

A REPORT OF THE CSIS GLOBAL
HEALTH POLICY CENTER

The Future of the U.S.–South Africa HIV/AIDS Partnership

TRIP REPORT OF THE CSIS DELEGATION TO SOUTH AFRICA, JANUARY 2013



March 2013

Delegation Members

Sally Canfield	Heidi Ross
Christy Gleason	Sharon Stash
Alisha Kramer	Todd Summers
Anne Oswalt	Tom Walsh



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THE FUTURE OF THE U.S.–SOUTH AFRICA HIV/AIDS PARTNERSHIP

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Introduction

South Africa has the highest burden of HIV/AIDS in the world, with 5.6 million people living with the virus and over 400,000 newly infected annually. Since 2004, the United States government has committed more than \$4 billion to combating HIV/AIDS in South Africa—the largest U.S. investment in HIV/AIDS worldwide. Continued progress in controlling HIV/AIDS in South Africa, the epicenter of the pandemic, is pivotal to sustained progress against the disease worldwide.

Over the past three years, a joint U.S.–South Africa effort has been underway to transition responsibility for HIV/AIDS programming and policies to the South African government. The South African and U.S. governments negotiated a Partnership Framework outlining the broad terms of this transition; the agreement was signed in October 2010 by former Secretary Clinton and her South African counterpart Maite Nkoana-Mashabane. Through this process, the United States is moving from a lead role in the provision of lifesaving services to an approach focused increasingly on technical support.

The quickly evolving partnership is among the most important dimensions of the United States' bilateral relationship with South Africa. A successful U.S.–South Africa transition will bolster confidence in the U.S. Congress in U.S. funding for HIV/AIDS, as well as inform U.S. approaches during similar transitions with other partner governments in the future.

To examine the transition's progress and challenges, and to assess it as a model for similar efforts in other countries, the CSIS Global Health Policy Center led a delegation to South Africa in August 2011. The delegation drew from its visit five recommendations to U.S. policymakers: do more to get the facts out to those responsible for the transition, especially at the provincial, district and service provider levels; strengthen the U.S. and South African negotiating teams; develop a five-year mutually agreed framework that includes clear milestones; improve communications to the public, in particular to people living with HIV who benefit from U.S. support, and nongovernmental providers and advocacy groups; and signal clearly that the U.S. commitment to the partnership is long-term, extending beyond a five year transition plan.¹

CSIS sponsored a second delegation to South Africa in January 2013, including CSIS staff, senior staff from four Congressional offices, and a representative of the Bill & Melinda Gates Foundation. The central aims were to gain a deeper understanding of how this vitally important U.S.–South Africa transition has continued to evolve since August 2011; examine what critical challenges lie ahead during the Obama administration's second term, when a central U.S. policy

1. Suzanne C. Brundage, *Terra Nova: How to Achieve a Successful PEPFAR Transition in South Africa* (Washington, D.C.: CSIS, December 2011), <http://csis.org/publication/terra-nova>.

focus will be to achieve successful transitions that effectively promote country ownership and shared responsibility; and to formulate priority, actionable policy recommendations for consideration by the Obama administration and the U.S. congress.²

Mutual Self-interest Drives Progress Forward

A number of important advances have been made since the CSIS delegation visited South Africa in August 2011.

In August 2012, the U.S. and South African governments signed a Partnership Framework Implementation Plan (PFIP) laying out a detailed and mutually agreed five-year timeline. Central to the transition plan is a reduction in U.S. annual assistance from \$484 to \$250 million by 2017, as South African health commitments are projected to increase from \$1.1 to \$1.8 billion over the same period. The U.S. funding decrease will be relatively small for the first three years, as South Africa expands its responsibilities; but after 2015, U.S. aid will drop precipitously.

South Africa developed a national strategic plan for HIV/AIDS, which provides a basis for both countries to set realistic goals and assess costs, current capacities, and future requirements. South Africa and the United States have created several new joint bodies to manage the transition, deepening bilateral planning and trust. In addition, discussions have commenced on how the three principal funding streams—from the South African government, PEPFAR, and the Global Fund to Fight AIDS, Tuberculosis and Malaria—could be integrated better to make the most of limited resources.

