Reimagining the Future of Global Health Initiatives

Country Case Study Summary

South Africa

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### Acronyms and Abbreviations

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<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>BOD</td>
<td>Burden of Disease</td>
</tr>
<tr>
<td>BRICS</td>
<td>Brazil, Russia, India, China and South Africa</td>
</tr>
<tr>
<td>C19RM</td>
<td>COVID-19 Response Mechanism</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CEPI</td>
<td>Coalition for Epidemic Preparedness Innovations</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>COP</td>
<td>Country Operational Plan</td>
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<tr>
<td>COVID-19</td>
<td>Coronavirus Disease 2019</td>
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<tr>
<td>CSOs</td>
<td>Civil Society Organisations</td>
</tr>
<tr>
<td>DAH</td>
<td>Development Assistance for Health</td>
</tr>
<tr>
<td>FIND</td>
<td>Foundation for Innovative New Diagnostics</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>GHIs</td>
<td>Global Health Initiatives</td>
</tr>
<tr>
<td>GHS</td>
<td>Global Health Security</td>
</tr>
<tr>
<td>HiB</td>
<td>Haemophilus influenzae type b</td>
</tr>
<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
</tr>
<tr>
<td>HR</td>
<td>Human resources</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communication Technology</td>
</tr>
<tr>
<td>IFIIm</td>
<td>International Finance Facility for Immunisation</td>
</tr>
<tr>
<td>KIIIs</td>
<td>Key Informant Interviews</td>
</tr>
<tr>
<td>LMIC</td>
<td>Low- and middle-income countries</td>
</tr>
<tr>
<td>MDR</td>
<td>Multidrug-resistant</td>
</tr>
<tr>
<td>MOH</td>
<td>Minister of Health</td>
</tr>
<tr>
<td>MOUs</td>
<td>Memoranda of Understanding</td>
</tr>
<tr>
<td>NCDs</td>
<td>Non-communicable Diseases</td>
</tr>
<tr>
<td>NDOH</td>
<td>National Department of Health</td>
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<tr>
<td>NGOs</td>
<td>Non-governmental Organisations</td>
</tr>
<tr>
<td>NHI</td>
<td>National Health Insurance</td>
</tr>
<tr>
<td>OOP</td>
<td>Out of pocket payment</td>
</tr>
<tr>
<td>PCV</td>
<td>Pneumococcal conjugate vaccine</td>
</tr>
<tr>
<td>PEA</td>
<td>Political Economy Analysis</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President's Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission pre-exposure prophylaxis</td>
</tr>
<tr>
<td>SA</td>
<td>South Africa</td>
</tr>
<tr>
<td>SAHPRA</td>
<td>South African Health Products Regulatory Authority</td>
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<td>SANAC</td>
<td>South African National AIDS Council</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal Health Care</td>
</tr>
<tr>
<td>UMIC</td>
<td>Upper Middle-Income country</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
</tbody>
</table>
USG United States Government
WHO World Health Organization
YLL years of life lost
1. Introduction

South Africa (SA) is a young democracy, where a new post-apartheid dispensation began in 1994. The need to transform social conditions, to create a country that serves all its people, and to forge an independent way forward, without domination, is very much embedded in the consciousness of those who live and work there. In SA, political parties and a broad range of stakeholders are vested in the health interests of the local population. However, despite being an upper-to middle-income country, vast inequality drives the persistence of infectious diseases, which are diseases of poverty.

Global Health Initiatives (GHIs) provide resources, expertise, and support to address priority public health issues, improve healthcare infrastructure, provide optimal health services, and achieve health goals. SA is neither wholly dependent on GHIs, bilateral organizations, and other donors to support its health system, nor is it in an economic position to independently transition from support. This case study aimed to better understand challenges experienced by SA as a recipient of GHI funding, and to provide unique insights into the understanding of the role of GHIs, within a context in which political independence, and by extension health systems independence, are strongly held values that exist alongside the acknowledgement that support from GHIs and other donors remains essential. This case study therefore explored the future of GHIs within the local context over the next 15–20 years from the perspective of a range of local stakeholders holding senior government positions, and who lead public health research, implementation, and support within southern Africa.

