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United States - South Africa Binational Commission

Science and Technology Committee

Health Working Group

Briefing Paper in preparation of the 3rd US-South Africa Binational Commission
Health Working Group meeting to be held on 25 February, 1998

DRAFT

22 January 1998

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I. EXECUTIVE SUMMARY OF PROGRESS IN HEALTH WORKING GROUP PRIORITY AREAS

HHS, in cooperation with USAID, is developing a program of health cooperation under the United States - South Africa Binational Commission (BNC). Cooperation in health was initially addressed under the BNC's Science & Technology (S&T) Committee. In 1997, an informal health working group (HWG) was established to provide a more in depth forum for discussion. HWG priority areas include: biomedical research, emerging and re-emerging infectious diseases, HIV/AIDS, STDs, Violence, Tobacco and other substance abuse, mental health, school health promotion, the National School of Public Health, the Equity Project, and occupational medicine. The following is a summary progress since the July meeting.

Emerging and Reemerging Infectious Diseases

Outbreak Investigation and Control

- Two provincial epidemiology training courses have been held.
- National guidelines on outbreak investigation and control have been implemented.
- A workshop on *Surveillance and Control of ERIDs* was held in September, 1997.

Tuberculosis Programmatic Support

- Site visits to the CDC assisted TB program in Botswana occurred in November.

Tuberculosis Laboratory Microscopy

- A CDC laboratorian made a two week visit in January and provided training in three Provinces to improve smear microscopy services in the diagnosis of TB.

Laboratory Collaboration

- The NIV is collaborating with CDC regarding Ebola Virus outbreaks
- The NIV is collaborating with CDC on laboratory aspects of diarrhoeal diseases.
- Collaboration is continuing between WHO, CDC, NIH and the SAIMR in conducting an efficacy trial of a polyvalent pneumococcal vaccine.
- CDC, SAIMR and the Association of State and Territorial Public Health Lab Directors have agreed to conduct an assessment of South African laboratories. Based on this assessment collaborative efforts among the three agencies will be developed.

Research

- NIAID has announced a special initiative for research cooperation with South Africa. It is expected to focus on population based research and clinical trials

HIV/AIDS/STDs

The HIV/AIDS/STD Capacity Building Project has been designed

- The overall objective for the Capacity Project is "the enhanced capacity to provide effective HIV/AIDS/STD and TB prevention care and treatment." nationally and in 3 provinces.
- Five key components will comprise assistance to provincial-level capacity building: 1) network development; 2) management and related support systems; 3) service delivery; 4) advocacy; and 5) use of quality data and findings from intervention-linked research.
- It is expected that the agreement for the HIV/AIDS/STD capacity building project will be signed in February 1998.

Establishment of an STD Research Station

- There have been discussions between CDC and the DOH to establish an STD Research Station in South Africa.

HIV Related Research

- The Orange Farm Progestin Study designed to assess the possible association between HIV and progestin contraception has begun. This is a collaborative effort between CDC and Investigators at Baragwanath Hospital and the University of Witwatersrand.
- Collaboration has continued between CDC and South Africa in transfer technology of molecular techniques to diagnose and investigate genital ulcer disease.
- USAID participated in the planning of the extended periodic presumptive treatment of women at high risk in the Free State.

Other Areas

- The AIM advocacy workshop was held in August 1997.
- Two applications from South African investigators for the HIV/NET program were approved, one in Soweto and one in KwaZulu Natal.
- CDC collaborated with the DOH to review the MRC proposal for HIV/AIDS/STD surveillance.

Intentional Injuries

- The Director of NCIPC gave the keynote address during a conference on community violence prevention held in Pretoria, South Africa in November and held meetings with DOH and MASA officials.
- CDC collaborated with the DOH and others to develop protocols to collect information for intentional injury surveillance.

Tobacco and other Substance Abuse

- CDC supported South African representatives to attend the 10th World Conference on Tobacco and Health in Beijing, China in August.
- CDC participated in an African regional workshop to begin development of a Tobacco Control Action Plan for Africa.
- In collaboration with the World Bank, CDC will participate in the 'Economics of Tobacco Control' Conference in Capetown in February.
- Eleven US researchers visited Capetown in November and assisted in the development of a pilot project on FAS. The project began in January.

School Based Health Promotion

- CDC has disseminated detailed information on its school health programs to the DOH including programs addressing behaviours that contribute to: 1) unintentional and intentional injuries; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviours that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; 5) dietary behaviours; and, 6) physical activity.
- Discussions have taken place between CDC and the DOH to explore the possibility of conducting a Youth Risk Behaviour and Violence survey
- CDC has shared evaluations of prevention programs including successful and unsuccessful efforts.

- A South African Health Promoting Schools Committee has been established with representatives from the Departments of Health and Education.
- HHS supported two South Africans to attend the U.S. National Injury Conference in November 1997.
- A CDC representative attended a Conference in Capetown in November on Health Promotion in Schools and had meetings with Provincial and National Health and Education Officials.

Mental Health

- A workshop to discuss integration of mental health services into primary health care and to develop a pilot program is scheduled for 16-28 February. Three representatives from the US are expected to attend.
- In response to a request from the Truth and Reconciliation Commission, NIMH is doing an assessment of scientific studies of the psychiatric consequences of torture and extreme violence.
- Two persons from South Africa participated in the September Conference on Services Research and Primary Care Research in Washington, D.C.

Occupational Health

- A senior South African occupational medicine physician is currently working as a senior scientist in the NIOSH Office of the Director.
- Several members of the scientific staff at NCOH will work at NIOSH for several months in 1998 to acquire specific skills in conducting occupational health surveillance, assessing workplace ergonomics, and organizing service programs to evaluate and recommend corrective measures for workplace hazards.

National School of Public Health

- Funding has been received from the Departments of Education and Health
- A Strategic Plan *Meeting the Challenges of the New South Africa* has been published.
- The Dean has met with various officials from NIH, CDC, and the Association of Schools of Public Health who have pledged support.

USAID - Equity Project

Increased access to PHC services

- Developed catchment area mapping methodology to define populations with physical access to PHC facilities.
- Designed draft PHC package for the Eastern Cape.
- Developed clinic assessment tool to collect baseline data on PHC service delivery.

Increase effectiveness of the health care referral system

- Identified existing protocols and procedures for inclusion in draft PHC package.
- Established working group to strengthen use of transportation and communication infrastructure.

Improve the management of the PHC delivery system

- Formed human resources management and incentives task groups.
- Assessed clinic staffing patterns, requirements and staffing norms.

- Initiated facility survey to collect data on resources and productivity.
- Collected baseline data on pharmaceutical availability and utilisation.
- Implemented methodology to develop more accurate clinic budgets.
- Developed two-page reporting format for essential PHC service data and corresponding list of indicators.
- Conducted international workshop on management of decentralized health systems, with emphasis on district planning.
- Developed PHC clinical training event schedules.
- Conducted training needs assessment.
- Facilitated Eastern Cape participation in an international workshop on contracting in the health sector.
- Prepared draft paper on training indicators.
- Established HIV/AIDS/STD and TB Management Committee and Barrier Methods Task Group.
- Completed study tour of training resource centers in Tanzania and Kenya.
- Supported PHC management training for 14 sub-district level managers.

Other

- A Demographic and Health Survey, partially supported by USAID has begun field testing.

GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
BNC	United States - South Africa Binational Commission
CDC	U.S. Centers for Disease Control and Prevention
DOH	National South African Department of Health
ERID	Emerging and Reemerging Infectious Diseases
FAS	Fetal Alcohol Syndrome
HCFA	U.S. Health Care Financing Administration
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HWG	Health Working Group
MASA	Medical Association of South Africa
MEDUNSA	Medical University of South Africa
MRC	Medical Research Council
NCIPC	U.S. National Center for Injury Prevention and Control
NIV	National Institute of Virology
NIH	U.S. National Institutes for Health
NIAID	U.S. National Institute for Allergy and Infectious Diseases
NIOSH	National Institute for Occupational Safety and Health
NIMH	National Institute of Mental Health
PASA	Participating Agencies Services agreement
PHC	Primary Health Care
S & T	Science and Technology Committee
SAIMR	South African Institute for Medical Research
STD	Sexually Transmitted Diseases
TB	Tuberculosis
WHO	World Health Organization

II. BACKGROUND

The U.S. Department of Health and Human Services (HHS), in cooperation with the U.S. Agency for International Development (USAID), is taking the lead in developing a program of health cooperation under the United States - South Africa Binational Commission (BNC). Initially, health was addressed under the BNC's Science & Technology (S&T) Committee. At the first S&T Committee meeting in December 1995, three areas were identified for cooperation in health: biomedical research, telemedicine, and emerging and re-emerging infectious diseases.

In early 1997, it was decided to form an informal health working group to provide a broader and more in depth forum for discussion. The first meeting of the Health Working Group (HWG) was held in Cape Town in February 1997 which proceeded the S&T Committee Meeting. The deliberations of the HWG are reported to the S&T Committee and, subsequently, to the BNC as part of the S&T Committee's report.

Within the HWG the original areas of collaboration have been expanded to include: HIV/AIDS, STDs, Violence, Tobacco and other substance abuse, mental health, school health promotion, the National School of Public Health, the Equity Project, and occupational medicine. Telemedicine was discussed during the meetings in December 1995 and February 1997 but has been deleted at the request of the South African delegation. The National School of Public Health, and School Based Health Promotion were first discussed during the July 1997 HWG meeting.

III. BRIEF SUMMARY OF THE HEALTH WORKING GROUP MEETING ON JULY 28, 1997 AND RECENT PROGRESS

The Second Meeting of the HWG was held on July 28, 1997, in Washington, D.C. at the U.S. Department of Health and Human Services. The meeting was co-chaired by Dr. Olive Shisana, Director General, South African Department of Health (DOH) and Dr. John Eisenberg, Acting Assistant Secretary for Health, Department of Health and Human Services (HHS).

The South African delegation provided several documents as background for the discussions. These included the *White Paper on the Transformation of the Health System*, the *DOH Annual Report*, and the *DOH National Drug Policy*. U.S. Agencies including the National Institutes of Health (NIH), the National Institute of Mental Health (NIMH), and the Centers for Disease Control and Prevention (CDC) also shared numerous documents throughout the meeting.

Several guiding principles for the HWG were accepted. These include:

1. Cooperation should be in areas of mutual interest and benefit.
2. Effort should be made to coordinate activities and resources in accordance with priorities set by the Health Working Group.
3. Although the HWG priority areas involve several countries in Southern Africa, in the context of the BNC, South Africa can only commit to activities within its own

- borders. Coordination on Southern Africa regional issues may involve other organizations, including the Southern Africa Development Community (SADC) and the World Health Organization (WHO).
4. Collaborative activities should focus on capacity building and program sustainability.

The following is a summary of the key items discussed, current areas of collaboration, and progress since the July meeting. These reflect information obtained at the time of this report and are expected to be modified as the February 1998 meeting date approaches.

A. EMERGING AND REEMERGING INFECTIOUS DISEASES (ERIDS)

General areas of collaboration that have been previously identified include: 1) surveillance; 2) outbreak investigation and control; 3) research; 4) prevention; and 5) laboratory support. Current efforts include:

- Collaboration between CDC and the National Institute of Virology (NIV) on the laboratory diagnosis of the Ebola Virus and joint authorship of a manuscript on Ebola and haemorrhagic fever.
- Collaboration between WHO, CDC, NIH, and the SAIMR in conducting an efficacy trial of a polyvalent pneumococcal vaccine.
- Two seminars on research related to ERIDs were held in South Africa in April 1997. A two-day grants workshop was also held and U.S. scientists, including key NIH/NIAID grantees participated. Three applications were received from South African investigators for the HIV/NET program.
- CDC assistance to the DOH in developing short and long term plans for epidemiology training including the Applied Epidemiology Training Program. It was recommended that a long term advisor in epidemiology be continued.
- CDC assistance to the DOH in developing National Guidelines for Outbreak Investigation and Control

Progress since the July Meeting

Outbreak Investigation and Control

- Two epidemiology training courses have been held in the Northern and KwaZulu Natal Provinces.
- National guidelines on outbreak investigation and control have been adopted and are being implemented.
- A workshop on *Surveillance and Control of ERIDs* was held in September, 1997. Although the HWG agree to partially support this conference, there was a problem in obtaining approved funds.

Tuberculosis Programmatic Support

- Site visits to the CDC assisted TB program in Botswana occurred in November.
- CDC has agreed to provide short term technical assistance in 1998.

Tuberculosis Laboratory Microscopy

- A CDC laboratorian made a two week visit in January and provided training in three Provinces to improve smear microscopy services in the diagnosis of TB.

Laboratory Collaboration

- The NIV is continuing to collaborate with CDC regarding the Ebola outbreaks in Central Africa and in Johannesburg.
- The NIV is collaborating with CDC on laboratory aspects of diarrhoeal diseases.
- Collaboration is continuing between WHO, CDC, NIH and the SAIMR in conducting an efficacy trial of a polyvalent pneumococcal vaccine.
- The Director of SAIMR visited CDC and also met with The Association of State and Territorial Public Health Lab Directors (ASTPHLD) in January. CDC and ASTPHLD have agreed to conduct an assessment of South African laboratories. Based on this assessment collaborative efforts among the three agencies will be developed.

Research

- NIAID has announced a special initiative for research cooperation with South Africa. It is expected to focus on population based research and clinical trials

Possible discussion areas for the upcoming meeting

- Possible HWG assistance in conducting a Southern Africa regional workshop on ERIDs.

B. HIV/AIDS AND STDs:

Previous U.S. assistance has focused on support to NGOs and selected technical assistance to the DOH. The USAID Equity Project will also seek to integrate HIV/AIDS into routine primary health care services. During the meeting it was announced that USAID would provide \$10 million over 5 years to support HIV/AIDS/STD efforts. Additional discussions included the following:

National HIV/AIDS/STD Review

- A National review of the HIV/AIDS/STD program, which included the participation of USAID, NIH, and CDC, was completed in July 1997. This review identified several recommended areas of improvement including:
 - Capacity building at District, Provincial, and National levels, including training of health workers in the public and private sectors;
 - Integration of TB and HIV/AIDS programmes;
 - Improvement in the management of risk factors for HIV transmission such as STD treatment, partner notification, promotion of the use of barrier methods and

counselling.

- Support for advocacy activities to promote a multi-sectoral response to the HIV/AIDS epidemic
- Enhance current community mobilization efforts

Presentations from USAID and CDC identified areas of potential assistance to support the DOH in the previously identified areas.

HIV related research

- CDC and South African researchers developed a research proposal to investigate the possible association between injectable contraceptives and HIV infection
- Collaboration between NIH NIAID and SAIMR on studies of Interleukin-2 in patients with HIV infection.

STD related research

- CDC and the DOH have held discussions on the possible establishment of a research station on STDs.
- Collaboration has continued between CDC and South Africa in transfer technology of molecular techniques to diagnose and investigate genital ulcer disease.
- CDC is collaborating with the Institute for Urban Primary Health Care on a study of STD partner notification.

Progress since the July Meeting

HIV/AIDS/STD Capacity Building Project (\$10 million assistance program)

- USAID and CDC participated in a DOH Meeting to consolidate the National HIV/AIDS/STD Review recommendations.
- USAID conducted a stakeholders meeting that explored the programmatic direction for its technical assistance program.
- A USAID design team developed an initial results package document which was discussed with the DOH. These discussions led to the identification of three focus provinces (KwaZulu Natal, Mpumalanga and the North West) and further revisions in the result package document.
- The overall objective for the Capacity Project is "the enhanced capacity to provide effective HIV/AIDS/STD and TB prevention care and treatment."
- Five key components will comprise assistance to provincial-level capacity building: 1) network development; 2) management and related support systems; 3) service delivery; 4) advocacy; and 5) use of quality data and findings from intervention-linked research.
- Assistance will focus on accelerating interventions to reduce HIV/AIDS/STD/TB prevalence and to improve the effectiveness of services.
- Documenting and utilizing "lessons learned" will guide USAID assistance.
- Assistance will emphasize South African organizations currently working in the HIV/AIDS/STD/TB sector
- Training will emphasize mentoring and follow up
- A performance and evaluation plan will be developed
- National-level capacity building will focus on management systems, advocacy, and use

of results from intervention linked research

- It is expected that the agreement for the HIV/AIDS/STD capacity building project will be signed in February 1998.

Establishment of an STD Research Station

- There have been additional discussions between CDC and the DOH to establish an STD Research Station in South Africa. Further discussion and formal agreement from the DOH is required.

HIV Related Research

- The Orange Farm Progestin Study designed to assess the possible association between HIV and progestin contraception has begun. This is a collaborative effort between CDC and Investigators at Baragwanath Hospital and the University of Witwatersrand.
- Collaboration has continued between CDC and South Africa on the etiology of genital ulcer disease which impacts HIV transmission.
- USAID participated in the planning of the extended periodic presumptive treatment of women at high risk in the Free State.

HIV/TB collaboration

- Discussions have taken place between CDC and the DOH on short-term technical assistance in this area.

Other Areas

- The AIM advocacy workshop was held in August 1997. Follow-up advocacy training workshop was held in November 1997.
- Two applications from South African investigators for the HIV/NET program were approved, one in Soweto and one in KwaZulu Natal.
- CDC collaborated with the DOH to review the MRC proposal for HIV/AIDS/STD surveillance.