Increasingly, the United States is investing in activities designed to improve the sustainability of South Africa's HIV/AIDS program, as the United States shifts from a model focused predominantly on service delivery to one focused on technical assistance. The South African government, which now covers more than 70 percent of total national HIV/AIDS expenditures, has assumed lead responsibility—politically, financially, and organizationally—to meet ambitious targets to expand HIV/AIDS treatment, care, and prevention activities.

The progress made in the transition process so far reflects considerable good faith on both sides, thanks in large part to high-level engagement from the U.S. secretary of state, the South African president, ministers of international relations, health and finance, and their envoys and senior health officials.

It was clear to the CSIS delegation that both countries feel they have a substantial stake in an orderly, well-planned, and coordinated transition, and both are strongly motivated to ensure success. Both countries understand that the transition cannot place at risk the 2.5 million persons on antiretroviral treatment in South Africa, of whom PEPFAR supports approximately 1.7 million. Achieving this level of coverage has been an extraordinary accomplishment, which accelerated after the Zuma government came to power in late 2009.

Both countries also recognize that the transition cannot jeopardize South Africa's political commitment to expand treatment to 3 million persons by the end of 2014 and to broaden access to care and prevention services.³

2. Details on the delegation and its itinerary are in appendix E.

3. See appendix A: The HIV/AIDS Epidemic and Response in South Africa.

During its visit, the CSIS delegation witnessed the impressive dynamism of South Africa's premier medical schools and nongovernmental organizations (NGOs) whose work has resulted in major advances in HIV treatment and prevention, including medical male circumcision, the first partially effective vaginal gel to prevent HIV acquisition by women (a microbicide), and guidelines for treating TB in HIV-positive individuals.

Recognizing the private sector's key role in combating HIV/AIDS, the delegation also visited clinical sites supported by global mining firm Anglo American. As South Africa's largest private sector employer, Anglo American has pioneered impressive programs for HIV-positive workers and their families, utilizing innovative programmatic and technical approaches.⁴

Considerable Risks and Uncertainties

It was clear to the delegation that South African political and health leaders fully endorse the transition, even though opinions vary over details and optimal timing. That said, despite its considerable achievements so far, the U.S.–South Africa transition remains vulnerable. Unresolved technical and political challenges will require continued high-level focus in the coming years.

The transition's timing and tempo, as laid out in the PFIP, are a source of continuing debate—in particular concerning the gap between the ambitions laid out in the transition plan and the on-the-ground realities. While there is a strong case for using agreed PFIP schedules to drive change, many South Africans, both inside and outside government, have legitimate fears that a rushed transition, at a time of weak South African capacities, could disrupt life-sustaining HIV treatment and seriously damage confidence among South African citizens. At present, provincial and district government facilities are insufficiently equipped to assume responsibilities for the many people who have been receiving HIV treatment through nongovernmental channels.

Before 2010–2011, when the transition began in earnest, U.S.-supported NGOs provided treatment for approximately 80 percent of all South Africans on HIV/AIDS drugs, and U.S. programs paid staff salaries for more than 20,000 health workers delivering care through NGOs, which have significant, proven capacity to deliver services in both urban and rural settings. It is difficult to ensure continuity of services patient-by-patient, as patients are shifted from the responsibility of NGOs to government agencies, because the necessary information systems are not yet in place. In addition, the South African government suffers from poor internal communication, coordination, and trust, most evident in the acutely strained relations between the national government, on the one side, and authorities at the provincial and district levels on the other. The complex roots of this dysfunction lie both in the legacy of the apartheid era's racial domination and in challenges that have intensified since the 1994 transition to democracy: acute economic disparities across regions; intense political rivalries based on party affiliation and ethnicity; and the choice by several provinces during the Mbeki era to defy national policy and take the lead in providing treatment to address South Africa's HIV/AIDS crisis.

The CSIS delegation repeatedly heard a number of timing-related questions for which there are, as yet, no ready answers.

For example, will the South African government be able to meet its steeply rising financial commitments beyond 2015 (the period for which the Ministry of Finance has already obligated

4. See appendix B: Public-Private Partnership: Anglo American.

resources)? What will happen if it cannot? The current plan envisions a relatively brief, 36 month window of continued high U.S. financial support, followed by a sudden decline by almost 50 percent of U.S. funds: how realistic is that strategy? Also, how will the critical handoff from NGOs to the South African government be accomplished, and will it be handled effectively?

Four additional concerns rose to the fore in the delegation's discussions.

