health Councils and Clinic Health Committees	SANAC, USG
Strategic Enabler 2: Monitoring and Evaluation and Strategic Information		
Develop standard templates for data collection and build capacity for strategic information management at the district level	Provide support to increase the availability and quality of programmatic and epidemiological evidence base for health programs	SAG, USG

SAG Activities	USG Activities	Accountable Stakeholder
Capacity building for monitoring and evaluation of NSP activities	Build capacity to increase data use at the facility and district levels	SAG, USG
	Align PEPFAR indicators and reporting systems with those of the SAG and rely on SAG data systems as the primary source for reported data	USG
	Support the SAG to strengthen the management of M&E and Quality Improvement across the HIV and TB response	USG
Ensure implementation of the 3-tiered ART monitoring system	Support the implementation of the 3-tiered ART monitoring system	DOH, USG
Strategic Enabler 3: Research		
Facilitate the implementation of the research priorities identified by the Research Forum	Support research of the costs of various HIV, STI, TB and health system interventions	SAG, USG
Advocate for domestic resources for the NSP research agenda	Support operation research activities on HIV, STIs, TB and health systems	SAG, USG
	Provide TA to build local research capacity	USG
Strategic Enabler 4: Medical products, vaccines and technologies		
	Support policies, legislative frameworks, and guidelines relating to pharmaceutical services and products to be enhanced and implemented	USG
Ensure and support compliance with National Care Standards as determined by the Office of Standards Compliance	Support improved compliance of Pharmaceutical Services with National Core Standards (NCS) for Health Establishments	DOH, USG
	Support human resource development related to pharmaceutical services and management	USG
	Support improved efficiency of national and provincial procurement systems	USG
Enhance implementation of the pharmacovigilance strategy across all facilities	Support improvement of pharmacovigilance systems at national, provincial and facility levels	DOH, USG
Strategic Enabler 5: Health workforce development		
Ensure training of service providers	Support the training of new priority health care workers through pre-service training determined by SAG	DOH, USG
Ensure training of service providers	Support the development of existing health care workers through In-service training	DOH, USG
Identify priority staff categories for absorption	Support the efficient transition of priority health care workers from PEPFAR funded organizations to the government	DOH, USG

SAG Activities	USG Activities	Accountable Stakeholder
Strengthen Regional Training Centers to promote in-service training of existing health care workers	Strengthen Regional Training Centers to promote in-service training of existing health care workers	DOH, USG
Build district management and leadership capacity	Build district management and leadership capacity	DOH, USG
Support the development of a Human Resources Information Management System and build capacity to strategically manage and plan staffing needs	Support the development of a Human Resources Information Management System and build capacity to strategically manage and plan staffing needs	DOH, USG
Strategic Enabler 5: Health systems financing		
Develop standard curriculum for capacity building for costing	Build capacity of provinces and districts in cost modeling to develop provincial strategic plans (PSPs), district strategic plans (DSPs)	SAG, USG
Implement Annual Planning Tool to determine health and HIV budgets and expenditures	Complete PEPFAR expenditure analysis to identify amount and location of PEPFAR expenditures	SAG, USG
Conduct provincial Conditional Grant reviews	Build provincial financial management capacity, in order to manage conditional grants	USG and SAG
Implement NHI	Support the rollout of NHI through technical expert assistance	USG and SAG