Possible discussion areas for the upcoming meeting

- Possible signing of the agreement of the Capacity Project
- STD Research Station proposal
- Possible short term technical assistance to the DOH for 1998 under the current CDC PASA with USAID. Potential areas include: surveillance (both disease and behavioral), TB programmatic support, TB laboratory microscopy, HIV testing and counselling, evaluation of newly implemented protocols, inventory, documentation and sharing of lessons learned, and community level prevention through a community planning process.
- Possible CDC technical assistance after the current PASA ends in September 1998.

C. INTENTIONAL INJURIES

This area was first discussed in February 1997 and recommended areas of collaboration include surveillance and shared information on the impact of violence prevention programs. CDC is working with WHO to develop a uniform violence surveillance model which may be useful in this cooperation. Although surveillance would be the principal cooperative venture, future collaboration will include prevention interventions, providing care for victims, and training for health workers in all aspects of victim care. Current areas of collaboration include the following:

- Consultations between the CDC, DOH, MASA, and the University of South Africa on surveillance methodology in order to delineate the magnitude of violence in South Africa.
- Participation by CDC in workshops and meetings during July 1997 in South Africa to develop a strategy for development of the injury surveillance system.
- The U.S. National Center for Injury Prevention and Control (NCIPC) received funding to support staff travel to advance this cooperation.
- Three South African experts participated in NIMH's conference on victims of torture. Subsequent to this conference, it was agreed that NIMH would prepare a scientific assessment of the effects of torture and the implications for rehabilitation and treatment.
- The February 1997 report to the U.S. Congress on "Crime Prevention-- What Works and What Doesn't Work" was shared with the South Africa delegation.
- There are discussions to develop a protocol to document and monitor fatal and non-fatal injuries for use in hospitals and mortuaries.

Progress since the July Meeting

- The Director of NCIPC gave the keynote address during a conference on community violence prevention held in Pretoria, South Africa in November and held meetings with DOH and MASA officials.
- CDC collaborated with the DOH and others to develop protocols to collect information for intentional injury surveillance. CDC is expected to participate in the training of provincial staff in June.

D. TOBACCO AND OTHER SUBSTANCE ABUSE

Tobacco

The U.S. offered to share its experience in addressing the tobacco issue - including issues associated with access by children and youth to tobacco and related products, efforts to regulate nicotine as a drug and cigarettes, chewing tobacco and snuff as medical devices, as well as educational efforts directed toward prevention of smoking and other uses of tobacco by children youth. There was consensus that tobacco is a major cause of death and disability and that both countries support the worldwide effort to address this problem. There was discussion of the litigation involving the U.S. and the tobacco industry and the desire of the South African delegation that developing countries be included in U.S. efforts to limit tobacco distribution.

It was felt that the harmful effects of tobacco use should also be dealt with as part of school-based health education programs, along with such issues as alcohol use, drug abuse, and violence prevention.

Fetal Alcohol Syndrome

Collaboration on substance abuse has focused on the problem of fetal alcohol abuse and there are current research efforts between NIH and the University of Capetown. It was also agreed that:

- NIH and CDC will participate in South Africa's prevention intervention workshop in November 1997. Its aim is to formulate general and specific guidelines for at-risk rural and urban populations.
- South Africa experts will visit U.S. Native American populations to learn from their experiences.
- The U.S. will share its experience on warning labels on alcohol beverage containers.
- There are numerous opportunities for research collaboration in addition to FAS with HHS agencies.
- South Africa will take advantage of training opportunities provided by NIH National Institute of Drug Abuse, including both the Hubert Humphry Fellows Program and the INVEST Program.

Progress since the July Meeting

- CDC supported South African representatives to attend the 10th World Conference on Tobacco and Health in Beijing, China in August.
- CDC participated in an African regional workshop to begin development of a Tobacco Control Action Plan for Africa.
- In collaboration with the World Bank, CDC will participate in the 'Economics of Tobacco Control' Conference in Capetown in February.
- Eleven US researchers visited Capetown in November and assisted in the development of a pilot project on FAS. The project began in January.

Possible discussion areas for the upcoming meeting

- Possible CDC collaboration with the MRC, which is a WHO Collaborating Center on tobacco control.

E. SCHOOL BASED HEALTH PROMOTION

A representative from CDC made a presentation on school-based health promotion. The concept of 'health-promoting schools' has been developed by the World Health Organisation. School-based health promotion holds the potential to address a number of behavioral issues, including violence, STDs, and substance abuse that are South African priorities.

Progress since the July Meeting

- CDC has disseminated detailed information on its school health programs to the DOH including programs addressing behaviours that contribute to: 1) unintentional and intentional injuries; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviours that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; 5) dietary behaviours; and, 6) physical activity.
- Discussions have taken place between CDC and the DOH to explore the possibility of conducting a Youth Risk Behaviour and Violence survey
- CDC has shared evaluations of prevention programs including successful and unsuccessful efforts.
- A South African Health Promoting Schools Committee has been established with representatives from the Departments of Health and Education. The initial task of this committee has been to investigate the proposed curriculum, make suggestions for the inclusion of health issues, and, in collaboration with the provinces, set up a pilot network of schools to be involved in the project.
- HHS supported two South Africans (one from the DOH and one from the Department of Education) to attend the U.S. National Injury Conference in November 1997.
- A CDC representative attended a Conference in Capetown in November on Health Promotion in Schools and had meetings with Provincial and National Health and Education Officials.

F. MENTAL HEALTH

A representative of the National Institute of Mental Health (NIMH) previously met with DOH staff, the faculty at MEDUSA, and others concerning mental health services. NIMH has agreed to collaborate with the DOH on the development of community-based mental health programs and the integration of mental health in primary care. A workshop on these issues was discussed and planned to take place in early 1998 in South Africa. The HWG agreed to support the request for \$50,000 for the workshop and related consultations.

Progress since the July Meeting

- The workshop to discuss integration of mental health services into primary health care and to develop a pilot program is scheduled for 16-28 February. Three representatives from the US are expected to attend. Although the HWG agreed to partially support this conference, there was a problem in obtaining approved funds.
- In response to a request from the Truth and Reconciliation Commission, NIMH is doing an assessment of scientific studies of the psychiatric consequences of torture and extreme violence.
- Two persons from South Africa participated in the September Conference on Services Research and Primary Care Research in Washington, D.C.
- Total NIMH expenditures in the past year in support of South African activities, not including staff time, approximate \$100,000.

G. OCCUPATIONAL HEALTH

Three phases of planned collaboration were described. The first phase has been completed:

- A U.S. team of 3 experts from NIOSH spent two months (Feb-Mar.1997) in South Africa. Their report recommended:
 - * Enhancing occupational hygiene technical capacity in NCOH,
 - * Developing an occupational health and safety information system in South Africa,
 - * Developing an occupational health surveillance system,
 - * Improving capacity for occupational health field studies and research,
 - * Developing packages for occupational health nurse training, and
 - * Building upon existing technical skills of NCOH staff.
- A senior U.S. occupational medicine expert also visited South Africa to investigate training of occupational medicine specialists

Phase Two is for further cooperation in 1998

- Improve occupational hygiene capacity by assigning NIOSH practitioners to South Africa.
- Develop technical information system by linking provinces to NCOH.
- Provide training fellowships for NCOH staff to work at NIOSH.
- Pesticides training and research

Phase Three

- Identify training packages for primary care providers

Progress since the July Meeting

- A senior South African occupational medicine physician is currently working as a senior scientist in the NIOSH Office of the Director.
- Several members of the scientific staff at NCOH will work at NIOSH for several months in 1998 to acquire specific skills in conducting occupational health surveillance, assessing workplace ergonomics, and organizing service programs to evaluate and recommend corrective measures for workplace hazards.

H. BIOMEDICAL RESEARCH

The Director, Office of Minority Health of NIH, described the functions of his office directed toward increasing capacity of traditionally African American institutions in the U.S. and U.S. minority scientists, including efforts to attract talented minority group high school students into science careers. These efforts, in cooperation with NIH's Fogarty International Center, have opened opportunities for international students. It is felt that the same concepts might be utilised in South Africa to develop scientific capacity of the "majority" population.

The South African delegation outlined their priority concerns, including:

- An acute shortage of black scientists and other health experts in the health sector
- The process of transformation and need for capacity building.
- The need to conduct appropriate research on health problems with high incidence in black populations
- The role of MRC in South Africa to promote capacity building and possible assistance from NIH through funded scholarships
- That investment in historically black universities and technikons are essential to provide adequate numbers of trained black scientists.
- The importance of emerging and reemerging infectious diseases and the need for well trained scientists to work in this area.
- The need to promote research capacity of institutions in South Africa and to earmark funding to train more black scientists

A lead official from the NIH Fogarty International Center identified a number of funding mechanisms that are currently available and provided materials on all of these opportunities. She also identified a number of specific areas (e.g. hypertension, ageing, alternative medicine) in which NIH institutes had an interest in cooperation with South Africa and could be a vehicle for capacity building in addition to the specific research objectives. The Director, NIH Office of Minority Health, pledged close cooperation with counterparts in South Africa to address the issue of capacity building and NIH will continue to promote the development of research in priority areas identified by the Working Group.

I. NATIONAL SCHOOL OF PUBLIC HEALTH

The South African delegation outlined plans for the development of the new National School of Public Health, which will be located at MEDUNSA. These included:

- The objectives of the new school represent a shift from the biomedical focus to a public health approach.
- There has been support from both the Ministers of Health and Education.
- While the school will be located at MEDUNSA, the existing regional initiatives located in Western Cape, KwaZulu Natal and Gauteng will be seen as complementary in nature.
- A number of approaches are being explored, including the introduction of a public health practice approach reinforced by community participation through a "school-without-walls concept."
- Joint appointments of personnel employed at the DOH with expertise and training in public health will be explored.
- HHS was pleased to learn that Dr. Allen Herman, a physician of South African origin who is currently at NIH, will be the Dean of this new institution.

A representative of the U.S. Association of Schools of Public Health made a presentation on the role of the Association in relation to the 29 U.S. schools of public health. It was felt that the Association could assist South Africa. Other U.S. organizations which could provide assistance are the American Public Health Association and CDC. Recommended future activities include additional meetings with the Association of Schools of Public Health and visits to selected Schools of Public Health in the U.S.

Progress since the July Meeting

- Funding has been received from the Departments of Education and Health
- A Strategic Plan *Meeting the Challenges of the New South Africa* has been published.
- The Dean has met with various officials from NIH and CDC who have pledged support.
- The Dean has met with the Association of Schools of Public Health who have offered the new school provisional membership.
- The Dean has presented the objectives of the School at the American Public Health Association and the International Medical Exchange Conferences.

J. USAID - Equity Project

Progress on the seven year \$50 million Equity Project was discussed. The objective of the Equity Project is to assist in the provision of a more equitable, unified and sustainable health system which is capable of delivering primary health care (PHC) services to all South Africans. This will be achieved through five areas: 1) increased access to an integrated package of PHC services; 2) an effective health care referral system in operation; 3) improved management of integrated PHC delivery systems at the provincial level; 4) PHC training programs strengthened and institutionalized at the provincial level; and 5) increased capacity of the PHC system to deliver appropriate HIV/STD prevention and treatment. Management Sciences for Health, the primary contractor, initiated programmatic assistance in February 1997

Progress since the July Meeting

The following are selected progress within the Equity Project in the Eastern Cape Province.

Increased access to PHC services

- Developed catchment area mapping methodology to define populations with physical access to PHC facilities.
- Designed draft PHC package for the Eastern Cape.
- Developed clinic assessment tool to collect baseline data on PHC service delivery.
- Initiated Community Health Worker assessment.

Increase effectiveness of the health care referral system

- Identified existing protocols and procedures for inclusion in draft PHC package.
- Established working group to strengthen use of transportation and communication infrastructure.

Improve the management of the PHC delivery system

- Formed human resources management and incentives task groups.
- Assessed clinic staffing patterns, requirements and staffing norms.
- Initiated facility survey to collect data on resources and productivity.
- Collected baseline data on pharmaceutical availability and utilisation.
- Implemented methodology to develop more accurate clinic budgets.
- Developed two-page reporting format for essential PHC service data and corresponding list of indicators.
- Conducted international workshop on management of decentralized health systems, with emphasis on district planning.
- Developed PHC clinical training event schedules.
- Conducted training needs assessment.
- Facilitated Eastern Cape participation in an international workshop on contracting in the health sector.
- Prepared draft paper on training indicators.
- Established HIV/AIDS/STD and TB Management Committee and Barrier Methods Task Group.
- Completed study tour of training resource centers in Tanzania and Kenya.
- Equity Project facilitated two-day national level workshop on estimation of drug requirements.
- Collected baseline data from 4 randomly selected clinics in each of 21 health districts.
- Supported PHC management training for 14 sub-district level managers.

Other

- A Demographic and Health Survey, partially supported by USAID has begun field testing.

IV. SOUTH AFRICAN DEPARTMENT OF HEALTH MANAGEMENT STRUCTURE RELATED TO BNC HEALTH WORKING GROUP

Figure 1 presents the DOH management structure with respect to the HWG. Dr. S. Hendricks has replaced Dr. M. Jeenah as the coordinator of DOH activities. Regular meetings take place to report on HWG activities and summaries of these meetings are also reported in monthly DOH Management Meetings that include Chief Directors and Directors. Primary responsibility for the HWG priorities are shown in Figure 1. Management of the USAID Equity Project has not been channelled through Dr. Hendricks but through R. Mabope, Chief Director, National Health System.

In a related development, South Africa has been chosen to be the health sector focus of SADC. The primary focus for these activities have not been finalized.

V. DATE AND VENUE FOR THE HEALTH WORKING GROUP MEETING

As of the date of this report a date and venue for the HWG meeting has not been confirmed. Tentative dates are:

February 25: Health Working Group
February 26: Science and Technology Committee
February 27: BNC Plenary Session

I have also heard that there is a proposal for 'research roundtables' to precede the Health Working Group meeting on February 24. These would be chaired by Dr. Allen Herman, Dean of the School of Public Health

VI. AGENDA ITEMS

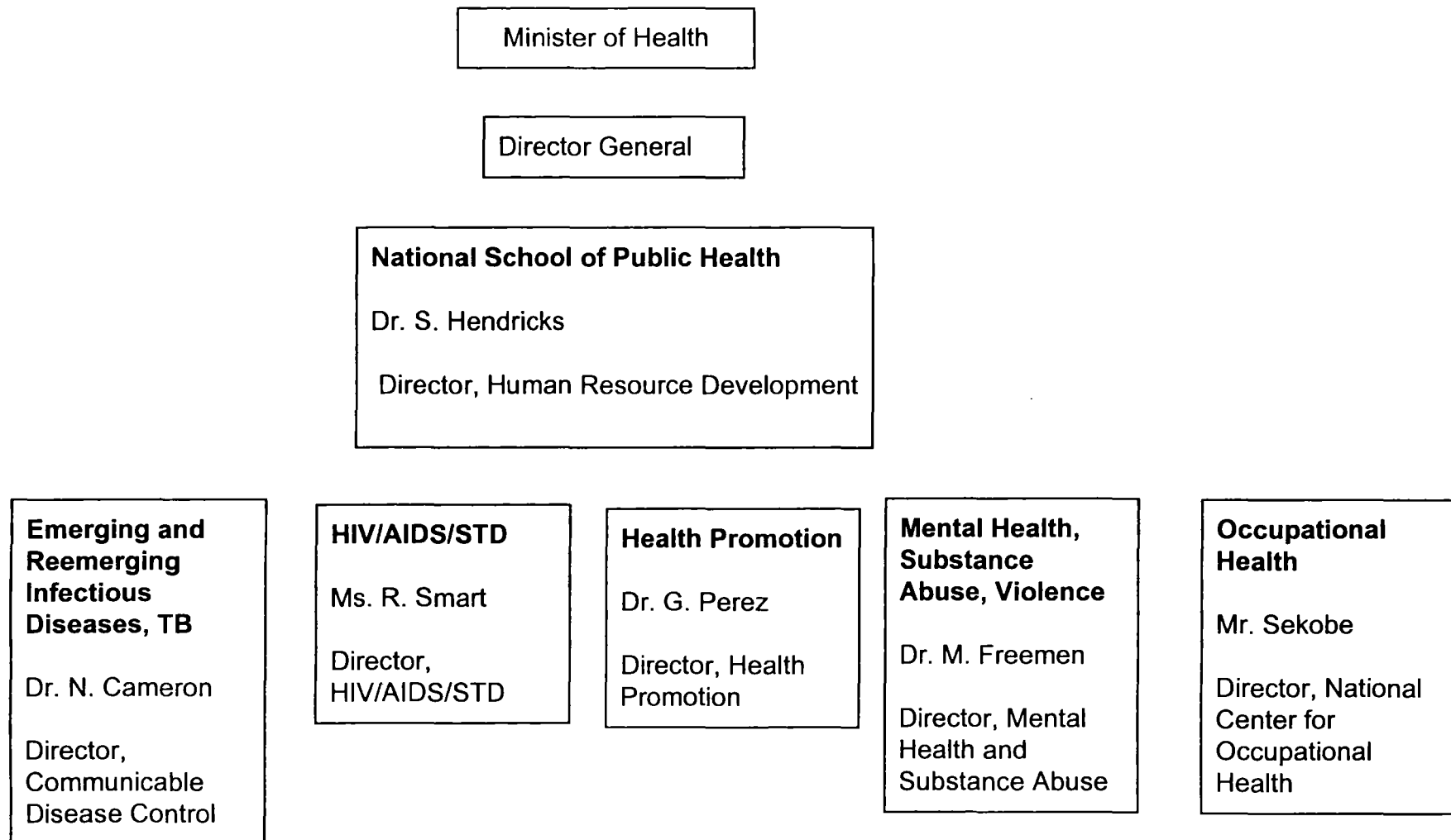
As of the date of this report the agenda has not been determined. HHS will send a letter to the DOH asking it's recommendation of agenda items.