First, in the rush to expand treatment, South Africa may lose its focus on HIV prevention. Despite impressive gains in preventing mother-to-child transmission of HIV, more than 17.3 percent of adults are currently infected with HIV and the country's rates of new infections remain among the highest in the world—especially in a few highly impacted provinces, for example, KwaZulu Natal and Gauteng. While the national HIV/AIDS strategic plan aligns with the core elements of the U.S. approach for an AIDS-free generation, it remains unclear whether South Africa will have the political will to pursue these prevention goals in earnest, as it struggles to cover increasing treatment costs.

Second, gender violence remains a profound, urgent challenge. While women and girls in South Africa enjoy strong rights and protections under the national constitution and policies, in reality they are subject to (and have inadequate recourse from) exceptionally high levels of sexual abuse and violence. This results in grave health implications, including high rates of HIV infection. Young girls in particular are at extremely high risk of HIV infection relative to boys of the same age. The situation defies quick fixes, and there are limited proven effective interventions to curb the spread of HIV/AIDS in this vulnerable group. Nonetheless, given the gravity of the problem, gender violence demands higher levels of attention throughout the transition, by both the South African and U.S. governments.⁵

Third, the Global Fund has yet to be fully integrated into a three-way dialogue with the South African and U.S. governments to better plan investments by these three major HIV/AIDS funding sources. With a newly adopted strategy and funding model, the Global Fund seems well positioned to join the United States in supporting the South African government's HIV/AIDS strategy. However, as of the date of this report's publication, the Global Fund is not a full partner in the discussions.⁶

Fourth, the United States, whose leverage as a donor and partner will steadily wane as its funding declines, faces several serious challenges: balancing competing policy interests; redeploying its staff to priority needs; defining clearly its technical assistance contributions; and resolving persistent interagency tensions among the Office of the Global AIDS Coordinator, USAID, and CDC.

At times, competing interests pull the United States in contrary directions. For example, the United States is trying simultaneously to expedite the process through which the South African government assumes greater responsibility for care and to protect individuals living with HIV who have been receiving U.S.-supported treatment services. This also has created a communication challenge, with the United States wanting to assure patients and their direct care providers of its ultimate commitment to continuity of care while at the same time maintaining pressure on the South African government to take over.

Though the United States is expected to help address critical gaps in the transition, technical assistance priorities have not yet been defined, and U.S. staff remain heavily concentrated in Pretoria, the capital city, rather than in the key provinces and districts where detailed transition work is taking place.

5. Appendix C: Gender Dynamics of the AIDS Epidemic.

6. Appendix D: Global Fund.

Finally, while the delegation saw evidence of improved U.S. interagency collaboration, it also heard blunt reports of lingering interagency turf and budget battles (involving OGAC, USAID, CDC) from several high-level U.S. officials.

Recommendations

The United States has made significant advances in its transitional partnership with the South African government. To carry that progress forward, the CSIS delegation recommends five priority steps.

1. *Intensify high-level engagement to oversee progress.* There should be regular, senior level U.S.–South Africa assessments of the transition, with a special focus on making adjustments to the timing and pace of implementation that match the realities on the ground; anticipating and preparing for contingencies, such as funding shortfalls; and better integrating the Global Fund into planning. Priorities for the United States should include resolving interagency tensions, strengthening the U.S. ambassador’s ability to bring about a unified U.S. approach, and devising better metrics and milestones for evaluating the impacts of U.S. investments.
2. *Channel U.S. technical assistance to priority provincial and district sites.* U.S. technical assistance should be targeted to clearing critical management roadblocks in those provinces and districts that bear the largest burden of HIV infections and have the most people on treatment: they represent the transition’s fault line. U.S. expert personnel should be deployed on a priority basis to these same provinces. The U.S. government should test strategies for transferring service delivery from NGOs to the national government. One promising solution may lie in hybrid government-NGO services, institutional arrangements in which the United States has considerable expertise.
3. *Work to elevate gender’s priority in South African policy and programming:* U.S. government officials should work with South African counterparts to ensure a serious push over the next five years to employ South Africa’s research community and NGO implementers to improve HIV prevention for young girls. U.S. funding of high-quality implementation research, innovative programs, and improved program evaluations could set the stage for successful efforts to be implemented at scale by the South African government.
4. *Channel U.S. technical assistance to priority prevention programs:* The United States remains at the forefront of prevention efforts in South Africa and needs to stay engaged. Strong, consistent U.S. leadership is needed to expand targeted investments, by all funding sources, in a combination of high-impact HIV prevention interventions, including male circumcision, early treatment with antiretroviral drugs, condoms, testing and counseling, and prevention for most-at-risk populations. Investments in prevention now will maximize the benefits of new scientific findings, paving the way for a more effective HIV prevention program in South Africa. It also will help defray the considerable human and financial costs of HIV/AIDS.
5. *Work with the South African government to expand partnerships with South African innovators:* South African universities, medical centers, NGOs, and businesses have produced innovative health technologies and models of private sector care for HIV/AIDS. The U.S. government should use its leverage to ensure more robust public and private sector investments in South African partnerships that improve the delivery of HIV/AIDS services, including the development of new technologies.