2. Methods

2.1. Study design
A multi-method qualitative research design (key informant interviews (KIIs) and an online consultation) was employed. Secondary analyses of datasets and literature were conducted to assess the burden of disease (BOD), health financing trends and GHIs relevant to SA.

2.2. Data collection and analysis
Key SA stakeholders representing government, Civil Society Organisations (CSOs), academia, the private sector, and non-governmental organisations (NGOs) were purposively selected based on experience, expertise, and knowledge of GHIs. Data were collected using KII and an online group consultation. A summary of the participants is presented in Table 1. Thematic and Political Economy Analysis (PEA) were undertaken to analyse the data.
### Table 1 Online KII and online consultation demographics

<table>
<thead>
<tr>
<th>Type of Respondent</th>
<th>Number (n=)</th>
</tr>
</thead>
<tbody>
<tr>
<td>South African Government (n= 2 Presidency/National Treasury; n= 4 Department of Health (NDOH); n=2 Provincial representative; n=1 District)</td>
<td>9</td>
</tr>
<tr>
<td>Academic</td>
<td>7</td>
</tr>
<tr>
<td>Regional organisation with South African footprint</td>
<td>2</td>
</tr>
<tr>
<td>Non-governmental organisation/Civil society organisation</td>
<td>4</td>
</tr>
<tr>
<td>Regional organization with a South African footprint</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>

### 3. Context: South African Health System

#### 3.1. Governance architecture, services, and challenges

Post-1994, health reforms were introduced in SA to redress past injustices due to apartheid, and redesign the primarily hospital-centric, curative care-focused health system, which then mostly catered for the minority White population. The health system was also highly fragmented due to the apartheid regime’s creation of underserved homelands (Bantustans), which serviced the larger African Black population, as well as due to a split in the management and financing of health services between national, provincial and municipal levels of government.

Transformation efforts therefore focused on integrating health services to ensure equitable access to good healthcare, no matter where people lived, or at what level they were seeking health services. The decentralized public health system is now designed as a single national health authority with three government tiers: one National Department of Health (NDOH), nine provinces and 52 districts. Despite integration, the federal nature of national government means that provinces work within the national health framework, while maintaining some fiscal and decision-making autonomy. The public health sector is nurse-driven, with primary health care (PHC) the key focus delivered through the District Health System. SA has a mixed health system comprising both public and private sectors. Most of SA’s population (>80%) is uninsured and therefore receives care within the public health sector. The private sector services the remaining (<20%) citizens and consumes about 50% of all healthcare expenditure in SA compared to the public sector. Consequently, SA has a dual health system where the private sector is highly resourced (e.g. doctors, hospitals, beds) and contributes an approximated similar proportion of health expenditure compared to the public sector. To address these inequities, and despite strong opposition and vociferous public debate from political parties and several private sector actors, the National Assembly passed the National Health Insurance (NHI) Bill in June 2023, thereby approving legislation for establishing a
financing mechanism towards attaining universal health care and providing high quality health care in years to come.

The NDOH is responsible for developing national health policies, setting standards, monitoring and evaluating health service performance nationally, and overseeing health regulatory bodies. Its six programmes focus on administration, NHI, communicable and non-communicable diseases (NCDs) PHC, hospital systems, health system governance, and human resources (HR). Provinces manage provincial budgets, adapt national and make local policies, employ and manage staff, and deliver health services. The NDOH receives an annual budget allocation from National Treasury, primarily sourced through nationally raised general tax revenue, of which the bulk is allocated to provinces using a formula based on service demands (i.e., equitable share formula allocations) and direct conditional grants. PHC services are free and are positioned as the entry point into the health system. A range of preventive (e.g., childhood immunizations) and curative (e.g., tuberculosis (TB) and HIV/AIDS treatment) services are offered at PHC level. Referrals are to district, regional, and tertiary hospitals, depending on individual healthcare needs.

Despite numerous successes, the SA health system remains fragmented and inequitable, and SA faces a number of challenges to delivering high-quality health care. A recent review of SA health reforms 2015–2020 concluded that much is still required to strengthen the health system, and that political will, stewardship, and combating corruption are key to facilitating reform. Focal areas include gender inequality, the health of women and girls, intersectoral collaboration to address the broader determinants of health and enhancing the effectiveness of health services, and active citizenry to hold government accountable. In recent years, there has been little progress and important challenges towards developing implementation plans and preparing SA for NHI. Key changes will include creating a central funding pool, including public and private health financing, and managing the disbursement of funds for a predefined package of health services provided by the public and private sectors from the NHI fund.