VII. POSSIBLE SITE VISITS

A possible site visit for the Chairpersons of the HWG is the Alexandra Health Centre (AHC) and the Institute of Urban Primary Care. The AHC, located within the Alexandra township, is a non-government, non-profit organization providing comprehensive primary care services. It has received financial support from CDC. The Institute of Urban Primary Health Care was established in 1990 as a partnership project of the AHC and the University of Witswatersrand. Its mission is to conduct training, education, and research in the field of primary health care.

During the July meeting, Dr. Herman also spoke of a ground breaking ceremony for the National School of Public Health occurring at the next HWG meeting.

Figure 1. DOH Management Structure relative to the HWG



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VIII. POSSIBLE HWG DISCUSSION ISSUES

Although there are possible discussion issues relative to each of the HWG priority areas, there are several general issues relating to the work of the HWG itself. These include the following:

Management and Communication of HWG Activities: The managerial responsibilities for HWG activities in South Africa might be reviewed and more clearly defined. Lead agencies for each priority area, subcommittees, and clear objectives should be developed. In addition, the communication of HWG activities among U.S. Agencies between formal BNC meetings might be improved.

Priority Setting and Resource Identification: Many collaborative projects have been proposed in HWG meetings and it is unclear what resources are available to support these efforts. Within the proposed activities a system of priority setting might be developed. The funding available to support proposed efforts should be determined and procedures for accessing these funds clearly identified.

School Based Nutrition: I understand that the Department of Agriculture is interested in developing collaborative efforts in this area.

Separate Health Committee: HHS has previously favoured a Health Working Group to facilitate collaborative efforts without the bureaucratic restrictions of a formal committee. I understand that this issue might be revisited.

THE PRESIDENT INTRODUCES INITIATIVES TO FULFILL HIS COMMITMENT TO DEVELOP AN AIDS VACCINE

Today President Clinton challenged the nation to commit itself to the goal of developing an AIDS vaccine within the next ten years. The President also announced a number of important initiatives to help fulfill this commitment, including high-level international collaboration, a dedicated research center for AIDS vaccine research at the National Institutes of Health (NIH), and outreach to scientists, pharmaceutical companies, and patient advocates to maximize the involvement of both the private and public sectors in the development of an AIDS vaccine. The President has already taken steps to enhance the possibility of developing an AIDS vaccine by increasing funding for NIH vaccine research and development over 33 percent in the last two years. The initiatives the President announced today, which build on an exceptional commitment to develop better ways to prevent, diagnose, treat, and eventually cure AIDS, include:

- **A New NIH AIDS Vaccine Center.** A dedicated intramural HIV vaccine research and development center is being established at the National Institutes of Health. This vaccine center, which will be fully operational within the next several months, is uniting outstanding scientists in immunology, virology, and vaccinology to join in a highly-collaborative effort to develop an AIDS vaccine. Bringing together a broad array of researchers in an intensely-focused environment has been a successful way of developing vaccines in the past.
- **A Global AIDS Vaccine Research Initiative.** The United States is proposing that the leaders of the eight major industrialized nations meeting at the Denver Summit in June agree to support a worldwide AIDS vaccine research initiative. The proposal calls for each nation to make a commitment to provide the necessary investments in their country to accelerate research toward the development of an HIV/AIDS vaccine as a scientific and public health priority. Joint meetings of key scientists from participating nations will address research progress, identify scientific gaps and opportunities, and design collaborative programs.
- **A Challenge to Pharmaceutical Manufacture Industry to Invest in Innovative Research to Develop an AIDS Vaccine.** We can only be successful in developing an AIDS vaccine if private and public sectors make this goal a priority. The President is challenging the pharmaceutical industry to join the government in a partnership to realize this important goal.

Background on HIV/AIDS. HIV/AIDS remains a global public health threat. More than 29 million men, women and children around the world have been infected with HIV -- more than 3 million infections occurring within the last year. Without an

HIV/AIDS/STDs CAPACITY-BUILDING PROJECT
(The CAPACITY Project)

**A Joint Activity of the Government of South Africa
(through the Department of Health)**

and

USAID/South Africa

DRAFT FOR INTERNAL REVIEW – NOT FOR DISTRIBUTION

REVISED 20 JANUARY 1998

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GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
AIDSCAP	USAID Global Bureau HIV/AIDS Project (now completed)
ALP	AIDS Law Project
BNC	Vice President Gore-Deputy President Mbeki Binational Commission
CDC	U.S. Centers for Disease Control and Prevention
CSW	Commercial Sex Worker
DFID	Department of Foreign and International Development (British)
D/G	Democracy and Governance
DOH	National South African Department of Health
EU	European Union
GP	General Practitioner
HCFA	U.S. Health Care Financing Administration
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HRSA	U.S. Health Resources Services Administration
ILRA	Intervention-linked Research Activities
IR	Intermediate Result
NACOSA	National AIDS Convention of South Africa
NAPWA	National Association of Persons With AIDS
NIH	U.S. National Institutes for Health
NGO	Non-governmental Organization
PASA	Participating Agencies Services Agreement
PCM	Prevention Case Management
PHC	Primary Health Care
PHN	Population, Health and Nutrition
PHRC	Provincial Health Restructuring Committee
PMP	Performance Monitoring Plan
PM&E	Performance Monitoring and Evaluation
PPASA	Planned Parenthood Association of South Africa
PSAP	Private Sector AIDS Presentation
PWA	Persons with AIDS
REDSO	USAID's Regional Economic Development Support Office (Nairobi)
RF	Results Framework
RP	Results Package
SA	South Africa
SAG	South African Government
SANTA	South Africa National Tuberculosis Association
SOAG	Strategic Objective Agreement
STD	Sexually Transmitted Diseases (also Infections)
TB	Tuberculosis
TOT	Training of trainers
USG	United States Government

EXECUTIVE SUMMARY

Today, South Africa has one of the fastest-growing HIV/AIDS epidemics in the world, with up to 2,000 new HIV infections a day and a national doubling time of from 20-24 months. National and provincial estimates of these and other statistics are derived from annual surveys of women attending antenatal clinics. According to these surveys, HIV prevalence has increased by a factor of 14 during the last six years. The national average prevalence is more than 14%, with wide variations among the nine provinces – from 3% in the Western Cape to more than 25% in North West. The highest rates are among the age groups 20-24 and 25-29. Estimates indicate that by the end of 1996, 2.4 million people were infected with HIV in South Africa.

The National AIDS Plan, initially developed by the National AIDS Convention of South Africa (NACOSA) in 1992, was endorsed by the new Minister of Health in 1994 as the national plan. Since that time, there has been concern that there hasn't been sufficient progress in combatting the epidemic, since prevalence was increasing at a rapid rate. USAID/South Africa offered assistance to the national Department of Health (DOH) in late 1996. The likely funding parameters proposed were \$10 million over five years. Both parties agreed that the nature of USAID assistance should be based on the outcome of a national assessment of what needed to be done. After discussion, the national DOH decided to carry out a joint HIV/AIDS and STD review, because of the strong interrelationship between HIV and STDs. A national TB review had been done in 1996, and would be used in conjunction with the HIV/AIDS/STD review in order to assess important programmatic links among all three programs.

The National Review was carried out in July 1997, with wide involvement of national and provincial government personnel, NGOs, donors, and other stakeholders. The review confirmed the need for increased efforts to reduce the impact of the epidemic. Following the review, there were several major consultations and workshops to plan an overall strategy, as well as to determine the best use of USAID resources. The initial outcome was a proposal from the national HIV/AIDS/STD Directorate within the DOH that USAID focus on three areas: (1) capacity building, with emphasis on the provincial level; (2) advocacy; and (3) intervention-linked (operational) research. Further refinement of this proposal, based on consultation with the DOH and other major stakeholders, and focussing on the *results* to be achieved, brought a decision that USAID would focus principally on capacity building in the provinces, integrating the concept of advocacy within the capacity-building approach.

The USAID program of assistance, known as The HIV/AIDS/STDs Capacity Building Project ("The CAPACITY Project"), consists of the following five major activities:

- Network development
- Management strengthening
- Advocacy

- Service delivery
- Use of research results and “lessons learned”

Since USAID resources would be limited to \$10 million, it was agreed that the USAID activity would focus on only three provinces, to insure impact and not stretch program efforts too thin. The three provinces chosen jointly by the national DOH and all nine provinces are KwaZulu Natal, Mpumalanga, and North West.

An overriding issue for every one of these proposed activities is the need for capacity building for all sectors, and at all levels. Key in the notion of capacity building is sustainability. In order to achieve sustainability, the capacity of the organizations and the managerial systems have to be assessed and strengthened, as well as the individuals who provide the services that are needed.

Assistance will focus on facilitating the building and strengthening of networks among organizations working at the provincial level in order to maximize the prevention and reduction in impact of HIV/AIDS/STD/TB. Networks will be formed to bring together actors to work on all relevant HIV/AIDS issues. The goal for these networks will be to become an effective mechanism at the provincial level to support HIV/AIDS prevention and care programmes, and thus contribute to sustainability of efforts. In addition to capacity-building at the provincial level, there will be specific, targeted national-level activities in support of management and advocacy. These activities will complement the provincial-level capacity-building. The details of this program strategy are described in the sections which follow.

I. PROBLEM STATEMENT

A. National HIV/AIDS/STD Program

1. HIV/AIDS and STDs in South Africa

The first case of AIDS was identified in South Africa in 1982. For the next four years, the prevalence of HIV in South Africa rose slowly, with a total of 44 people diagnosed with AIDS. In those early years, HIV/AIDS resembled the Type I epidemic found in Western countries where the majority of infections were among homosexual and bisexual men, with a few cases being attributable to intravenous drug use and blood transfusions. By 1987, this pattern had begun to shift, and increasing numbers of cases resulted from heterosexual transmission, associated with increasing numbers of pediatric infections.

Today, South Africa has one of the fastest growing HIV/AIDS epidemics in the world, with up to 2,000 new infections a day and a national doubling time of between 20 and 24 months in the number of HIV infections. According to the results from the annual survey of women attending public antenatal clinics, there has been a 14-fold increase in HIV prevalence over six years -- from 0.76% in 1990 to 14.17% in 1996. Highest rates were found in the age groups 20-24 (17.74%) and 25-29 (15.33%). The prevalence is increasing in all provinces with the highest

rates in the North West Province (25.13%) and KwaZulu-Natal (19.90%), and the lowest rates in the Northern Cape (6.47%) and the Western Cape (3.09%).

At the end of 1996, 2.4 million people were estimated to be HIV infected in South Africa. To date this is largely an invisible problem as the majority of HIV-positive people in South Africa are healthy and unaware of their HIV status. Although the majority of HIV infection in South Africa result from heterosexual transmission, there are identifiable groups who are at increased risk of HIV infection. These include:

- o women, who are vulnerable as a result of their physiology as well as their position in society;
- o infants born to infected mothers;
- o adolescents who become sexually active at an early age;
- o street children who may have high-risk sex as a survival strategy;
- o migrant workers who live apart from their families for extended periods of time;
- o persons with sexually transmitted diseases;
- o sex workers who have frequent partner changes, high rates of STDs and who do not, or are not able to practice safer sex;
- o prisoners who many engage in or be coerced into risky sexual practices
- o long-distance truck drivers, construction workers and members of the armed forces

Models projecting the future size of the epidemic suggest that the overall prevalence of HIV will reach almost 25% in the general population by the year 2010. At this time, it is estimated that South Africa will have about three quarters of a million AIDS orphans.

In addition to HIV/AIDs, the epidemic of STDs is one of the major challenges facing South Africa today. It is estimated that approximately 4 million episodes of STDs occur each year in South Africa. Sexual transmission of HIV is enhanced in the presence of STDs. In a Durban STD clinic in 1996, 32% of men and 61% of women with a discharge were co-infected with HIV. Co-infection in TB patients is even higher though it is variable across the country.

Tuberculosis (TB) is the most common presenting feature of HIV disease with about half the new TB cases attributable to HIV infection. TB is the most common opportunistic infection and the biggest killer of people living with AIDS. It is estimated that 25% of the 160,000 TB cases in South Africa in 1996 were attributable to HIV. Tuberculosis is often the first AIDS-defining illness which changes as person's status from HIV infected to 'full blown' AIDS. Because of the effect on the immune system, HIV infection makes a person 30 times more likely to progress from TB infection to TB disease.

The impact of the HIV epidemic on health services is starting to be felt as increasing numbers of infected individuals progress to AIDS. Some health services have experienced a 40% increase in hospital admission attributable to HIV disease or AIDS.

2. National HIV/AIDS and STD Review

Background:

In 1992, the National AIDS Convention of South Africa (NACOSA) was launched with a mandate to develop a national strategy. This strategy was formulated as the NACOSA National AIDS Plan and was endorsed by the Minister of Health, Dr. Nkosazana Zuma, in 1994. The HIV/AIDS epidemic has complex socio-economic and traditional roots, and efforts to address it have been undermined by denial and complacency as well as discrimination and human rights violations which continue to occur. Denial at a political, community and individual level blocked the commitment required for effective programmes; funding was inadequate as were essential health and social services.

In recognition of the seriousness of the epidemic, the HIV/AIDS and STD Programme was accorded the status of a Presidential Lead Project within the Reconstruction and Development Programme and situated within the Department of Health.

The Directorate: HIV/AIDS/STD was established in January 1995 as a strong vertical programme with an imperative to devolve implementation functions to the provincial structures as these structures develop sufficient capacity to assume and sustain the functions. The transition and restructuring within the national and provincial health departments has delayed this process. With the recent appointments of most of the provincial HIV/AIDS coordinators, the relationships between the national and provincial structures have been formalized and devolution of program implementation can be more actively pursued.

General review findings:

In July 1997, the Directorate conducted a review of the HIV/AIDS and STD programme to refocus attention and address the inadequacies of the programme. Implementation of the programme was evaluated against the three key objectives of the NACOSA/National AIDS Plan:

- o to prevent the transmission of HIV infection
- o to reduce the personal and social impact of HIV and AIDS
- o to mobilize and unify national, provincial, international and local resources

The major findings and recommendations of the review are summarized in Section V.

B. Focus Provinces

This section contains summary problem statements for the three focus provinces that have been selected for intensive assistance under the CAPACITY Project (see Section IV.B.3 for a discussion of the provincial selection process). These problem statements are directly linked to the description of specific, priority program components discussed in Section V.B. Expanded

versions of these problem statements are included in the provincial-level reports from the National Review for the three focus provinces (see Annexure A).

1. The Problem in KwaZulu Natal Province

By the end of 1996, the annual antenatal survey of women attending public antenatal clinics reported an HIV prevalence rate of 19.90% with an estimated 753,673 HIV infected individuals in KwaZulu Natal. KwaZulu Natal has the second highest rate of infection in South Africa. The HIV prevalence rate has continued to rise, from 14.35 % in 1994 to 19.90% in 1996. The HIV epidemic will have a major impact on this province and will become more visible as people progress from an asymptomatic infected state to a symptomatic stage and eventually death. The HIV/AIDS epidemic is having the greatest effect on the poor and marginalised in both urban and rural areas. In addition, women, youth and children have been the most vulnerable groups within the communities to HIV infection.

Findings of 1997 National HIV/AIDS/STD Review:

o Political Commitment, Public Leadership and Advocacy to HIV/AIDS/STDs:

Other than the Minister of Health and the Premier, there is no visible political commitment to the provincial AIDS programs in the province. The Minister of Health has repeatedly demonstrated his support and commitment through the media and speeches in Parliament. He promotes the idea of an intersectoral approach and sees HIV/AIDS as a developmental issue, one that should not be relegated to the health sector solely. The Premier and the Cabinet share the Minister of Health's commitment to strengthening the provinces response HIV/AIDS prevention and concern about the impact of the disease on communities.

Although there is commitment and support at this level, it appears as though there is a lack of commitment within the Department of Health, especially among senior management at both provincial and regional level. There is also a lack of commitment from many of the medical superintendents, who often do not see an active and direct role for themselves in the epidemic. Further, restructuring of the health service is a priority for the various layers of government officials within the Health Department. Many of the Regional Directors and Medical Superintendents, for example, have little knowledge of the status of the HIV/AIDS programme.

Public leadership is generally poor. Business, a key sector in the epidemic, has shown little or no active commitment. In general, influential groups like the religious sector have only recently mobilized a response.

A provincial advocacy plan has been drafted and implementation has begun. However, the capacity to engage in advocacy and follow-up is limited due to a lack of technical support, as well as financial and human resources. People in rural areas must be brought on board to actively advocate. Access to training, funding and increased participation of activists and staff of the various structures is needed to increase the capacity of the province to engage in advocacy. An

advocacy strategy is needed to give the programme focus and to mobilize the collective resources of the members of the network.

o Mobilizing and Organizing:

There is growing realization of the failure of the medical model to address the AIDS epidemic in a relevant and appropriate way. There is also an increasing recognition in KwaZulu-Natal that a well-coordinated, intersectoral response is critical to deal with the AIDS epidemic in a coherent and effective manner. The socio economic conditions that prevail in the province, including poverty and unemployment, low literacy levels, low education levels, political violence and crime, and the highly mobile population demand that the AIDS epidemic is dealt with as a development issue.