Closing

The U.S.–South Africa transition on HIV/AIDS has shown impressive achievements in the past year and a half, grounded in the shared desire to protect the interests of South Africans living with HIV, and reflective of the enduring national interests of both the South African and U.S. governments. This period has also brought forward far more clearly the risks, vulnerabilities, and uncertainties embedded in this complex process.

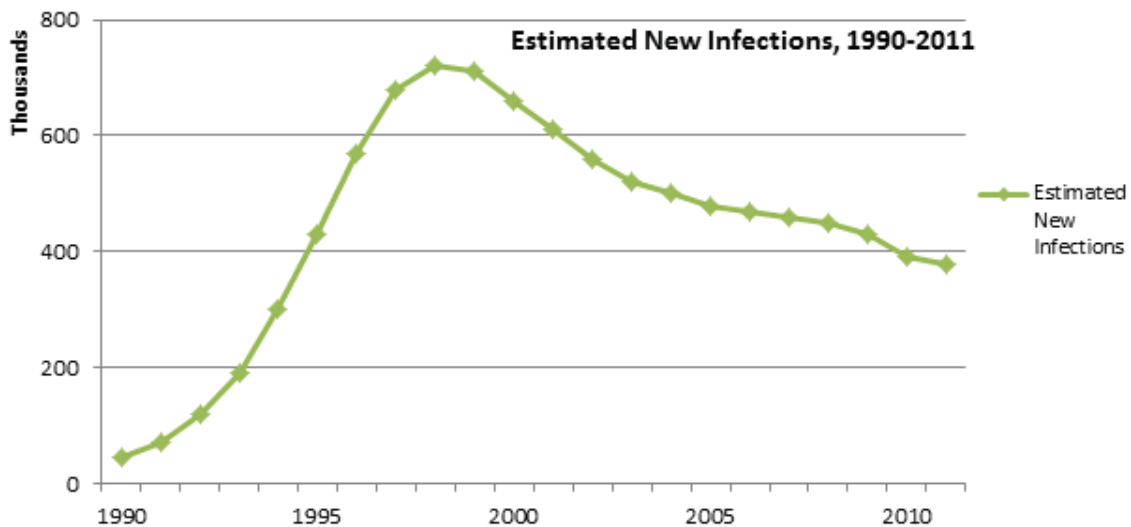
The transition will not be a clean, expedited shift from service delivery to technical support. Continued progress will require considerable time and patience, careful pragmatic management of the gap between ambitious plans and realities on the ground, and continuous high-level leadership and oversight.