3.2. Key strategies, policies, and plans
The Presidency developed a National Development Plan which provides recommendations to strengthen the health sector and system and forms the basis for numerous reforms, policies, and programmes. Since 1994, the NDOH developed several National Strategic Health Plans based on 5-year medium-term strategic frameworks, as well as Annual Performance Plans and Annual Reports. In turn, these form the basis of provincial strategic plans and monitoring frameworks. Several key programmatic strategic plans and policies have been developed, including the National Strategic Plan for HIV/AIDS, TB, and STIs, the Malaria Elimination Strategic Plan for South Africa 2019–2023, and the National Strategic Plan for the Prevention and Control of Non-Communicable Diseases 2020–2025.
4. Context: National Burden of Disease, Health Financing Trends, and GHIs in-country

4.1. Demography and epidemiology

In SA, 2% of adults live below the upper-bound poverty line. In 2022, the country’s population was 60.6 million, with an average life expectancy of 62.8 years. The fertility rate declined to 2.24 in 2022 from a peak of 2.66 in 2008. However, the population remains young, with 28.6% of citizens aged 0–14 years. Regardless, the population is showing a trend toward gradual ageing, with the proportion of citizens 60 years or older increasing from 1% in 2002 to 3% in 2019. SA is highly inequitable, with a Gini Coefficient of 63 and a low human capital index of 0.43 in 2020. This reflects the massive socio-economic challenges facing SA, including high unemployment rates (32.4% in 2022), educational attainment of less than 10%, and worsening poverty.

4.2. Burden of disease

SA faces a quadruple BOD, including HIV/AIDS and tuberculosis (TB), NCDs, other infectious diseases, maternal, newborn and child health, and violence. In 2000, the top single cause of mortality burden was HIV/AIDS followed by homicide, tuberculosis, road traffic accidents and diarrhoea. HIV/AIDS accounted for 38% of years of life lost (YLL) and was proportionally higher for females (47%) than for males (33%). Diseases of poverty and underdevelopment (including other communicable diseases, maternal, neonatal, and nutritional diseases) accounted for 25%; NCDs for 21%, and injuries for 16% of YLL. A later report on the BOD showed that in 2012 the quadruple BOD had persisted, but reversal of trends for HIV/AIDS, NCDs, and injury mortality were observed. In recent years, HIV-related mortality has declined, and TB, as a specific disease, and NCDs as a group, are now the leading causes of death, with just under 60% of total deaths attributable to these conditions in 2018. The major contributors to deaths from NCDs were diabetes mellitus, cardiovascular disease, other forms of heart disease, and hypertension. Injuries were the cause of 10% of deaths in SA in 2018. In 2019, the top risk factors driving the BOD included unsafe sex, risk factors for obesity, hypertension, and diabetes mellitus, and child and maternal malnutrition. SA has both significant under- and overnutrition, with 13% of children overweight, while of those under 5 years 6% were underweight, 3% wasted and 27% stunted for age. Only 30% of women and 59% of men were within the normal body mass index range, with a significant percentage being either overweight or obese. Infant and under-5 mortality had increased substantially in the 2000s due to HIV/AIDS but have since decreased, largely due to the availability of antiretrovirals and Prevention of Mother to Child Transmission (PMTCT) and donor funding support from the GFATM and PEPFAR. A steady decrease in neonatal mortality has been noted over time. Despite these gains, these mortality rates remain unacceptably high.
### 4.3. Morbidity

SA is on the global “high burden” lists for TB, HIV-associated TB, and multidrug-resistant (MDR) TB, and is one of only nine countries appearing on all three lists.\(^{20}\) The overall prevalence of TB in SA is 737 per 100,000 population based on a national TB Prevalence Survey conducted in 2018.\(^{21}\) \(^{22}\) Although the TB incidence and prevalence remain high, they have decreased from an estimated incidence of >2000 per 100,000 in the early 2000s largely due to increasing access to antiretroviral treatment (ART) and the subsequent decline in HIV-associated TB. Nevertheless, the prevalence remains high at 737 per 10,000 population and >50% of TB cases are still associated with HIV/AIDS, hence a major risk factor for TB.\(^{21}\) \(^{22}\)