The government sector, including the premier's office, and the welfare, health and education departments, were identified during the Review as priority areas for mobilization. KwaZulu-Natal proposes to deal with each department on an individual basis. This will be followed by an analysis of the extent to which the various offices and departments are actually working together as an integral part of the Provincial AIDS Programme.

o Intersectoral/Interdepartmental Collaboration:

An interdepartmental forum on HIV/AIDS and STDs was established by the Deputy Director of the Programme in late 1996. The objective of this structure is to mobilize AIDS activities and awareness within the various departments in the province. This structure - KwaZulu Natal Interdepartmental AIDS Committee (KIDACO) held an awareness day in late 1996 where each department developed a logo highlighting the potential role in the epidemic. Orientation workshops on AIDS information is planned along with the introduction of condom vending machines in all Departments.

Although the KIDACO has been established, there is no indication that individual departments have addressed HIV and AIDS programming within their own departments. There has been little discussion or planning regarding how each department will integrate and address HIV/AIDS issues within their functions and activities. Specifically, KIDACO has not identified the structures, capacity and expertise needed to assist the departments in the integration of HIV/AIDS related services/activities. Training and technical assistance support is needed to facilitate their full participation and contribution to the HIV/AIDS prevention efforts of the province.

o Comprehensive HIV/AIDS and STD Management:

The epidemics of HIV/AIDS and TB are new, but STD is an endemic condition which has been around for a long time. The numbers of people with STDs is reported to be increasing. Structures and personnel to control STDs are already in place, but they need to be retrained, re-motivated and re-directed to take STDs seriously and to link them with HIV/AIDS programs.

Other than four dedicated STD clinics in the Province, the management of STDs is integrated into PHC clinic services. Family planning clinics also treat STDs, although some of these clinics do not get medicines regularly from their base hospitals. Numerous policy guidelines/protocols have been developed for STD management and control in the province. STD and TB programmes are not linked, although a Communicable Diseases Unit is planned in Durban.

Although there were several strengths noted during the Review, the following weaknesses were identified:

- No permanent programme staff have been appointed;
- Staff shortages and rotation of staff leading to dilution of expertise;
- All hospitals are not supporting appropriate STD management;
- Contact tracing and partner notification is not working adequately;
- Participation of CBOs and NGOs in the STD structure and in the STD health promotion is not optimal;
- Difficulty identifying recurrent STDs in patients using multiple facilities; and
- NGOs and CBOs as well as professionals outside of the public health sector have not received training in STDs

o Other management issues:

Many of the posts in the HIV/AIDS program have not been filled, or have been filled by individuals who hold other posts and are in acting positions. As a result, there is a lack of line/funding/spending authority; lack of time for the program and lack of understanding by supervisors of dual roles and the need to work on HIV/AIDS issues even though the salary is not paid by HIV/AIDS funds; lack of continuity of personnel; lack of project ownership by assigned personnel; and position insecurity and lack of ability to plan for the future. In addition, there is a lack of capacity-building processes to develop and support personnel to work in HIV/AIDS on all levels -- from administration to education/counseling to care.

Although education of health care workers and communities has been attempted and is a strength of the province, the quality and quantity of these services is inadequate. There is no context for the training and workshops which have been developed and there is no evaluation process in place to assess the quality of the training .

2. The Problem in Mpumalanga Province

Mpumalanga has an HIV prevalence of 16% with 200 000 people thought to be infected at the end of 1996. Some 50 to 75 thousand new infections are thought to have occurred within the last 12 months, with teenagers being the single highest infected age group. Although the prevalence is increasing significantly, support for and effectiveness of HIV/AIDS and STD activities appear limited. A tremendous amount of denial is evident by both community representatives and key political personalities. Such a major impact has yet to be realized, yet a tremendous amount of denial and ignorance about the disease exists at all levels.

Major areas identified during the 1997 HIV/AIDS/STD Review highlighted areas where further development is required within the province and include -

1. Capacity Building - More technical support at the provincial level for the HIV/AIDS/STD Program.

- Changing role and devolution of National functions to provinces will place more demands on provincial coordinators. Examples include condom procurement and distribution and NGO funding.
- Diversity of expertise is required for HIV/AIDS/STD activities beyond the medical input.
- Need to promote an "expanded response" to the epidemic.
- Special areas of expertise will be necessary to ensure a balanced HIV/AIDS/STD Program within the districts.

2. Capacity Building - Full time HIV/AIDS/STD Coordinator in each district with appropriate supporting resources.

- Demonstrates commitment to the AIDS Programme in the midst of capacity building of the district management team and the restructuring process.
- Additional skills are required (besides clinical skills) in the Communicable Disease Control programs.
- Strengthen intersectoral liaison at the district level.
- Currently, HIV/AIDS/STD activities generally occupy a small portion of the time of the coordinators.

3. Clear, simple, streamlined procedure for accessing funding for all role players.

- Procedures need to be clearly laid out for all levels to access funding.
- Financial management systems need to be markedly improved. A yearly "feast and famine" approach to finances needs to be urgently corrected to ensure continuity of activities.
- NGO funding needs greater control and partnership with appropriate role players and the Department of Health.
- All roleplayers, including the Finance Department and Treasury, must understand the impact of HIV/AIDS within the province.

4. Strengthen involvement of PWAs in all aspects of the program, from province to district level to government departments and NGOs/CBOs.

- Need to widen thinking with respect to PWAs and to have their input.
- Increase program sensitivities.
- Strengthen human rights and legal support.
- Increase the number of PWAs within the Department of Health and Welfare and other government departments.

5. Develop a certified counselor training programme for health workers and community members.

- Current information is changing rapidly.
- Communities must be saying the same messages concerning health promotion.
- Need for training of trainers.
- Wide variation and quality of counseling services must be offered.
- Ensure quality control and prevent abusive situations developing.

6. Strengthen comprehensive care with an emphasis on compliance, contact tracing, condom promotion, and counseling in areas involving both HIV/AIDS and STD issues.

- Stronger efforts will be required to ensure that STD management is expanded beyond the clinics.
- HIV/AIDS and STD management must remain part of services offered in all health institutions. Special STD clinics should only be required with complicated cases and where the disease has not responded to normal medications.
- Counseling efforts with health institutions should be strengthened through increasing links with community representatives and working in partnerships.

7. Need to ensure that political support for the HIV/AIDS Program continues and is strengthened.

- An interdepartmental committee to be established to ensure all government departments are involved where they can with AIDS activities and give the epidemic the priority it deserves.
- Greater openness and discussion about HIV/AIDS by political leaders.

3. The Problem in North West Province

The ante-natal surveillance results of 1996 show that the province increased from 8% prevalence among ANC mothers in 1995 to 24.9% in 1996. This put the North West province at the top of the most affected provinces in South Africa. Using projections, it can be estimated that HIV prevalence among ANC attendees by the year 2000 will be 41%. This will have serious social and economic consequences on the Province and South Africa as a whole. If the epidemic affects the young population as evidenced now, it follows that the mining industry which is the backbone of the North West economy will be very much affected as the skilled workers succumb to the epidemic.

There seems to be very little change in sexual behavior among the general population despite the massive health education efforts of the Department of Health and other stakeholders. More advocacy is required. There seems to be a tremendous amount of denial among the population and blaming others for the epidemic. This might also be due to ignorance.

Major areas identified during the 1997 Review:

- **Political Commitment:** This was found to be lacking. This is an issue which has to be tackled as soon as possible. This is an important part of the expanded advocacy program. The district health system is now in place and it is hoped this might help in getting political commitment. Politicians need to be educated about the consequences of HIV/AIDS and its impact on development.
- **Capacity Building:** This is a burning issue. The about-to-be appointed HIV/AIDS/STD coordinators need training in STD management, project management and evaluation, facilitation and coordination, PMS and financial management. They also need to know how to develop materials for their grass-roots communities with the help of those communities.

The province needs to strengthen inter-sectoral collaboration both at the provincial and district level. For this, technical assistance may be required.

Capacity building of the NGOs is also very essential. The National Department of Health has provided R100,000 to each province for capacity building activities. Most NGOs in the North West are small and newly formed. They need training in project management and evaluation, business plan development and financial management. There should be networking among the provincial and district offices, NGOs and CBOs, and other stakeholders to avoid duplication of projects. All projects implemented in the province, including research, must be documented and an AIDS library set up.

- **Advocacy:** Advocacy training has to be expanded to all stakeholders, both at government and non-governmental levels.
- **PWA involvement:** Very few people living with HIV/AIDS have “come out” in the North West province. As such, they are not involved in the planning, implementation and evaluation of HIV/AIDS intervention programmes. It is imperative that more people be encouraged to “come out”. PWAs should form an integral part of any task force to design intervention programmes in the North West.
- **Community involvement:** Communities also need to be involved in the STD/HIV/AIDS programmes. There has been little community participation due probably to ignorance among the populace on the impact of this epidemic. Community mobilization must be intensified so as to arm the community, not only with knowledge of HIV/AIDS and its impact, but on how communities can be part of the intervention programs envisaged.
- **Integration and coordination:** There is collaboration between HIV/AIDS/STD and TB programmes, but it must be borne in mind that integration has the potential of one programme overshadowing the other. Both programmes are presently moving towards coordinated planning from provincial level and cascading to the service delivery level.

- **Comprehensive HIV/AIDS care:** There is need for the development of a care and counseling service at every level. The “Faces” and lay counselors programme are a welcome step. Technical assistance may also be required in this area. The policy document must be finalized as soon as possible since it will be the guiding light for everyone in the province, including government departments, the private sector, law and human rights issues, etc.

II RELATIONSHIP TO USAID/SOUTH AFRICA’S HEALTH DEVELOPMENT STRATEGY

The assistance described in this results package (RP) represents the second key component of USAID/South Africa's health development strategic objective (Strategic Objective 3, or “SO3”). As noted above, the other is the Equity in Integrated Primary Health Care Project (the EQUITY Project). Together, these programs aim to improve the primary health care system and the delivery of PHC services in South Africa. While the EQUITY Project will strengthen the broader national integrated PHC program, the CAPACITY Project will focus on critical priorities in strengthening the national HIV/AIDS/STD program itself. The activity described in this document is solidly based on several key South African and USAID strategies and documents:

- Reconstruction and Development Plan
- The DOH White Paper for the Transformation of the Health System in South Africa (April 1997)
- The 1994 NACOSA/National AIDS Plan
- The July 1997 National HIV/AIDS/STD Review
- The October 1997 National HIV/AIDS Strategic Planning Meeting
- The USAID Strategy for Sustainable Development
- The USAID/South Africa Country Strategic Plan
- The USAID Global Bureau/PHN Center's HIV/AIDS Results Framework and USAID Bureau for Africa strategies

The proposed HIV/AIDS activities are fully supportive of the National AIDS Plan and respond to many of the key findings from the July 1997 National HIV/AIDS/STD Review. As discussed below, the National Review was a major national activity sponsored by the national Department of Health to assess the status and gaps in implementation of the National AIDS Plan. Moreover, each of the results and illustrative activities identified in this RP are responsive to strategies and activities identified in the National AIDS Plan, and will help respond to the needs identified in the National Review.

Results and illustrative activities contained in this RP are in agreement with the USAID/South Africa goals and objectives. The goal of the overall USAID/SA program is Support for Sustainable Transformation. The expected result from this program is to increase the capacity of the health care system, particularly at the provincial level, to deliver HIV/AIDS/STDs and related services. In order to achieve this, the activities and strategies identified in this RP will contribute to the overall health care system's transformation, and ultimately to the national transformation.

Linkages to Strategic Objective 3. The ability to deal effectively with a rapidly expanding HIV/AIDS epidemic, along with its STD and TB co-factors, is a critical component of an effective health care system. **The SO3 strategic objective is stated as "more equitable, unified and sustainable system delivering integrated PHC services to all South Africans."**

The strategic objective statement, together with the five intermediate results (IRs), are shown in the figure on the following page. There are important linkages and synergies among these five IRS. For example, IRS 1-4 address expected results surrounding increasing access to and the effectiveness of management of integrated PHC delivery systems, including training, referral and management skills development. The activities under this RP will maximize the synergy with the other four IR activities, which are initially focused on the Eastern Cape Province. This will include coordinating USAID program management, sharing of EQUITY Project materials with the CAPACITY Project implementation team, and providing opportunities for joint training opportunities. In particular, the CAPACITY Project implementation team will coordinate fully with the HIV/AIDS program elements being implemented within the EQUITY Project.

Linkages with Other USAID Strategic Objectives. Given the multisectoral nature of HIV/AIDS/STDs, the CAPACITY Project implementation team will seek opportunities to work with other SO teams within the mission. In particular, Education (SO2) provides special opportunities given the relationship between schools and HIV education, and Democracy/Governance (SO1) offers linkages with respect to increasing political commitment and advocacy. The other three SOs (economic policy, private sector, and housing) can work with SO3 in assessing the potential impact of HIV/AIDS and addressing multisectoral issues; and may be able to benefit from involvement with HIV/AIDS issues through education and distribution of information.

USAID's HIV/AIDS program assistance to date. USAID/SA's prior and current assistance to the national HIV/AIDS/STD program relates to two rather different approaches. USAID/SA's initial support, which began in 1991 during the time of the former apartheid government, was through grants to selected NGOs who were struggling to insure that the emerging HIV/AIDS/STD epidemic would receive the attention required to help slow its pace. These NGO grants were critical in helping focus attention on developing a national strategy and begin implementation of a national program to combat the epidemic, and supported several national NGOs (e.g., NACOSA, The AIDS Consortium) to develop the national plan and strategy. Some of the USAID grants also provided support for much-needed programmatic interventions at the local and community levels. These grants have served these purposes well, and will all have ended by September 1998.

In addition, USAID/SA's current EQUITY Project also supports HIV/AIDS/STDs as an important element of the integrated PHC service delivery package. This PHC package focus is critical to expanding use of HIV/AIDS/STD services, but given the comprehensive nature of the EQUITY Project and its focus on strengthening systems development, HIV/AIDS/STDs receives limited support. This has caused USAID/SA to rethink its overall health development strategy, and to commit itself to this increased support for HIV/AIDS/STDs through the CAPACITY Project.

III. THE CONSULTATION PROCESS DURING PROGRAM DEVELOPMENT

The CAPACITY Project was planned and developed using USAID's reengineering principles, and takes account of the evolution of the HIV/AIDS epidemic in South Africa, changes in government since the 1994 elections, restructuring of the SA health care system, evolving relationships within the country (e.g., devolution of authority and responsibility to the provinces), and USAID development priorities.

The consultation process. USAID/SA began planning the new program design a year prior to the final design with discussions with national Department of Health leadership, the HIV/AIDS/STD Directorate and other departmental representatives; and with numerous NGOs and partners. Consultations were also held with various partners throughout the first half of 1997. During this period, the national DOH also was in the midst of planning for its future HIV/AIDS and STD programs, and USAID was able to provide short-term assistance in the planning and execution of the National Review in July 1997 by serving on the coordinating committee and providing 7 technical team members (1 USAID/SA, 2 USAID/W, 1 USAID/REDSO, 1 AIDSCAP, 2 CDC). As indicated earlier, the purpose of the national review was to assess the implementation of the national and provincial HIV/AIDS/ STD programs against the three principal objectives of the original NACOSA/National AIDS Plan, to assess the current situation in the country, and to mobilize new commitment against HIV/AIDS/STDs. USAID/SA had proposed using the results of the comprehensive national review as the analytical base for its own program design. The national review was led by the national DOH with strong participation by NGOs and CBOs, provincial governments, universities, donors, and other stakeholders, representing a highly participatory and transparent process.

The review was followed by a national strategic planning meeting, sponsored by the DOH, during the first week of October 1997. This meeting began to identify next steps for national and provincial action in response to the national review. Participants included representatives from all nine provinces, NGOs, and donors, including USAID (4 persons). At the conclusion of this meeting, and resulting from it, Ms. Rose Smart, national DOH HIV/AIDS Director, proposed three preliminary directions for USAID assistance: capacity building (primarily at the provincial level), advocacy/leadership, and operations research. Since October 1997, USAID/SA staff have maintained close relations and discussions with a variety of partners, including NGOs, donors, and various levels of the SA government's health structure.

USAID conducted individual donor and NGO interviews in November 1997 to obtain information on their respective ongoing activities and future priorities. A one-day USAID stakeholders meeting attended by 60 participants representing the DOH, provincial DOHs, the private sector, NGOs, religious groups and universities, explored in detail the programmatic direction for USAID's new HIV/AIDS program. This was followed up by a smaller meeting composed of nominated representatives of the initial stakeholder's meeting to review progress. The RP design team was also formulated to include representatives from all of the key agencies that would likely contribute to the CAPACITY Project: the national HIV/AIDS and STD Directorate, collaborating US Government agencies (the Centers for Disease Control and

Prevention, CDC, and the National Institutes of Health, NIH), as well as from USAID/Africa Bureau, the USAID/REDSO office in Nairobi and, of course, USAID/SA.