APPENDIX A

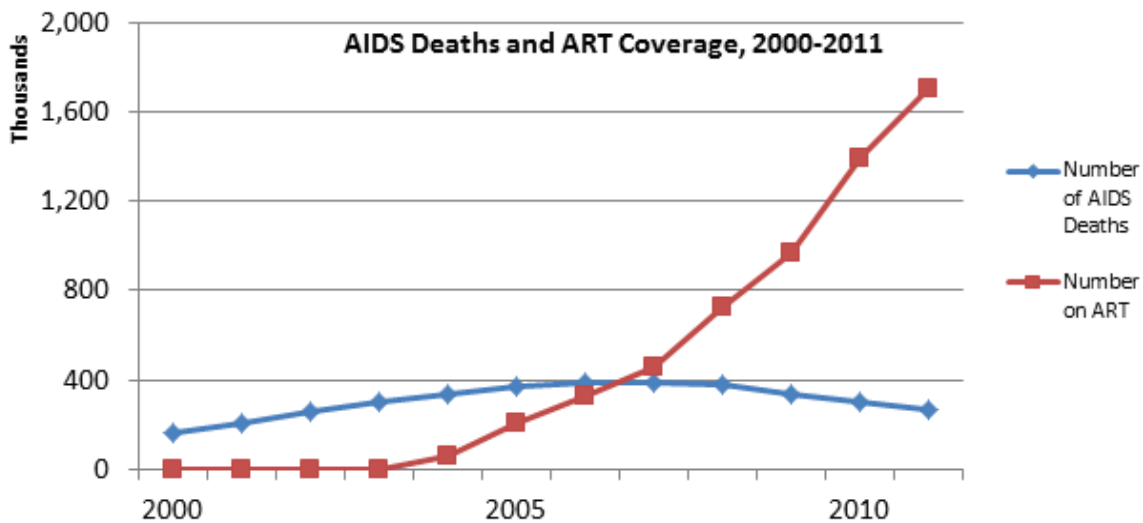
THE HIV/AIDS EPIDEMIC AND RESPONSE IN SOUTH AFRICA

HIV/AIDS in South Africa, 1990–2011



HIV rates in South Africa in 2011 remained among the highest in the world, with about 17.3 percent of adults (age 15–49) infected and approximately 410,000 new infections annually. Although new HIV infections began to decline around 2009, and have continued to do so, HIV prevention remains a high priority.

AIDS Deaths and ART Coverage, 2000–2011



Access to HIV/AIDS treatment has expanded rapidly over the last 5 years. Currently about 56 percent of people who are eligible for treatment are receiving antiretroviral drugs and AIDS deaths have begun to decline. U.S. PEPFAR helped provide treatment to about 1.7 million South Africans in 2012.⁷

7. Analysis of data from UNAIDS, “AIDSInfo: South Africa, 2010,” <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>.



APPENDIX B PUBLIC-PRIVATE PARTNERSHIP: ANGLO AMERICAN

Anglo American is a mining company with large-scale operations in South Africa. When the HIV/AIDS epidemic exploded in the late 1990s, Anglo began to see significant losses in worker productivity and company profits. At the epidemic's peak, Anglo needed to have a back-up employee for every skilled worker; it was uncertain when sick workers would be absent or disappear altogether.⁸

Anglo concluded that investing in detection and treatment for HIV/AIDS was smart business, as providing ART to one worker for one month cost \$126 but resulted in savings of \$219. Anglo American's coal mines created systems and structures to provide health services, specifically HIV/AIDS testing and treatment. The success of Anglo's program illustrates the potential impact the private sector can have on preventing, tracking, and treating new HIV infections, as well as for creating innovative approaches to health service delivery.

Testing and treatment. Anglo started offering treatment to all employees and their dependents in August 2002. In 2003, due to a high prevalence of stigma and discrimination, less than 10 percent of employees got tested for HIV; but by 2012, over 90 percent of Anglo's workforce was tested. The uptake of services by Anglo employees can be attributed in part to a dedicated group of peer educators—unpaid volunteers who encourage HIV testing and counseling.

Tracking. Anglo made a strategic decision to track their epidemic very closely. Daily updates on the number of HIV tests administered and the number of new infections recorded enables Anglo to track incidence of HIV infection in its workforce and to keep senior management informed and engaged.

Innovation. In addition to testing and treatment, Anglo created an advanced electronic health record system that uses fingerprint recognition technology connected with databases in the cloud to collect health-related information and track HIV and TB incidence. Anglo is piloting this new technology, Health Source, in two impoverished areas.⁹ The CSIS delegation visited one of these sites at the Ndlovu Medical Centre.

8. Interview with Anglo American management team, January 17, 2013.

9. World Coal Association, "Anglo American HIV/AIDS Programme: South Africa," February 2012, <http://www.worldcoal.org/resources/case-studies/anglo-american-hiv-aids-programme/>.