Despite progress in its response to HIV/AIDS, SA remains at the epicentre of the HIV/AIDS pandemic. HIV/AIDS prevalence in the total population was estimated at 13.4 in 2020, and more than seven million South Africans of all ages are living with HIV/AIDS.\(^{23}\) Women experience a disproportionate burden of the disease. This sex and gender disparity is most pronounced among adolescent girls and young women aged 15–24 years, whose HIV/AIDS prevalence is much higher than males of the same age.\(^{24}\) Other affected vulnerable groups are men who have sex with men, sex workers, transgender people and people who inject drugs.

Between 2015 and 2019, SA had between about 10,000 and 30,000 notified cases of malaria per year.\(^{25}\) In 2021, the reported incidence was 0.5 per 100,000 population.\(^{26}\) The country successfully reduced cases and deaths from malaria by 90% over the past 20 years and is targeting elimination by 2023.\(^{27}\) \(^{28}\) Malaria is currently limited to the northeastern part of the country in low-altitude areas, and the disease is distinctly seasonal, with the highest risk during the wet summer months.

NCDs are a leading cause of morbidity, with a prevalence of diabetes mellitus of 10.4% in citizens older than 15 years, and a prevalence of hypertension of 44% among adults aged 30–79 years.\(^{21}\) South Africans also experience a high burden of mental health disorders, with an estimated 12-month prevalence of 16.5% for common mental illnesses.\(^{29}\)

### 4.4. Service coverage

A relatively good overall health coverage score of 67 conceals extensive inequities across the public and private health sectors, health districts, race, and income groups in SA.\(^{30}\) The World Bank’s estimates of the UHC service coverage in SA in 2019 was 67, on par with the equivalent global average. Although access to health care has improved over the past few decades, the quality of care remains a concern, with less than 20% of health facilities meeting national quality standards in 2018/2019. The country had, however, made progress towards achieving the Sustainable Development Goal for maternal mortality, neonatal mortality, HIV/AIDS, and TB incidence, but had not shown improvements overall for under-five mortality and NCD mortality.\(^{31}\)

TB-effective treatment coverage for SA in 2021 was 57%.\(^{32}\) This measure combines TB treatment coverage with treatment success rates to estimate the proportion of TB cases that are detected and successfully treated. SA has the largest ART programme in the world and has
set targets for achieving the triple 90% for diagnosis, initiation of ART, and viral suppression on treatment. SA is also the first sub-Saharan country to approve and provide HIV pre-exposure prophylaxis. SA estimates are between 62–68% for 2021, representing the proportion of people living with HIV/AIDS on ART who were virally suppressed. Although approximately 92% of people living with HIV/AIDS knew their status in 2020, 73.7% were initiated on ART and 62% were virally suppressed in 2021. SA is also the first sub-Saharan country to approve and provide HIV pre-exposure prophylaxis.

Despite improvements in access to antenatal care, with 94% of pregnant women in SA receiving prenatal care in 2016, only 75.5% attended at least four antenatal visits during their pregnancy. Pregnant women tend to present late to health services, with approximately 68% attending the 1st antenatal visit before 20 weeks’ gestation between 2019 and 2021. The low couple year protection rate of 54% in 2019/20 and high teenage pregnancy rates of 14% (proportion of deliveries) in 2021 remain a concern. National coverage of immunisation under one year of age has shown a general upward trend, but at 83.5%, is still below the Global Vaccine Action Plan 2020 target of 90% coverage. Although the reported immunisation coverage levels of 87% for Pneumococcal conjugate vaccine (PCV) and 86% for Haemophilus influenzae type b (HiB) in 2021 exceed the global average of 51% and 71% respectively, the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) estimates of immunization coverage for SA show that, since 2014, coverage of individual doses has either plateaued or dropped. Several outbreaks of measles have occurred in the past decade, and coverage of individual vaccines including DTaP-IPV-Hib-HBV and measles further declined during the Coronavirus Disease 2019 (COVID-19) pandemic.