In discussions of the first-draft RP document with the Director General of Health in late November, she proposed that rather than waiting until after the new grant agreement was signed and early implementation had begun, the three focus provinces should be selected right away. This would allow for more specific planning of program activities and results in the three provinces, and would help to define more clearly the resources needed to achieve the results. Based on mutually agreed selection criteria (see Section IV.B.2), the selection was made on November 28 by the Provincial Health Restructuring Committee (PHRC), a group that includes both key national DOH leadership and the Permanent Secretary level from the nine provinces. The provinces selected by the PHRC are KwaZulu-Natal, Mpumalanga and North West. As a result of an early December meeting with the Minister and Director General, a detailed schedule was established for meeting with representatives of the three focus provinces and other key stakeholders to make revisions in the RP document. These included specific information about the HIV/AIDS/STD problem in each of the three provinces, and preliminary priorities, plans, and program results for each province. In addition, the group would recommend further modifications in the initial draft RP, in order to provide a final draft for formal review and approval by both the South African government and USAID/SA before the end of January 1998. A two-day workshop was held on January 6-7 and the necessary revisions and additions were developed and agreed to, resulting in the final draft for review and approval. The specific discussion of the planned programs in the three focus provinces is included in Section IV.B.3. Tables showing the preliminary implementation plans for each province in all five activity areas are included as Annexure A.

US/South Africa Bi-National Commission (BNC). The CAPACITY Project was developed in the context of the BNC priorities for HIV/AIDS/STDs resulting from the July 1997 BNC meeting, as follows:

- Build capacity at a number of levels, including training of health workers in the public and private sectors.
- Facilitate the integration of TB and HIV/AIDS/STD programs.
- Improve public- and private-sector management of major risk factors for HIV transmission such as STD treatment, partner notification, promotion of the use of barrier methods and counseling.
- Support advocacy activities to promote a multisectoral response to the epidemic.
- Develop and pilot models of care along a continuum.
- Establish a program of community mobilization.

Although these activity priorities were discussed during the BNC as a basis for broad US/SA collaboration, the CAPACITY Project is solidly grounded in these priorities and addresses all of them with varying emphasis.

Critical assumptions which may affect planned results. The critical assumptions inherent in the CAPACITY Project's Results Framework (see Section IV.A) include the following:

- General political stability
- Strong collaboration among key partners (national and provincial DOHs, NGOs, others, USAID)
- Availability of sufficient human and financial resources to support the HIV/AIDS/STDs program

In view of both the programmatic links and the disease co-factors among HIV/AIDS, STDs and TB, the continued support for an integrated primary health care approach encompassing all three diseases is critical. Overall threats to the implementation of an integrated PHC system include such issues as

- (1) the impact of the increased health care service volume arising from the free health care policy, which impact could overburden the health facilities;
- (2) fiscal crises at the provincial level which may result in reduced support for health, retrenchment of personnel, and the lack of implementation or disruption in planned activities; and
- (3) the potential difficulties arising from the decentralization process whereby provincial, municipal, and in some cases regional redefinitions of boundaries and of roles and responsibilities leads both to confusion and to obstacles and delays in implementation.

The need for program flexibility. USAID recognizes the very fluid nature of the emerging health care system in South Africa, including the HIV/AIDS/STD/TB components. Although ongoing reforms are targeted at transforming the health care system into a more equitable and effective system, they may also lead to delays, unexpected difficulties, and changes in priorities. In addition, the HIV/AIDS epidemic in South Africa is evolving, and program emphasis in the future may have to shift to respond appropriately. In recognition of these factors, the CAPACITY Project incorporates opportunities for periodic assessment and review of program strategies and activities to insure that they remain on track. On the basis of the Performance Monitoring and Evaluation Plan (described in Section IX), the expected results will be revised and programmatic directions changed as needed.

IV SUMMARY OF EXPECTED RESULTS AND ILLUSTRATIVE ACTIVITIES

A. Program Rationale and Results Framework

The USAID activity design process focuses first on results and program outcomes, and then determines appropriate activities to achieve the results, the interrelationships and relative priority

among those activities, and a time frame for implementation. This sequence of design steps for the CAPACITY Project has yielded the results framework summarized in the diagram on the following page. This results framework emphasizes the causal relationship of each set of results to the next higher result. For example, to achieve IR5.1 (HIV/AIDS/STD/TB program performance strengthened), all four of the sub-IRs (IR5.1.1 through IR5.1.4) must be achieved.

The results shown in the framework were selected based on several important factors:

- (1) input received from the national DOH, the three focus province DOHs and from other stakeholders;
- (2) consideration of USAID's comparative advantages and available funding;
- (3) coincidence with BNC priorities;
- (4) flexibility in programming to allow for future changes in priorities and program focus; and
- (5) an emphasis on integration of HIV/AIDS with the other key co-factors (STDs and TB) within the comprehensive PHC system.

As indicated earlier, **the IR for the CAPACITY Project is “the enhanced capacity to provide effective HIV/AIDS/STD and TB prevention, care and treatment.”** The three principal sub-IRs, along with the next lower level of results, are outlined in the subsections below, along with a brief narrative summary. Certain results in the framework are critical to achieve the causal link to a higher-level intermediate result (IR), but will not be supported by USAID directly. In the list below these results are shown in brackets; in the results framework diagram they are represented by a dotted-line box. In addition, the results and sub-results will require different resource levels to accomplish different results. For example, the result of strengthening program performance will require the majority of available USAID resources within this program.

IR5.1 HIV/AIDS, STD, and TB program performance strengthened (primarily in selected provinces)

- Provincial Department of Health management capacity increased (IR5.1.1).
- Broad-based implementation networks developed and implemented (IR5.1.2).
- Research outcomes used to strengthen service delivery (IR5.1.3).
- [NGO and local organization capacity and involvement strengthened] (IR5.1.4).

The National Review findings and USAID's stakeholders have consistently emphasized the immediate need for HIV/AIDS/STD-related planning and management strengthening at the provincial and program levels. Such capacity building is critical to the ability of the South African government (at all levels) and its partners to effectively reduce the impact of the epidemic. In order to achieve this result, the provincial departments of health must become effective in planning and managing HIV/AIDS/STD/TB and related activities. Given the

numerous stakeholders and program resources in any one province, the USAID stakeholders meeting strongly recommended the formation of provincially-based networks to increase coordination and collaboration in program planning, implementation, and resource allocation. This method would also assist in maximizing the impact of USAID's assistance and would lead to greater sustainability. In the short term, the networks would focus on developing the strategies and implementation plans for the programs in the respective focus provinces. In the long term, the networks will provide a much-needed broad coordination mechanism for all HIV/AIDS/STD activities in the province, and will help to facilitate mass mobilization. [See the expanded discussion of network development in sub-section B.2 below.]

IR5.2 Multi-sectoral action for HIV/AIDS, STD, and TB policies and programs improved

- [Public awareness increased] (IR5.2.1).
- Commitment in support of HIV/AIDS, STD and TB prevention, care, and treatment programs increased (IR5.2.2).
- Sector-specific HIV/AIDS programs developed (IR5.2.3).

The National Review and stakeholders' meeting both identified a number of key issues that hinder progress in combating the HIV/AIDS epidemic in South Africa. These include (1) large-scale feelings of fear of HIV/AIDS by the general population, (2) denial by many individuals that they could be infected by (or *are* infected by) HIV, and (3) lack of understanding by politicians and government units of the level of resources required to combat the HIV/AIDS epidemic, and lack of commitment to provide them. Specific sectors can play a role in HIV/AIDS prevention and care within the sectors themselves. In addition, resources (human and financial) are lacking at all levels. In order to help redress these obstacles, USAID will support advocacy training at the national and provincial levels to enhance stakeholders' knowledge and advocacy skills, as well as to provide technical assistance in order to increase commitment in support of HIV/AIDS programs. Sector-specific programs also need to be tailored to fit individual sectors. Finally, public awareness must be increased so that people understand the magnitude of the epidemic and change their behavior accordingly. Given the heavy investment by the DOH and EU in the Beyond Awareness campaign, USAID will not directly support this program area.

IR5.3 Selected strategies to reduce HIV/AIDS, STD, and TB transmission improved.

- Newly implemented prevention, care, and treatment protocols improved (IR5.3.1).
- Case management strategy developed and strengthened (IR5.3.2).
- [Maternal and infant transmission reduction strategies developed and evaluated] (IR5.3.3).

Increased effectiveness of the national HIV/AIDS/STD program is based not only on good program planning and management and strong collaboration and commitment among all sectors,

but also on the use of technically appropriate and up-to-date scientific and programmatic information. This information should be used to develop and strengthen service delivery strategies and treatment protocols to improve services to clients. While as noted earlier USAID will not fund such intervention-linked research, USAID will support the development and/or strengthening of services aimed at reducing the transmission of HIV/AIDS, STDs, and TB, based on the outcome of such research.

B. Program Components

1. Guiding Principles

Based on the National Review, the national strategy workshop outcome, and extensive stakeholder input, guidance for USAID's HIV/AIDS/STD/TB assistance was clear. Capacity building, with a strong emphasis on the provincial level, has emerged as USAID's principal focus for assistance, in accordance with the following guiding principles:

- Five key components will comprise assistance to provincial-level capacity building: (1) network development, (2) management strengthening, (3) advocacy, (4) service delivery and (5) use of research results and "lessons learned."
- Assistance will focus on facilitating the building and strengthening of networks among government units and other stakeholders working at the provincial level in order to maximize the prevention and reduction in impact of HIV/AIDS/STD/TB. A technical assistance team, likely led by an institutional contractor but comprised principally of South African experts, will assist in the facilitation and phasing of the development of provincial networks, as well as coordinating all elements of program implementation. The networks will be formed with the aim of bringing together actors to work on all relevant HIV/AIDS issues. As the respective provincial networks are developed, each province should consider options and then implement the most effective mechanism to insure that the network will become a sustainable, driving force in the province for the planning and implementation of overall HIV/AIDS/STD/TB strategies and program elements.
- Assistance will focus on accelerating interventions to reduce HIV/AIDS/STD/TB prevalence and impact, and to improve the effectiveness of services.
- Documenting and utilizing lessons learned throughout the comprehensive HIV/AIDS/STD/TB program currently underway in South Africa will guide USAID assistance. "Better practices" based on lessons learned from one program experience will be further identified, analyzed, adapted and expanded for use in other similar program settings.
- Assistance will emphasize involving South African organizations and individuals that are currently working effectively in the HIV/AIDS/STD/TB sector.

- All training will emphasize mentoring and follow-up to insure that the desired impact of training activities has been achieved.
- An effective performance monitoring and evaluation plan will be developed so that progress in achieving the desired results can be assessed periodically.
- National-level capacity building will focus principally on management systems, advocacy, and use of research results and lessons learned.

2. Selected Provinces Approach

During the consultative process, stakeholders indicated their desire for USAID to support programming in the areas identified above in all nine provinces. However, the stakeholders also understood that in the best interests of maximizing results for the amount of financial resources available, the proposed activities will be best implemented more fully in a few selected provinces rather than more superficially in many provinces. This will help to ensure both greater overall program impact and greater sustainability of the program interventions and systems introduced. In addition, there is a great need to learn about what works best and under what conditions, and to be realistic about the time necessary to learn how to develop and implement the programs.

As noted earlier, in November 1997 the PHRC selected the three focus provinces for the CAPACITY Project. Selection was made taking into account the following mutually agreed selection criteria:

- HIV prevalence
- Other significant risk factors (e.g., migration across provincial borders)
- Rural- and urban-based population mix
- Potential for interventions to have impact (e.g., population density, size)
- Access to existing HIV/AIDS/STD/TB and reproductive health donor funding

The January 1998 provincial workshop developed specific programmatic priorities and preliminary implementation plans for roughly the first three years for the three focus provinces. Once these plans are refined and finalized during early project implementation, they will become the basis for capacity-building activities in the focus provinces. These plans are shown in subsection 3 below under each major activity; that is, the specific plans for each of the five major activities are combined for all three provinces for easy comparison. The complete individual provincial implementation plans are also provided in Annexure B to provide a comprehensive view of each plan.

Lessons learned in the capacity-building effort in the focus provinces will be documented and actively disseminated, including to the other six provinces. For certain activities, all nine provinces will engage in activities supported through this results package. In addition, limited national-level capacity building will be undertaken; illustrative activities for the national level are shown in subsection 4 below. While USAID resources will only support comprehensive

capacity-building in three provinces, an effort will be made to ensure that with adequate planning and lead time, additional resources (through other donors, the national DOH, and perhaps the provinces themselves) will be identified and committed to ensure the rapid expansion of capacity-building activities to the other six provinces. Provision will be made for limited technical assistance to the other six provinces from the CAPACITY Project if and when they are interested in similar capacity-building efforts, and if the necessary resources are available.

3. Provincial capacity building

This subsection summarizes the five major capacity-building activities that will be undertaken in each province, followed by tables showing the specific provincial plans for each activity. The SO3 intermediate result(s) or sub-result(s) that each activity will help to achieve are noted in parentheses following the activity title. [Recall that the principal results and sub-results were summarized in Section IV.A. More detailed information is provided in the Performance Monitoring and Evaluation Plan (Annexure C).

Activity 1: Network Development (IR 5.1.2)

Recognizing the diversity among the three provinces, formulation of networks at the provincial level will differ. Some of the provinces may require little assistance in formalizing joint working relationships and plans, while others will require longer processes to develop and institutionalize operational networks. Individual focus provinces may take different approaches based on where they start with the networking process. For example, as shown in the table below, KwaZulu-Natal plans to begin at the regional or perhaps even the district level, while Mpumalanga will begin with its provincial network. The provincial DOH will likely be the driving force in network development, with the provincial HIV/AIDS coordinator taking the lead. The institutional contractor's technical assistance team will provide assistance to the focus provinces as needed to accomplish the following steps. If some of these steps have already been taken and the respective outcomes achieved, network development, implementation, and institutionalization will take place more quickly.

- 1) Conduct an inventory of all government units and other organizations and individuals (generalized as "organizations") working in the HIV/AIDS/STD/TB sector, including their potential resources and capabilities. This inventory will supplement the existing South African AIDS Network directory, and will include an assessment of each organization's actual and potential strategic involvement in the reduction of HIV/AIDS prevalence and its impact.
- 2) Analyze this inventory of organizations and recommend the roles each could play in a provincial network.
- 3) Conduct an initial joint planning meeting of all relevant organizations to (1) determine their interest in becoming part of the network, (2) determine which organizations are interested in and best suited for each of the five key activity components, and (3) establish a general framework (likely including formal terms

of reference) under which the network will be developed and will continue to function. This framework may include the concept of "task groups" that will develop or refine workplans for the five capacity-building areas, and assess progress periodically.

- 4) Specific follow-on steps will vary from province to province, but will likely include expanding and refining the preliminary implementation plans presented in this section, and beginning actual implementation. Thus the networks will facilitate the consultation process in the province in finalizing the strategies and
- 5) For a network to be effective, it must be useful, accountable for what it does and sustainable. Therefore, in each province the network should determine the appropriate arrangements and mechanisms to insure that it continues to perform these three roles effectively. This kind of entity may already exist in one or more provinces, or a current role might be expanded to fulfill the network function. In another province a new, formal organizational structure may be appropriate. For example, in the January provincial workshop one suggestion was to establish a Section 21 non-profit company to fulfill the network function and help to insure its sustainability. While the time required for network development may vary, the likely time frame proposed is from six months to a year.
- 6) As envisaged during the USAID consultation process, networks will become the long-term, broad coordination and oversight mechanism for all HIV/AIDS-related activities at the provincial (or other) level. In order to achieve the comprehensive results of the national HIV/AIDS program, the network approach - involving all major stakeholders - appears to be the most effective way to do so.

Summary of Network Development Activities in the Focus Provinces

Province	Target Population	Performance Indicator	Priority and Time Frame
KwaZulu Natal	·DOH/other departments ·NGOs/CBOs ·Private sector ·Politicians	IR 5.1.2 ·% or # of regions or districts where HIV/AIDS networks established ·% or # of regions or districts where service delivery task forces established ·% or # of regions or districts where advocacy task forces established ·% or # of regions or districts where management task forces established	Priority: High Time Frame: 1 July 1998 to 31 December 1998
Mpumalanga	·Whole of province ·Structures outside the province	·Groups networking ·Coordination activities ·Action plans implemented	Priority: High Time Frame: 1 July 1998 to 30 June 2000

North West	·Network - Health and Social Welfare Department ·NGOs/CBOs ·Private sector ·PWAs ·Department of Education ·Traditional healers ·Other sectors	·Two task forces established: Advocacy and Service delivery ·Action plan developed	Priority: High Time Frame: 1 July 1998 to 30 June 1999
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Activity 2: Management Strengthening (IR 5.1)

The National Review identified several constraints in achieving the objectives of the National AIDS Plan, one of which was "lack of administrative capacity at provincial and local levels". During the consultative process in the design of the CAPACITY Project, stakeholders consistently stressed the critical need for capacity building in provincial-level management in order to achieve impact. Once the provincial network is functioning, the management systems task group (with technical assistance and financial support from the technical assistance team) may undertake these illustrative activities as part of its overall implementation. Again, if one or more of these steps has already occurred in a province, implementation can be speeded up.

Activity 2A: Management Assessment: In order to improve the delivery of HIV/AIDS/STD/TB services, a "gap analysis" should be conducted to determine capacity weaknesses which prevent the efficient management of HIV/AIDS/STD/TB-related services. Based on this analysis, management strengthening activities can be determined. This assessment will also guide the development of an effective skills training package.

Activity 2B: Strategic and Programmatic Planning: This activity represents a major priority identified by the National Review and stakeholders. Approaches to these types of planning will be developed for use by the network. Emphasis will be placed on the implementation of plans and the feedback loop needed to link planning to implementation and evaluation of results achieved.