APPENDIX C GENDER DYNAMIC OF THE AIDS EPIDEMIC

Gender inequality is an important driver of the HIV/AIDS epidemic in South Africa. Women and girls are disproportionately affected by HIV/AIDS, with social and structural factors increasing their risk of HIV infection and complicating their situation once infected. As a result, women and girls account for more than 52 percent of all those living with HIV in South Africa.¹⁰

A key characteristic of the HIV epidemic in South Africa is the age-sex difference in HIV acquisition rates; young women acquire HIV infection about five to seven years earlier than their male peers as a result of intergenerational sexual patterns.¹¹ These age-sex disparate relationships sustain the HIV epidemic in South Africa. Not surprisingly, the power differences in these relationships limit young women and girls' ability to negotiate if, when, and how they have sex. As a result, young women and girls bear a disproportionate burden of HIV/AIDS, with infection in 15- to 19-year-old girls three to six times as high as males of the same age.¹²

The economy's influence on women's vulnerabilities has also received increased attention, as experts focus more on the structural drivers of the HIV/AIDS epidemic. For instance, women's movements to urban centers, driven by declining economic prospects and unemployment in rural areas, coupled with the growth of informal squatter settlements around industrial and commercial centers, continue to heighten the epidemic's trajectory in South Africa.¹³

Although South Africa's national constitution established unprecedented rights for women and girls and ensures their equality under the law, social statistics suggest continuing challenges. A complex set of factors, related to South Africa's history of apartheid and struggle for independence, labor migration, and gender norms result in high levels of partner violence and rape. Research from South Africa shows that women who have experienced sexual abuse in childhood are at a two-thirds greater risk of HIV infection; women who have experienced intimate partner violence are also more likely to be infected with HIV.¹⁴

To address the gender-related drivers of South Africa's HIV/AIDS epidemic, the South African government should pay greater attention to gender-based violence; access to legal services to pros-

10. UNAIDS, "HIV/AIDS Estimates (2011)," <http://www.unaids.org/en/regionscountries/countries/southafrica/>.

11. Olive Shisana et al., *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008: A Turning Tide Among Teenagers?* (Cape Town: HSRC Press, 2009).

12. Ibid.; and Warren Parker et al., *Concurrent Sexual Partnerships Amongst Young Adults in South Africa: Challenges for HIV Prevention Communication* (Johannesburg: Centre for AIDS Development, Research and Evaluation, 2007).

13. Mark Lurie et al., "Circular migration and sexual networking in rural KwaZulu/Natal: implications for the spread of HIV and other sexually transmitted diseases," *Health Transition Review* 7, supp. 3 (1997).

14. Rachel K. Jewkes et al., "Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study," *The Lancet* 376, issue 9734 (2010).

ecute rape and violence; intergenerational sex; women and girls' education and economic empowerment; and female controlled methods of HIV prevention. Political and tribal leaders should put the safety and well-being of women and girls at the top of their agendas, both to protect the rights of women and girls and to address key drivers of the AIDS epidemic.



APPENDIX D GLOBAL FUND

The Global Fund to Fight AIDS, Tuberculosis, and Malaria has to date invested \$307 million in South Africa through twelve grants for HIV and tuberculosis.¹⁵ South Africa has four active grants managed by two governmental and three civil society organizations that provide financial support for 10 percent of the country's antiretroviral treatment budget. In addition, these grants fund tuberculosis detection, medical male circumcision, behavioral change communication, voluntary counseling and testing, home based care, and HIV drug resistance monitoring and capacity building.¹⁶

The past 12 months were marked by increased tensions with the South African government as implementation challenges, coupled with a risk-averse Global Fund, caused significant delays in grant disbursement and triggered a review by the Global Fund's Inspector General. Grants are more or less back on track, but lingering negative views of the Global Fund remain among some South African officials and advocates.

As PEPFAR funding begins to decrease, it will become increasingly important to review, coordinate, and find efficiencies in other available resources. This is just the kind of transition envisioned by PEPFAR leadership, which hopes to ramp up domestic support in-country and Global Fund support as it reduces funding through its bilateral channels.

Under the Global Fund's new grant management structure, South Africa is identified as a "High Impact Country," a designation that brings increased staffing and oversight. Under its recently approved new funding model, which weights funding towards countries with higher disease burdens, South Africa should have access to additional money, even though it is an upper-middle-income country.

For the next three years, the Global Fund has identified opportunities for financing South Africa's HIV/AIDS response in the following areas: filling the treatment gap; supporting HIV prevention among key populations; encouraging community treatment adherence; and continuing TB/HIV activities.¹⁷ However, ultimate success will depend on the degree to which PEPFAR, the South African government, and the Global Fund can work with greater synergy in this next important phase.