Activity 2C: Management Training: In provinces where a management training system is in place, the training needs analysis and training package, just described, will help to complement ongoing management training activities. In provinces without a management training system, a different model may be developed. At a minimum, a training package should include the following major areas:

- financial and resource allocation management
- human resource management
- strategic and program planning
- management information system development
- activity/project management
- performance monitoring and evaluation.

Training of management trainers to carry out this program is a critical element in capacity building, and a strategy for building a strong cadre of management trainers in each province

(perhaps to serve broader needs than HIV/AIDS/STD/TB) must be an integral part of the training program development. The network, with assistance as needed from the technical assistance team, should set objectives for TOT activities and carefully monitor implementation. The curricula for management training should become standardized to the extent possible in all of the provinces – not just the three focus provinces. Linkages with the EQUITY Project will provide access to appropriate curricula, methods, and materials already developed, and should provide a quick start to the management training program. Similarly, the EQUITY Project should be useful in demonstrating effective methods for assessing management training impact. Strategies for institutionalizing management training capacity will likely vary among the three provinces, given existing differences in management training development. For example, in Mpumalanga Province, a provincial Health Sciences College is currently being considered; if implemented, it would provide broad health worker training programs within the province

Activity 2D: Strengthening Management Systems: The EQUITY Project strategic approach for strengthening PHC management has already demonstrated the value of the comprehensive approach. Clearly, improving management skills is a necessary first step, but must extend to assessing and modifying health care management systems to make them more effective and responsive to client needs. The same is true for HIV/AIDS/STD/TB services, especially to insure that they become integrated into the PHC delivery system. The network's management task team should take on the broad role of overseeing the development and implementation of an effective management system (including management training) for HIV/AIDS/STD/TB.

Activity 2E: Performance Monitoring and Evaluation: As discussed earlier, performance monitoring and evaluation will be strengthened to insure adequate assessment of progress in achieving HIV/AIDS/STD/TB program impact.

Summary of Management Strengthening Activities in the Focus Provinces

Province	Target Population	Performance Indicator	Priority and Time Frame
KwaZulu Natal	- Program managers - HIV/AIDS and STD coordinators - TB coordinators	% or # of districts or regions that are capable of AIDS/HIV/STD and TB activity design, implementation and evaluation	Priority: High Time Frame: 1 July 1998 to 30 June 2001
Mpumalanga	Network structure of province	- Analysis of management capacity - Training needs - Training framework in place - HRDU structure supported - Trained personnel	Priority: High Time Frame: 1 July 2000 to 30 June 2001
North West	- DOH program managers - HIV/AIDS and STD coordinators - TB coordinators - HIV/STD provincial officers	# of projects well planned, implemented and evaluated # of managers able to develop business and operational plans for HIV/AIDS/STD program	Priority: Medium Time Frame: Ongoing

Activity 3: Advocacy (IR5.1, IR5.2.2, IR. 5.2.3)

“Advocacy” is often viewed narrowly, and thus the full benefits of using advocacy principles broadly to strengthen HIV/AIDS/STD/TB programs and expand resources are not achieved. The National Review and consultations with stakeholders identified a number of obstacles to achieving the desired impact in the national HIV/AIDS/STD program. Several key strategies have been identified at the national level to address these barriers and obstacles, to mobilize resources, and to create a supportive environment for HIV/AIDS activities. These strategies include:

- Enhancing the ability of South Africans to advocate for resources, leadership and support, and to effect change in underlying factors preventing an effective response to the HIV/AIDS epidemic and its related conditions.
- Developing a coordinated approach to conducting advocacy for HIV/AIDS and related conditions in South Africa at the provincial and national levels.
- Focusing on influencing local leaders and developing their leadership potential regarding HIV/AIDS.
- Supporting the inter-sectoral approach to preventing and mitigating HIV/AIDS/STD/TB (already underway within the national government).

- Insuring that advocacy efforts move along a continuum to policy change and formulation, action, and evaluation.
- providing technical assistance on how to increase public support for policies and interventions conducive to successful HIV prevention efforts.

The CAPACITY Project will support activities determined by the provincial networks' advocacy task groups to achieve these strategies. Other advocacy activities will be supported at the national level (see subsection 4 below). To accelerate the development and implementation of these strategies at the provincial level, the technical assistance team will support the following activities.

Activity 3A: Identification of Barriers and Opportunities: The advocacy task groups will need to assess the current situation to determine the major constraints preventing the desired impact of the HIV/AIDS/STD/TB programs in each province. Once a clear understanding is reached within a province about which barriers exist (e.g., organizations, individuals, misinformation), and which strategies might be used to eliminate the barriers, a provincial advocacy plan and related activities can be developed.

Similarly, by identifying key individuals and organizations who are supportive of HIV/AIDS/STD/TB efforts, these new advocates can be employed to strengthen the advocacy program. Groups to consider – both as “barriers” and “advocates” – include politicians, political candidates, religious groups, traditional leaders, the medical community, traditional healers, and others.

Activity 3B: Coordinated Planning for Advocacy. This network activity is designed to assist provincial organizations, public and private, that are involved in advocacy for HIV/AIDS/STD/TB to increase coordination and thus rationalize and increase their cumulative impact. For example, in a multi-sectoral communication effort aimed at changing behavior, efforts could include identifying key messages, audiences, strategies; establishing a plan and timetable and deciding how to mobilize resources. Planning might first focus on provincial-level targets and then move to regions and/or individual districts that are a high priority.

Activity 3C: Materials Development and Improvement: Effective advocacy, policy dialogue, and improvement of public awareness of HIV/AIDS rely on the availability and effective packaging of useful information. For example, target audiences need information which is designed to persuade them to improve their perceptions, attitudes and/or behavior concerning HIV/AIDS/STD/TB-related issues. Effective materials would be developed for different audiences such as political decision makers, technical decision makers, business groups, youth, and others. In addition, research findings from key studies should be translated into policy-relevant materials useful for advocacy.

Activity 3D: Advocacy Training: Advocacy training has already begun at the provincial level, in part through USAID assistance from its centrally-funded Policy Project. Training of key individuals will be critical to progress in advocacy both at national and provincial levels. The

networks' advocacy task teams, with assistance from the technical assistance team, will evaluate training needs and develop and implement an effective advocacy training program similar to the one described above for management training.

Activity 3E: Combating "Denial", facilitating Disclosure and Supporting PWAs: There is clear recognition in South Africa that "denial" is a serious constraint in the HIV/AIDS/STD prevention and care continuum. This includes denial by those who are HIV positive, those with AIDS, and those in the seronegative population who deny the risk of becoming HIV positive and thus will not change risky behavior. Facilitating disclosure of HIV status to clients is a key area for improvement. A related aspect contributing to denial is the lack of a supportive environment for PWAs -- an important goal of advocacy. The technical assistance team will provide assistance to the provincial-level advocacy task teams to learn more about denial, disclosure, and PWA support strategies, prepare plans to address them, and conduct related campaigns and follow-up activities.

Summary of Advocacy Activities in the Focus Provinces

Province	Target Population	Performance Indicator	Priority and Time Frame
KwaZulu-Natal	·DOH and other departments ·NGOs ·Private sector ·Politicians	IR 5.1 ·% or # of districts or regions where integrated AIDS/STD/TB services are provided with PHC IR 5.2.2: ·% of provincial health budget for AIDS/STD/TB programs IR 5.2.3: ·% of provincial departments with approved HIV/AIDS policies	Priority: Medium Time Frame: 1 July 1998 to 30 June 1999 - DOH and other departments 1 July 1999 to 30 June 2000 - NGOs, private sector and politicians
Mpumalanga	·Network personnel ·NGOs ·Private sector ·Politicians	·Increased support ·Increased population awareness ·PWAs supportive environment	Priority: Medium Time Frame: 1 July 2000 and ongoing
North West	·DOH and other departments ·Policy makers ·Private sector ·Political leadership	IR 5.2: ·AIDS policy environment score ·Document which identifies barriers and provides strategies to address barriers ·Appointment of advocacy coordinator(s)	Priority: High Time Frame: Activity 4A: 1 July 1998 to 31 December 1998 Activity 4B: Ongoing Activity 4C: 1 July 1998 to 30 June 1999

Activity 4: Service Delivery (IR 5.1, IR 5.3.1, IR 5.3.2)

The National Review noted several weaknesses which relate to service delivery. These include (1) lack of policies, guidelines, and management protocols for a comprehensive care and counseling strategy at both national and provincial levels, and (2) lack of adequate systems of referral and continuum of care encompassing prevention and treatment strategies. One key recommendation of the National Review was to set up mandatory training of doctors on the national guidelines for STD diagnosis and management. Considerable attention is now being paid to STD training and related diagnosis and treatment throughout the provinces, resulting from this national focus.

The CAPACITY Project will support targeted activities in the focus provinces that will expand the national plan to the provinces and accelerate its implementation to support the need for the continuum of care. The networks' service delivery task teams will lead and coordinate service delivery strengthening activities in the focus provinces, especially in the training of medical personnel to eliminate "medical barriers" and improve the concept of prevention case management (PCM).

The PCM concept involves the assessment of HIV risk behavior and the assessment of other psychosocial and health service needs in order to provide risk-reduction counseling and to insure appropriate referrals (HIV/AIDS clinical management including TB screening and treatment, drug treatment, and/or other services). The referrals for care require providers to establish formal linkages and use a team approach, so that the individual can be cared for in an environment of "shared confidentiality". PCM provides intensive, individualized support and prevention counseling to assist clients to remain seronegative or to reduce the risk for HIV transmission to others. PCM is intended for persons who are having or who are likely to have difficulty initiating and sustaining safer behavior.

The clinical provider's ability and desire to deliver quality, integrated services is critical in the mitigation of the impact of HIV/AIDS/STDs/TB. Estimates indicate that about 80% of clients seeking STD services are seen by private-sector general practitioners. Nurse practitioners (and other public health workers) are also key providers of services. Improving the quality of treatment, counseling, and referral skills of these providers is fundamental to reducing incidence, prevalence, and the related impact of these diseases. The provincial service delivery task teams, with help from the technical assistance team, will develop advocacy and training strategies targeting this group of practitioners so that they provide more effective, comprehensive HIV/AIDS/STD/TB services.

Summary of Service Delivery Activities in the Focus Provinces

Province	Target Population	Performance Indicator	Priority and Time Frame
KwaZulu Natal	· Training to public and private sector health care providers · Health trainers · NGOs/CBOs, religious groups, etc.	IR 5.1: · % or # of districts or regions where integrated AIDS/STD/HIV and TB services are offered with PHC IR 5.3.1: · % of protocols evaluated and improved IR 5.3.2: · Case management strategy developed and improved	Activity 3A: HIV prevention case management - Priority: HIGH Activity 3B: Overcoming medical barriers; Priority: HIGH Time Frame: 1 July 1998 to 30 June 2001
Mpumalanga Activity 3A: HIV Prevention case management Activity 3B: Training medical community Activity 3C: Intervention linked research activities	· Public and private medical community · Community target groups	· Reduction in HIV incidence · Reduction in risk behaviors · TOT trained · # of best practices	Priority: Medium Time Frame: 1 July 1999 to 30 June 2001
North West	· Hospitals · CHWs · Hospices · ATICS · NGOs/CBOs · Unions · Insurance companies · Lay counsellors	IR 5.3.1: · % of protocols evaluated · % of protocols improved IR 5.3.2: · Case management strategy developed and improved	Priority: High Time Frame: 1 July 1999 to 30 June 2001

Activity 5: Use of Research Results and "Lessons Learned" (IR 5.1.3, 5.2.2, 5.3)

Throughout South Africa there are a number of lessons that have been learned about "what works" programmatically in improving HIV/AIDS/STD/TB strategies and services. Some have been developed through intervention-linked research, while others have simply evolved in the process of improving the effectiveness of service delivery and other programs. However, these lessons are neither well documented nor widely disseminated. To maximize the utility of lessons learned at the provincial level, the CAPACITY Project will support the systematic assessment, documentation and dissemination of these valuable lessons learned.

As discussed earlier, the national DOH has decided that high-priority, intervention-linked research (ILR) will be supported by the DOH budget rather than via programs of donor assistance. However, since the use of research *results* from ILR was agreed to be a priority area for USAID support, the capacity-building approach described here will include a strong link with

DOH-funded research effort to insure that research results are used to develop effective service delivery approaches. Thus, this activity will incorporate both ILR and other program-based lessons learned as the basis for the materials development and dissemination activities described below.

Similarly, the CAPACITY Project will coordinate with other relevant research efforts (either ongoing or planned) that will have relevance to this activity. For example, through efforts being coordinated through the US/SA Bi-National Commission, research activities being planned or considered in HIV/AIDS/STD/TB would utilize support from the U.S. National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). These sources of support will provide an important additional resource for intervention-linked research in South Africa, and using the research outcomes will be part of the task of this lessons learned activity.

In addition to using research results, an inventory of lessons learned and documentation of better practices will be conducted. South African organizations, especially NGOs, often have initiated innovative approaches and programs which appear to work well on a small scale. To date, however, these activities have not been well documented, evaluated, or shared with others. An inventory of such programs and assessments, and case studies of the most promising activities in the context of current HIV/AIDS/STDs/TB priorities, will be an important step in increasing their adoption by others and expanding their use to the provincial and/or national levels.

Criteria will need to be carefully selected and established in order to manage the examination of lessons learned in a cost-effective way. At a minimum, the documentation of lessons learned should be conducted when the intervention:

- constitutes a "better practice" (an approach or strategy that "works")
- has been institutionalized or is likely to be, and
- can be cost-effectively replicated or adapted for expanded use elsewhere.

Activity 5A: Selecting and Documenting Lessons Learned: The provincial network "lessons learned" task team, together with the technical assistance team, will canvass health service providers and organizations in each province to identify which lessons learned should be examined and documented using the agreed-upon criteria. As appropriate, site visits to the program or project will be made, interviews will be conducted, observations of the practices will be made, and case studies (or other relevant materials) will be developed to document the results of the better practice.

Activity 5B: Transfer of Capacity to Assess Lessons Learned: Provincial-based staff, at least from the three focus provinces, will be selected to work alongside those assessing and documenting lessons learned, to ensure the transfer of skills to provincial-level staff.

Activity 5C: Dissemination and Follow-Up: The findings from the documentation process will be disseminated at the provincial and the national levels. Workshops and conferences will be planned for this dissemination, and follow-up plans to monitor the expansion of the lessons learned will be prepared at the end of each meeting. Where these better practices should be

incorporated into the formal training programs for health care personnel, appropriate materials and methods will be developed and incorporated.

Activity 5D: Increasing Understanding of the Impact of HIV/AIDS: National Review results and stakeholder assessments indicate that there is a great lack of understanding of the impact, current and future, of HIV/AIDS on the health and other sectors. Development and application of methods to assess the impact on health care utilization and public expenditures will be developed, and these will be incorporated into programs to promote an understanding of the devastating result. This impact information will also be important in the advocacy area (Activity 3).

Summary of Research Results and “Lessons Learned” Activities in the Focus Provinces

Province	Target Population	Performance Indicator	Priority and Time Frame
KwaZulu Natal	·DOH researchers ·DOH management ·Universities and other tertiary institutions ·NGOs/CBOs ·AIDS resource centers	IR 5.3: ·% of reduction strategies evaluated and improved and new ones developed IR 5.2.2: ·% of provincial health budget for HIV/AIDS/STD/TB activities IR 5.1.3: ·Not useful	Priority: Medium Time Frame: 1 July 1998 to 30 June 1999 - Activity 5A: Selecting and documenting lessons learned 1 July 1999 to 30 June 2001 - Activities 5B to 5F
Mpumalanga Community Support for PWAs	·PWAs ·General community	·PWAs open about their HIV status	Priority: Medium
North West	·Program officers (HIV/AIDS/STD and TB) ·CDCs and HIV/STD coordinators ·District manager and assistant director of community health ·NGOs/CBOs ·Network	·Documentation of "lessons learned" ·Workshops and seminars conducted to disseminate information to stakeholders and network ·Document which describes the impact of HIV/AIDS	Priority: Medium Time Frame: Ongoing

4. National-level Capacity Strengthening

The national Department of Health -- especially after the change of government in 1994 -- has provided strong leadership and support for HIV/AIDS/STD/TB activities. However, the National Review identified areas where the Department lacks capacity and sufficient staff to carry out its responsibilities and programs. Without additional support for capacity building, the DOH may fall short in meeting its broad goals and objectives.

As reflected in the 1998/99 operational plan of the Directorate of HIV/AIDS and STDs, the national DOH program has the following three goals:

- Prevent HIV and STD transmission,
- Reduce the personal and social impact of HIV infection, and
- Mobilize and unify national, provincial, international and local resources.

Among the programs developed to achieve these goals, several have been identified during the USAID consultation process as important for USAID support. These areas were confirmed during the January 1998 provincial workshop, further strengthening the rationale for support under the CAPACITY Project. The key areas proposed will be highlighted in the following paragraphs, using the same capacity-building framework as for the provincial programs. As with the focus provinces, the activities are illustrative and will be finalized during follow-up discussions during early project implementation.

Activity 1: Network Development

The national DOH has initiated both national Interdepartmental and Interministerial Committees during the last year. The DOH also plans to establish a National AIDS Council in 1998, and to link this effort with the Office of the Deputy President to insure political visibility and commitment. On request from the DOH, the CAPACITY Project will provide support in this effort. Once the National AIDS Council is functioning, there may be further opportunities to provide support through the advocacy activity that will help the Council to fully understand the need for swift and coordinated action to address the AIDS epidemic, and to strengthen its commitment to do so.

Activity 2: Management Strengthening

The CAPACITY Project can provide management capacity building to the DOH (principally in the HIV/AIDS and STD Directorate) in several specific areas. Those proposed and considered include (1) strategic planning, (2) performance monitoring and evaluation, (3) selected training, and (4) technical assistance to develop intervention-linked research protocols. Note that this latter technical assistance would likely be provided to research institutions identified by the national DOH.

Additional assistance could be provided in developing impact assessment methodologies that will forecast the impact of HIV/AIDS on national public health system utilization and expenditures would help planning and advocacy efforts.

Activity 3: Advocacy

Advocacy assistance, as requested, will support the national networks discussed in Activity 1, as well as the national advocacy program under the Directorate's mobilization and unification goal. This assistance could support the development of HIV/AIDS as an election issue in 1999, and more broadly help to secure commitment from political and public leadership (e.g., Parliament,

business leaders). For example, one USAID-developed initiative, the Private Sector AIDS Presentation, has been extremely useful in other countries in helping to inform the business community of the potential socioeconomic impact of the AIDS epidemic, and to obtain the support of business to combat the epidemic. The CAPACITY Project could also assist in the planned campaign, to be conducted in conjunction with the provinces, to change public attitudes and behavior toward PWAs.

Activity 4: Service Delivery

One specific area of assistance highlighted during the consultative process is to provide support for a DOH consultant to develop national service delivery protocols and guidelines that will unify and standardize selected service delivery interventions and referral mechanisms. While this support will likely also be linked with using some of the outcomes from research results and lessons learned (Activity 5), there is an urgent need for expanding the capacity in the Directorate to carry out this work. Since this need will be ongoing as the HIV/AIDS/STD/TB program evolves, this is an important area to insure that DOH resources will be available at a reasonable point in the future, so that national protocol and guideline development will be sustainable. Other potential areas for CAPACITY Project assistance would be to support other Directorate programs under the HIV/STD prevention goal; these might include STD management, barrier methods, and other targeted interventions.

These national service delivery protocols and guidelines would be developed and/or adapted for use in training programs for PHC health care workers (both pre-service and in-service programs). This will insure the rapid use of these protocol and guidelines - thus improving service delivery to clients.

Activity 5: Use of Research Results and Lessons Learned

The importance of using research results and lessons learned to improve program performance and effectiveness was discussed under Activity 5 in subsection 3 above. Initially this will be a major effort requiring both short- and long-term technical assistance from the CAPACITY Project. As with national-level Activity 4 just discussed, there will be a long-term need for capacity in the national Directorate to insure that future research findings and lessons learned will be used effectively as well. The consultation process suggested that the CAPACITY Project could also provide support for a long-term consultant in the national Directorate who would initially work with the technical assistance team in developing useful materials for improving program effectiveness. However, as with the consultant discussed in Activity 4, this position would be institutionalized within the Directorate to insure adequate long-term capacity in this activity area. Key areas of the Directorate's 1998/99 operational plan that the CAPACITY Project could also support through this research results mechanism would include (1) integration of HIV and TB, (2) reduction of maternal to child transmission, and (3) care counseling and support.

V. FEASIBILITY ANALYSIS

The primary analytical work detailing feasibility of activities included in this Results Package was the "National STD/HIV/AIDS Review: Comprehensive Report - Volume 1-4," July 14-18, 1997. The review was carried out by the Department of Health, with participation of USAID and CDC personnel as members of the review team. General Review Findings from this comprehensive document, are summarized as follows. These findings were instrumental in guiding the joint DOH/USAID analytical process to narrow down potential interventions and in structuring the extensive consultation process, from which activities included in this RP emerged.

Key Strengths Identified

- There is a high level of commitment from the Health Ministry.
- The National Department of Health has recently taken the initiative to collaborate at various levels to insure strengthened interdepartmental and inter-sectoral response.
- NGOs have been highly motivated and active in the response, with limited resources. The establishment of NAPWA has facilitated the participation of PWAs in prevention, intervention and care strategies.
- There is a large core of NGOs and CBOs delivering comprehensive care.
- Drug supply and accessibility for STD management is good in most clinics.
- TB services are available to people dually infected with HIV and TB.

Key Constraints Identified

- Major restructuring of national and provincial health departments has delayed appointments of personnel, and capacity, both human and financial resources, at all levels. District structures have not been established in most provinces. [Note: Limited district structures have been established subsequent to the review, e.g. in North West Province.]
- There is a lack of visible commitment outside the health department to effective interdepartmental implementation of the programme.
- There are continued high levels of discrimination and human rights abuses of infected and affected persons with HIV/AIDS.
- No policies guidelines or management protocols exist for a comprehensive care and counseling strategy at both the national and provincial level; there are no structured referral systems and no continuum of care; home-based care and terminal care facilities are lacking.
- There is a lack of integration of STD/HIV/AIDS and TB care.
- Promotional materials are not always available in the vernacular and are not client-sensitive or user-friendly.

Major Recommendations

- Increase resources and build capacity at provincial and district levels to manage, organize and implement the HIV/AIDS and STD Program. Provincial-level authorities should designate coordinators responsible for HIV/AIDS/STD in every province and district.
- There is an urgent need to secure political leadership from the Deputy President and to increase political commitment and public leadership.
- Strengthen interdepartmental and inter-sectoral response to the epidemic.
- A concerted effort by all stakeholders needs to be made to protect human rights and counter discrimination and stigmatization.
- Support and strengthen PWA initiatives and increase full involvement of PWAs (i.e., not tokenism) in programme design, implementation and evaluation.
- Increase collaboration between HIV/AIDS/STD and TB Programs.

Through the extensive consultation process carried out among the DOH, other partners, stakeholders and USAID, as discussed in Section II above, USAID was requested to fund interventions in the area of capacity building at the national and provincial levels. USAID has agreed to this based on the critical need for capacity building and USAID's comparative advantage of delivering assistance in the required areas.

To provide more information on the National Review, the Summary Report of the Review is included as Annexure C. Copies of the national Comprehensive Report are available from USAID.

VI. CUSTOMER SERVICE

The participatory development of this results package has set the stage for future collaboration with USAID's customers, and obtaining and using their feedback. The CAPACITY Project Management Team, described in Section VII B, provides the first opportunity for customer feedback. The team is composed of representatives of the national DOH, the three focus provinces, and perhaps key stakeholders from the national and provincial networks. The role of the Management Team is to work collaboratively to provide overall strategic guidance, discuss issues and problems, resolve them, and as "customers" to provide feedback to the USAID and the CAPACITY Project.

Customer needs will be assessed in several ways. For example, the network structure, including the five component task forces, has been designed to empower the customers to identify their prioritized needs that are to be met by the provided assistance. These needs may change over time and the program is designed to respond to these changes. Additional sources of customer feedback will include the opinions of the non-USAID members of the Management Team as the results of the PM&E plan are discussed and USAID's performance is assessed as part of the monitoring process. Specific surveys of various target audience needs, perceptions, and requests will be conducted as appropriate in order to obtain additional customer feedback. Feedback will also be channeled through the provinces (via the networks) to the Management Team.

Thus, the opportunities to obtain customer feedback are numerous. USAID will be responsive to this information and will utilize it to improve service to its customers at all levels.

VII PROGRAM IMPLEMENTATION AND MANAGEMENT

A. Implementation Mechanisms

Funds for the CAPACITY Project will be obligated through a bilateral Strategic Objective Agreement (SOAG) to be signed with the Department of Health. This agreement, once expanded, will include both the EQUITY Project and the CAPACITY Project. This arrangement will streamline the grant funds approval mechanisms within the South African Government, and will help to integrate the philosophy and management of the two related projects. As with the EQUITY Project, although there will be designated, formal signatories within the DOH in relation to the CAPACITY Project, the DOH's overall oversight and management functions will be integrated within the Management Team (see subsection B below).

1. Capacity-building implementation mechanism

USAID/SA will use the USAID/Washington Global Bureau field support mechanism to obtain the services of the centrally-procured Policy Project (a consortium of three organizations -- The Futures Group International, the Research Triangle Institute, and CEDPA). The Policy Project has been working in close collaboration with the South African Department of Health during the past year to facilitate the development of sound HIV/AIDS advocacy strategies. In this process, the Policy Project has demonstrated the desire and ability to make maximum use of South African expertise, a key factor in the capacity-building thrust of the CAPACITY Project. Having established productive working relationships with its South African partners, the Policy Project is strategically positioned to implement the results package rapidly and effectively. In addition, utilizing this centrally-procured project will minimize the mission's management burden and will streamline the procurement process, facilitating a more timely implementation schedule.

In implementing the results package, the Policy Project will make every effort to utilize local expertise. This is very important in the South African context (given the high quality of health care professionals), and is more cost-effective. With the likely exception of the technical assistance team leader and Policy Project home office support staff, South African institutions and individuals will normally be used both for long- and short-term technical assistance.

The planned approach to the field support implementation activity is divide the project into two phases. During the Phase 1 (years 1-3), USAID will utilize the Policy Project to implement the program. Based on a comprehensive evaluation early in Year 3, performance will be assessed, changing needs and resources will be carefully evaluated, and the nature of continued long-term technical assistance will be determined. Based on these conclusions, the necessary technical assistance resources for Phase 2 will be contracted.

The Policy Project will hire a long-term advisor (likely to be an expatriate) as team leader for the first three years to provide overall technical and management assistance to insure that the capacity-building program achieves the results described in the implementation plans outlined in Section IV. A second long-term advisor will be necessary in the main project office (based in Pretoria) specifically to oversee the technical assistance and support to the three provincial-level programs. Based on the clear need supported by the provincial workshop in January 1998, the Policy Project will also hire three long-term technical specialists to work in each of the three focus provinces. Short-term technical assistance will be provided as necessary to support the national and provincial implementation plans.

2. Specialized short-term technical assistance mechanism

In Section IV, Summary of Expected Results and Illustrative Activities, a number of specialized, short-term technical assistance needs were identified. For example, assistance to develop research protocols, leading to important intervention-linked research, was highlighted. This specialized short-term assistance can be provided through an interagency agreement (technically a Participating Agency Services Agreement, or PASA) with another U.S. Government agency. One possibility, subject to the ability to extend the authority to use the remaining available funds, would be to use the existing PASA agreement with CDC that currently supports both the CDC Advisor to the national DOH and USAID's HIV/AIDS Advisor. Sufficient funds remain in this agreement to provide the needed specialized short-term assistance, which will probably be required only during Phase 1 of the CAPACITY Project (Years 1-3). If this arrangement is somehow not possible, then a new PASA could be negotiated and executed with the U.S. Department of Health and Human Services or one of its sub-agencies (e.g., CDC or NIH). In either case, the level of technical assistance and the corresponding cost are relatively low (approximately \$300,000-400,000).

B. Program Management

1. USAID/SA Personnel

Internal USAID/SA management and oversight of this program will be the responsibility of a full-time professional manager (expected to be a South African) who will report to the SO3 Team Leader, and will be assisted by an Administrative Assistant. The program manager will coordinate the providers of technical assistance and the overall activity management team. These two staff members will be funded by the grant (see the budget in Section VIII).

2. CAPACITY Project Management Team

The broad oversight and guidance for the program's activities will be provided by a management team composed (at a minimum) of representatives from the national DOH, focus province DOHs, the institutional contractor, and USAID/SA. NGOs and other representatives of the networks may also have a role either in the management team or in an advisory capacity. The team's

deliberations will be advisory given US foreign assistance funding laws and regulations, but will function essentially as the EQUITY Project Strategic Management Team operates. The team will meet periodically (initially probably monthly) to approve project implementation plans, discuss operational and strategic issues, and generally oversee project implementation. At a broader level, the team will consult annually with an expanded team of individuals who represent non-focus provinces and organizations to insure that the CAPACITY Project is providing assistance that meets the needs of these stakeholders as well.

The Management Team's effectiveness will be affected by the nature and quality of information it receives on progress and problems. Although the details have not yet been worked out, the individual networks from the three focus provinces will also function as management teams in their respective provinces. Thus, one of their responsibilities will be to keep the overall CAPACITY Management Team apprised of progress and problems, so that areas requiring attention can be adequately and promptly addressed.

3. Linkage with other USAID/SA Strategic Objective Teams

As described in Section II, the SO3 staff responsible for managing the program will also be responsible for linking with other USAID strategic objective teams to explore means to integrate HIV/AIDS programing information into their programs and to establish relationships among grantees, contractors, etc., as opportunities present themselves.

4. Criteria for activity selection

Section IV describes a number of high-priority, illustrative activities which are planned to achieve the intended results for each of the five major activities at both national and provincial levels. As the implementation plans are fine-tuned and finalized for approval by the CAPACITY Project Management Team, the activities selected for each province and the national DOH should be based on the following criteria:

- Potential for achieving both programmatic and financial sustainability (e.g., the provincial networks, including the task teams, should be sustainable by the end of Year 3).
- Clear and demonstrable link to the intermediate results and sub-IRs for the CAPACITY Project.
- High priority in relation to the phasing of implementation (e.g., establishment of the task teams is an early priority for network development).
- Feasibility in relation to what the activity is supposed to achieve.
- Potential for achieving impact on the relevant target population(s).

VIII FINANCIAL PLAN

C. Financial Plan

1. Resource Requirements

USAID Contribution: The funding for the CAPACITY Project is anticipated to be \$10.0 million as shown in the table on the following page. Of this amount, USAID has already obligated a total of \$4 million in previous fiscal years for the new HIV/AIDS activity. In addition, SO3 expects to obligate \$2 million in 1998, \$2 million in 1999 and \$2 million in 2000. The USAID program-funded management costs will amount to approximately six percent of the total USAID program funding for this Result Package - covering the cost of a full-time program manager and administrative assistant for the HIV/AIDS program, plus other program-related administrative costs. Therefore, of the \$10.0 million anticipated for the CAPACITY Project, \$600,000 (or approximately \$120,000 annually) will be used to fund SO3 program management costs.

The illustrative budget contains a 5% inflation factor and a 10% contingency. The inflation factor provides a cushion against the inevitable inflation which South Africa will experience. The contingency will provide flexible funding to cover the cost of activities which will undoubtedly be identified during program implementation as critical constraints to achieving program objectives. This contingency will be especially needed to provide flexibility during Phase II of the program (years 4 and 5) which will be designed in detail following a mid-term evaluation to be conducted at the beginning of year 3.

Counterpart Contribution: The Department of Health will provide to USAID an assurance that it will meet the 25 percent requirement for a counterpart contribution prior to obligation of funds under the proposed bilateral agreement. This contribution is expected to be the Rand equivalent of approximately \$3.3 million, to be provided incrementally as implementation occurs. This counterpart contribution will be provided through DOH budgetary support for HIV/AIDS/STD/TB program activities. USAID and the DOH will agree on appropriate line items from the national and focus province budgets to support the CAPACITY Project. Each year the DOH will report on actual expenditures under these agreed upon budget categories. USAID will review these expenditure reports and formally advise the DOH of the approved annual contribution against the total counterpart requirement. USAID will develop and negotiate an agreement with the DOH on an appropriate tracking and reporting system to accurately reflect the total counterpart contribution.

IX. PERFORMANCE MONITORING AND EVALUATION PLAN

A. The Results Framework

The detailed performance monitoring and evaluation plan (PM&E) for this RP appears as Annexure C. The indicators included in this plan were summarized in the discussion of the results framework in Section IV.A. In addition to these indicators of progress towards achieving IR5 and the various contributing lower-level results, indicators are included to complement those already tracked by USAID/South Africa at the mission goal level and the strategic objective level.

At the USAID/South Africa goal level, where "Improved Health Status" is the relevant sub-goal for this activity, HIV prevalence figures among young women at antenatal clinics will be used as a general indicator of the course of the HIV/AIDS epidemic in South Africa. At the Strategic Objective level, trends in the use of condoms with "non-regular" partners will indicate the extent to which South Africans have begun to adopt safer sexual behavior, the most effective method to prevent HIV transmission. This indicator is intended to measure the overall level of success achieved by the South African health system, and South African society in general, in facilitating the behavioral changes necessary to reduce the impact of HIV/AIDS. It joins comparable indicators established at the SO level: the contraceptive prevalence rate to indicate use of family planning, and immunization coverage rates to indicate use of child survival services.

The remaining indicators under IR5 comprise various measurements of essential intermediate results toward building South African capability to achieve this success, addressing necessary steps in capacity-building, policy development, and technical advancement that the mission's program will pursue. These preliminary indicators, shown in Annexure C, may change during early CAPACITY Project implementation when the illustrative activities described in Section IV will be refined and finalized. During this process, a number of lower-level "milestones" will likely be established to help monitor annual progress towards achieving impact.

B. Data Collection

The indicators in the results framework and the corresponding performance monitoring plan have been selected with data collection needs in mind. For the majority of the indicators, reporting will not require the creation of new data collection tools. Tables for each indicator in the Performance Monitoring and Evaluation Plan specify the source of data (see Annexure C). Data collection instruments to be used include:

Demographic and Health Survey (DHS): Two national, population-based surveys examining knowledge and behavior in the areas of health (including HIV/AIDS) and family planning are already scheduled for implementation during this RP. These surveys will not require any additional funding under this RP. The 1998 DHS will coincide with the RP start-up of activities and will establish timely baselines for two of the indicators in the PM&E Plan; a follow-up

survey is scheduled for 2003, the year that activities under this RP are scheduled to be completed. Two of the 19 indicators included in the PM&E Plan will rely on the DHS.

Routine Activity Reporting. Data for all of the lower-level indicators will be the product of routine reporting by implementing organizations.