15. The Global Fund, "South Africa," February 2013, <http://portfolio.theglobalfund.org/en/Country/Index/SAF>.

16. The Global Fund, Briefing Note, January 2013.

17. The Global Fund, Briefing Note, January 2013.



APPENDIX E DELEGATION AGENDA

Delegation Members

Ms. Sally Canfield, Deputy Chief of Staff for Policy, Senator Marco Rubio (R-FL)
Ms. Christy Gleason, Senior Policy Adviser, Senator Chris Coons (D-DE)
Ms. Alisha Kramer, Research Assistant & Program Coordinator, CSIS Global Health Policy Center
Ms. Anne Oswalt, Senior Health Policy Adviser, Senator Bob Corker (R-TN)
Ms. Heidi Ross, Senior Policy Adviser, Congressman Eliot Engel (D-NY)
Dr. Sharon Stash, Deputy Director & Senior Fellow, CSIS Global Health Policy Center
Mr. Todd Summers, Senior Adviser, CSIS Global Health Policy Center
Mr. Tom Walsh, Senior Program Officer, Bill & Melinda Gates Foundation

Monday, January 14: Pretoria

Country team meeting with senior U.S. embassy officials, led by Charge d'Affairs Virginia Palmer.

Meeting with South Africa's National HIV/AIDS program officials:

Dr. Fareed Abdullah, South African National AIDS Council (SANAC)
Ms. Sholeen Mooljee, Department of International Relations and Cooperation
Ms. Nono Simelela, Special Adviser to Deputy President Motlanthe

Working Lunch on epidemic trends and drivers of HIV/AIDS:

Dr. David Allen, Bill & Melinda Gates Foundation
Dr. Rachel Jewkes, Medical Research Center
Ms. Steve Letsike, Civil Society Representative, SANAC

Meeting with U.S. PEPFAR team in South Africa:

Ms. Christina Chappell, Director, Health Office for USAID/Southern Africa
Dr. Nancy Knight, Country Director, CDC in South Africa
Mr. James Maloney, PEPFAR Coordinator for South Africa

Meeting with Global Fund representatives:

Mr. Victor Bampoe, South Africa Fund Portfolio Manager
Mr. Jorge Mancillas, Specialist in Donor Relations

Dinner on the political and social context of the HIV/AIDS epidemic in South Africa:

Dr. Brian Brink, Chief Medical Officer, Anglo American PLC Group

Ms. Janet Love, Legal Resources Center, Johannesburg

Mr. Neil Morrison, Adviser to McKinsey&Company, Johannesburg

Dr. Ayanda Ntsaluba, Executive Director, Discovery Holdings, Johannesburg

Professor Helen Rees, University of Witwatersrand, Johannesburg

Tuesday, January 15: Orange Farm, Johannesburg, and Durban

Visit to Orange Farm Voluntary Medical Male Circumcision site, Gauteng Province

Working lunch on health systems strengthening:

Dr. Farley Cleghorn, Futures Group, Washington, D.C.

Ms. Rehmeth Fakroodeen, Medical & Nursing Education Partnership Initiative

Mr. Dion Guy, Supply Chain Management Systems (SCMS)

Dr. Letitia Robinson, Medical & Nursing Education Partnership Initiative

Dinner with Consul General to Durban, Taylor Ruggles, PEPFAR Liaison Chalone Savant, and Kwazulu-Natal provincial authorities, Durban

Wednesday, January 16: Durban

Visit to eThekweni regional tuberculosis hospital and clinical research site

Working lunch on biomedical prevention interventions for HIV/AIDS with Dr. Salim Abdool Karim

Site visit to CAPRISA Offices at the Doris Duke Medical Research Institute

Thursday, January 17: Johannesburg and Limpopo

Site visit to Anglo American thermal coal mine and presentation on workplace HIV/AIDS

Site visit to Anglo American Highveld hospital

Site visit to Ndlovu Medical Center

Friday, January 18: Pretoria

Meeting with South Africa Department of Health officials:

Ms. Malebona Precious Matsoso, Director General, MOH

Dr. Yogan Pillay, Deputy Director General, MOH

Dr. Nono Simelela, Special Adviser to the Deputy President Motlanthe

Out-briefing with U.S. embassy officials



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