National and Provincial Government Data. Data for two indicators (HIV prevalence and the percentage of health budget allocated to HIV/AIDS/STD and TB programs, will be routinely available from the national and provincial DOH. Data to monitor the HIV/AIDS policies of various ministries will also be available from the DOH.

Health Facility Surveys, Organizational Assessments and Policy Assessments. Data on service quality, organizational capacity, and the policy environment will require the implementation of health facility surveys and other assessments of organizational capacity and the policy environment. Wherever possible, relevant available data will be solicited from national and provincial governments and NGOs. Capacity-building for monitoring and evaluation at the provincial level will be designed to facilitate the collection of relevant data by provincial organizations and the networks, both for their own use and for USAID/South Africa's performance monitoring needs.

Where special survey tools are required, past experience of USAID/South Africa, USAID/Washington, and USAID's development partners in South Africa will facilitate the creation of such tools. USAID/South Africa is already engaged in monitoring organizational capacity in other sectors and can use this experience to great advantage for performance monitoring under this RP. The Mission is also supporting health facility surveys in Eastern Cape Province under the CAPACITY Project. Tools to assess the HIV/AIDS policy environment have been created and put into operation elsewhere for USAID performance monitoring and are available from G/PHN/HIV-AIDS.

C. Evaluation

As discussed in earlier sections, there will be a comprehensive evaluation of the CAPACITY Project early in Year 3. The purpose is both to assess overall progress during Phase 1 and to determine needed changes in strategy and/or implementation in order to achieve the intended impact. This evaluation will also help to determine technical assistance and project management needs during Phase 2 (Years 4-5).

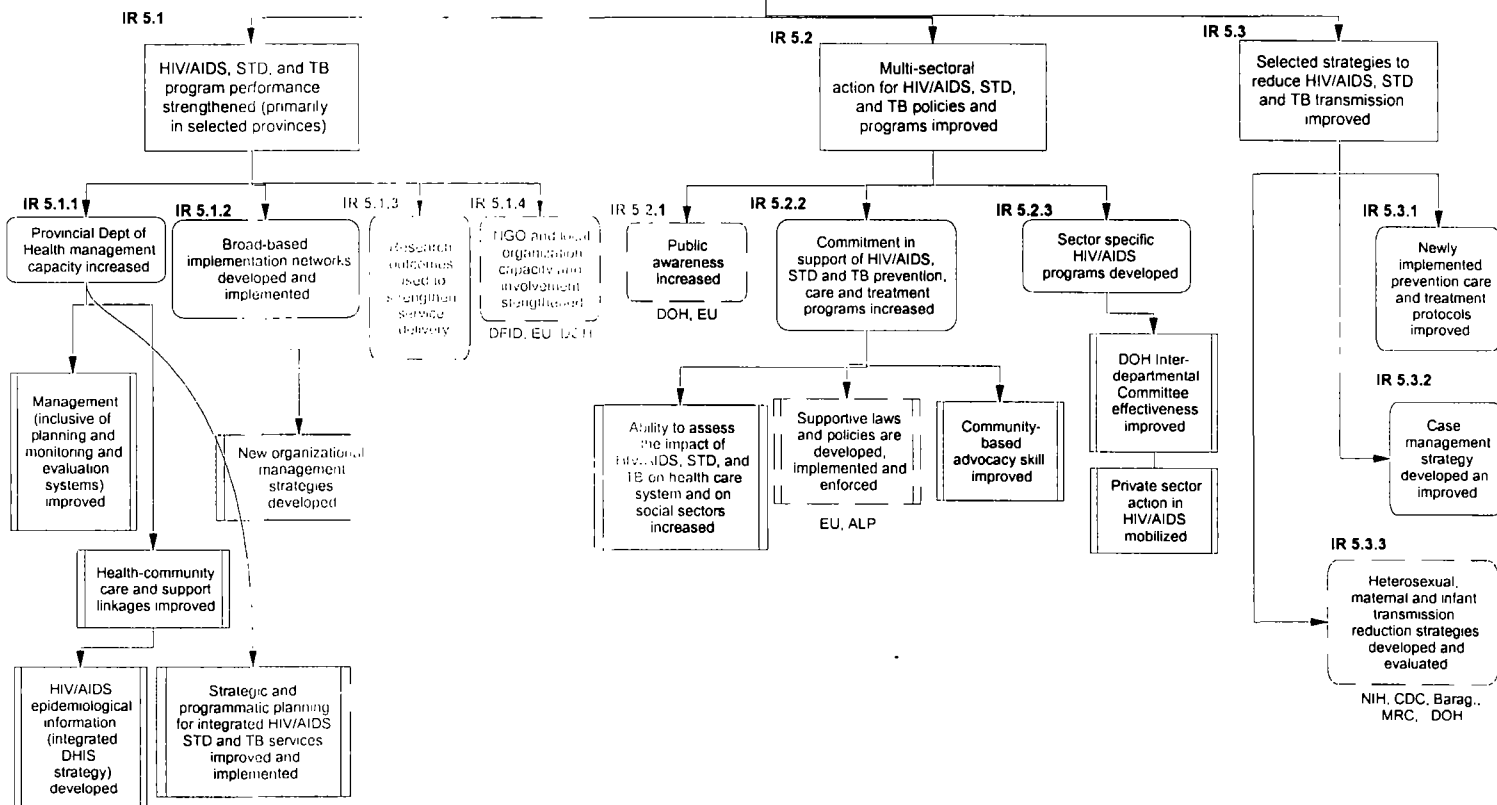
In addition, the Project Management Team is expected to develop mechanisms and a time frame for periodic (e.g., annual) evaluation of progress based on the results achieved through annual implementation plans.

DRAFT
11/21/97

More equitable, unified, and sustainable system delivering
integrated PHC services to all South Africans

IR 5

**Enhanced capacity to
provide effective HIV/AIDS,
STD, and TB prevention,
care, and treatment**



ANNEX B

Sub-Goal: Political, Economic and Social Development

Goal / Result: Improved Health Status						
Indicator	Baseline Year & Value	1998	1999	2000	2001	2002
HIV prevalence, pregnant women age 15-24, antenatal clinics nationwide	15.2% (1996)					
Data Unit:	percent					
Data Source:	DOH					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: 1. This indicator is recommended by WHO (Prevention Indicator 9). 2. Baseline can be revised in 1998 to coincide with start of RP activities. 3. Data quality has been inconsistent from some provinces but is expected to improve. 4. Baseline calculated from DOH estimates for national population (<i>Epidemiological Comments</i> 23:2 (1997), p. 12, Table 3).						

Strategic Objective 3: More equitable, unified and sustainable system delivering integrated PHC services to all South Africans

SO3: More equitable, unified and sustainable system delivering integrated PHC services to all South Africans						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
% of people ages 15-49 who report the use of a condom during the most recent act of sexual intercourse with a non-regular partner - males - females - total	t.b.d. (1998)					t.b.d.
Data Unit:	percent	Numerator = men and women ages 15-49 who report use of condom in last act of sexual intercourse with a non-regular partner. Denominator = men and women ages 15-49 who report act of sexual intercourse with a non-regular partner in the last 12 months. For definition of "non-regular partner," see South Africa DHS 1998.				
Data Source:	DHS					
Frequency of Data Availability:	5 years					
Responsible Officer:						
Comments: 1. This is a USAID "Common Indicator." 2. Baseline and target can be established after results of 1998 DHS are available. 3. USAID-supported interventions will contribute to safer sexual behavior, and specifically increased use of condoms, among South Africans by improving access to effective HIV/AIDS prevention programs. Although not the only method of reducing the impact of HIV/AIDS, safer sexual behavior is currently the single most effective means of reducing HIV transmission.						

IR5: Enhanced capacity to provide effective HIV/AIDS, STD, and TB prevention, care, and treatment						
Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
1. Individuals presenting with STDs in health facilities who are assessed and treated in an appropriate way (according to national standards)	t.b.d.			t.b.d.		t.b.d.
Data Unit:	percent	Definition of appropriate is determined by national standards.				
Data Source:	health facility surveys					
Frequency of Data Availability:	every 2-3 yrs.					
Responsible Officer:						
Comments: 1. EQUITY is establishing a baseline for Eastern Province focussing on syndromic management of STDs. 2. Definition of agency-wide "Common Indicator" includes appropriate diagnosis only. Data for the common indicator will be available as a component of the above indicator ("assessed and treated in an appropriate way") and may be reported to G/PHN/HIV-AIDS separately.						

IR5: Enhanced capacity to provide effective HIV/AIDS, STD, and TB prevention, care, and treatment						
Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
% service delivery points for HIV/STD, STD, and TB prevention, care, and treatment meeting basic minimum quality criteria (in selected provinces)	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	svc. delivery points	<i>service delivery points for:</i> - HIV/STD, STD, and TB prevention and case management - support for people living with AIDS, family members, and survivors <i>criteria:</i> to be determined through input from Provincial Networks and national coordinating body				
Data Source:	health facility survey / assessment					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: USAID monitoring on this indicator will rely on the development of program monitoring capacity at the provincial level in focus provinces. Reporting from Provinces will come from the provincial DOH and/or the provincial capacity-building networks.						

IR5.1: HIV/AIDS, STD, and TB program performance strengthened (primarily in selected provinces)						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
Number of provinces where integrated HIV/AIDS, STD, and TB services are routinely offered with PHC services	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	province	Specific criteria for integration of services to be determined.				
Data Source:	USAID/DOH assessment					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: USAID's impact on integration of services will occur both in focus provinces and on a national level. Monitoring on this indicator will therefore consider developments on the national level though the greatest impact will presumably occur in focus provinces.						

IR5.1.1: Provincial Department of Health management capacity improved						
Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
Provincial DOHs that are capable of designing, implementing, and evaluating HIV/AIDS, STD, and TB activities	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	Prov. DOH	Provincial DOH = Provincial Office of Department of Health Definition of "capable of designing, implementing, and evaluating HIV/AIDS, STD, and TB activities" to be determined through consensus among USAID, the Provincial Capacity-Building Networks, and the national coordinating body.				
Data Source:	organizational survey / assessment					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: 1. The following organizational assessment tools may be adapted to suit the mission's needs to assess institutional development of Provincial Departments of Health in the context of program performance monitoring: a. PASCA model has been proposed by G/PHN/HIV-AIDS as an instrument for USAID units to assess management capacity for HIV/AIDS programs in particular (see G/PHN/HIV-AIDS PMP). b. PACT model was prepared specifically to monitor organizational capacity in the NGO sector and is being considered as a model for measuring NGO capacity building results (see PACT Handbook). c. "Organizational Capacity Guide" is a survey instrument designed by the Human Sciences Research Council to measure capacity and effectiveness of organizations assisted under USAID/South Africa's SO4, supporting economic growth (see HSRC, Organization Capacity Assessment Instrument). 2. Because USAID's greatest impact will presumably occur in focus provinces, survey instruments will monitor developments in those provinces only. Reporting may be conducted on the national level only if sufficient data are readily available to assess capacity elsewhere.						

IR5.1.2: Broad-based implementation networks formed and improved						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
- # of Provinces where HIV/AIDS Community-Building Networks have been established - # of Provinces where all three Task Forces have established Action Plans - # of Provinces where all three Task Forces have implemented Action Plans	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	Prov. DOH					
Data Source:	assessment by USAID/South Africa					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments:						

IR5.1.3: Research Outcomes Used to Strengthen Service Delivery						
Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of times research findings, evaluation results, or improved protocols adopted or applied in subsequent program design and implementation	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	adoption or application					
Data Source:	monitoring by USAID implementing partner					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: Monitoring for progress under this IR will be conducted as follow-up to monitoring of intervention-linked research conducted under IR5.3.						

IR5.1.4: NGO and local organization capacity and involvement strengthened						
Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of NGOs that are capable of designing, implementing, and evaluating HIV/AIDS, STD, and TB activities	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	NGOs					
Data Source:	see comment					
Frequency of Data Availability:	annual (see comment)					
Responsible Officer:						
Comments: 1. USAID will not be held accountable for this result but may track progress to check assumption that others are achieving the result. Monitoring responsibility may ultimately lie at provincial level and/or with the DOH, DFID, or EU implementing organizations. 2. Some options for monitoring methods are outlined under IR5.1.1. 3. G/PHN/HIV-AIDS has proposed to monitor a "Measure of HIV/AIDS Community Based Organization (CBO) Institutional Strength (number with minimum institutional strength composite indicator)" which may inform efforts to monitor this indicator.						

IR5.2: Multi-sectoral action for HIV/AIDS, STD, and TB policies and programs improved						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
AIDS Policy Environment Score • national • by focus province	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	index score					
Data Source:	USAID implementin g partner					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: The AIDS Policy Environment Score is an agency-wide "Common Indicator." It is calculated through an index examining the degree to which the policy environment in a given country supports efforts to: (1) prevent the spread of HIV/STDs (2) provide quality care for people with AIDS (3) ensure the rights of people with AIDS (4) ameliorate the negative impact of AIDS on individuals, families, communities, and society						

IR5.2.1: Public awareness increased						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
% of people aged 15-49 citing at least three acceptable ways of protection from HIV/STD infection - males - females - total	t.b.d. (1998)					t.b.d.
Data Unit:	percent	Acceptable ways of protection include 1. Abstinence 2. Use of condom 3. Reduction of number of partners/mutual monogamy				
Data Source:	DHS					
Frequency of Data Availability:	5 years					
Responsible Officer:						
Comments: 1. USAID will not be accountable for progress toward this intermediate result but will monitor the indicator in order to check the assumption that awareness is increasing. Though the result implies an increase in general awareness of HIV/AIDS, STDs, and TB, the indicator focusses on personal awareness of methods to prevent HIV transmission, for which data will be readily available following the 1998 Demographic and Health Survey (DHS). Other interim survey data may be used if available before a second DHS (planned for 2003). 2. This indicator will be monitored globally by G/PHN/HIV-AIDS. A variation on this indicator is recommended by WHO (Prevention Indicator 1, specifying that only two methods need to be cited).						

IR5.2.2: Commitment in support of HIV/AIDS, STD, and TB prevention, care, and treatment programs increased						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
% of government health budget allocated to HIV/AIDS, STD, and TB programs - national - by focus province	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	percent	Reporting to include both numerator and denominator as well as percentage. Numerators may also be reported adjusted for inflation to better indicate the real trend in spending in fixed-value currency.				
Data Source:	Budget reports by Govt. of RSA, Provinces					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: Budget figures are a proxy for overall public sector commitment. The national figure is nearly identical to the agency-wide common indicator, which specifies spending allocated to HIV/AIDS programs only. If available, national budget data for HIV/AIDS programs only may be provided as well.						

IR5.2.3: Sector-specific HIV/AIDS programs developed						
Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of government ministries with appropriate HIV/AIDS policies	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	ministry	appropriate HIV/AIDS policies = establishment of HIV/AIDS program within sector; appropriate internal policies (<i>needs refining</i>)				
Data Source:	DOH					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: 1. This indicator is intended to measure the effectiveness of advocacy efforts by the DOH Interdepartmental Committee on HIV/AIDS. 2. Scores from individual questions on the AIDS Policy Environment Index survey instrument may also inform reporting on this indicator.						

IR5.2.3: Sector-specific HIV/AIDS programs developed						
Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
Number of commercial firms with appropriate HIV/AIDS policies	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Collection Method: Data Source:	firm assessment by USAID implementing partner	appropriate HIV/AIDS policies – providing HIV/AIDS information and services to their employees; appropriate internal policies (employee regulations, insurance coverage, etc.) (needs refining)				
Frequency of Data Availability:	annual (?)					
Responsible Officer:						

Comments:

1. G/PHN/HIV-AIDS plans to monitor a similar indicator on a global level: *Number Commercial Firms Providing HIV/AIDS Information and Services to their Employees*. This may be calculated and reported separately.

2. Scores from individual questions on the AIDS Policy Environment Index survey instrument would also inform reporting on this indicator.

IR5.3: Improved Strategies to reduce HIV/AIDS, STD, and TB transmission						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of reduction strategies evaluated # of reduction strategies improved # of new reduction strategies developed	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	strategy	"Reduction strategies" include means to interrupt heterosexual transmission and maternal-infant transmission of HIV as well as other methods of STD prevention and control				
Data Source:	USAID implementing partners					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments:						

IR5.3.1 Newly-implemented prevention, care, and treatment protocols improved						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of protocols evaluated # of protocols improved	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	protocol					
Data Source:	USAID implementin g partners					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments:						

IR5.3: Improved Strategies to reduce HIV/AIDS, STD, and TB transmission						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of reduction strategies evaluated # of reduction strategies improved # of new reduction strategies developed	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	strategy	"Reduction strategies" include means to interrupt heterosexual transmission and maternal-infant transmission of HIV as well as other methods of STD prevention and control				
Data Source:	USAID implementing partners					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments:						

IR5.3.2: Case management strategy improved						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
Case management strategy developed Case management strategy improved	no (1998) no (1998)	t.b.d.	t.b.d.	t.b.d.	t.b.d.	yes yes.
Data Unit:	strategy	Define case management strategy here				
Data Source:	USAID implementin g partners					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments:						

IR5.3.3: Heterosexual, maternal, and infant transmission reduction strategies improved						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of reduction strategies evaluated # of reduction strategies improved # of new reduction strategies developed	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	strategy					
Data Source:	other donors, implementing partners					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: USAID will not be accountable for progress toward this intermediate result but will monitor the indicator in order to check the assumption that strategies such as barrier methods are being evaluated and improved.						