In terms of NCDs, diabetes mellitus treatment coverage (the percentage of patients receiving treatment) was 37.5% in 2020; and the treatment gap for mental health care is high with only one in four people with a common mental health disorder receiving treatment of any kind.

4.5. Global health security

The Global Health Security (GHS) Index benchmarks health security in the context of other factors critical to fighting outbreaks, such as political and security risks, the broader strength of the health system, and country adherence to global norms. SA ranked 56 out of 195 countries assessed, with a score of 45.8, exceeding the global average of 38.9 out of 100. Of the six categories assessed, the country scored lowest on health systems capacity (29.2), prevention (32.1) and compliance with international norms (43.1); and slightly better on detection and reporting (50), the risk environment (58.5) and rapid response (62). The International Health Regulations core capacity score measures the average percentage of attributes of 13 core capacities that have been attained at a specific point in time per country, largely for outbreak and other significant disasters preparedness and response. The country’s score of 79% suggests that much of the appropriate capacity is in place and differs somewhat from the GHS Index findings.

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1 Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (HiB) and hepatitis B vaccine
4.6. Health financing trends

SA spends around 14.9% of the total government expenditure on health, and more than 8% of the overall gross domestic product on healthcare. In 2018, this exceeded the average expenditure on health by Upper Middle-Income countries (UMIC), and approximates the target of 15% health expenditure agreed to by African Union member countries to support the achievement of UHC. The annual growth in health expenditure between 2011 and 2020 exceeded 8% per annum; however, post-COVID-19, the budget growth declined to a 2% increase per annum. Government health expenditure represents the largest portion of health spending (54%), with the private sector contributing around 38%, and out-of-pocket payments around 7.7%.

Importantly, donor funding, which includes GHIs, represents a relatively small portion of overall health expenditure at approximately $616 million per annum, representing <5% of total health expenditure. Furthermore, additional external donor funding is channelled directly to a range of institutions and civil society organizations and does not appear on the national health accounts with most donor funding allocated for HIV/AIDS.

The largest donor is the United States President’s Emergency Plan for AIDS Relief (PEPFAR) (under $500 million per annum), which was excluded from our present discussion. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is the second-largest country donor and the single largest of the GHIs under review. Since its inception, the GFATM has disbursed $970 million to SA. For the 2023–2025 cycle, $536 million is allocated for HIV/AIDS and TB; of this amount, $463.6 million (86.5%) is allocated to HIV programmes, and $72.4 (13.5%) to TB programmes.

In SA, the bulk of spending on HIV (79.8%), TB (66.5%) and malaria (74.7%) are from government sources. Development Assistance for Health (DAH) represents 15.6% of HIV/AIDS funding, 26.8% of TB funding and 2.9% of malaria funding (Table 2), with the government providing the bulk of these services. No data was available from this source for DAH financing of other health areas in SA.

SA has to raise the vast majority of its malaria financing due to its low disease burden (a large amount of imported cases are from neighbouring countries) and UMIC status, which largely excludes it from external funding. However, SA bears some of the regional burden. Nevertheless, SA is a recipient of regional, cross-border initiatives funded by the GFATM (Elimination 8 and MOSASWA initiatives). This is unfortunately insufficient to address existing health challenges. In response, SA mobilized its own domestic financing using a five-step resource mobilization strategy for investment. Domestic malaria financing was subsequently increased by the government, and a new conditional grant for malaria was developed. SA also co-finances malaria control efforts in Mozambique. This serves as a lesson for other countries in the region on the value of technical assistance and interdisciplinary collaboration and use of data and research for decision-making.
### Table 2: Health Expenditure (by source) on different programmes in South Africa in 2017 (Source: [https://vizhub.healthdata.org/fgh/](https://vizhub.healthdata.org/fgh/))

<table>
<thead>
<tr>
<th>Spending as % of total health spending (2017)</th>
<th>HIV/AIDS</th>
<th>TB</th>
<th>Malaria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>79.79%</td>
<td>66.50%</td>
<td>74.70%</td>
</tr>
<tr>
<td>Private</td>
<td>3.18%</td>
<td>2.72%</td>
<td>22.38%</td>
</tr>
<tr>
<td>Out of pocket payments (OOP)</td>
<td>1.39%</td>
<td>3.98%</td>
<td>0.05%</td>
</tr>
<tr>
<td>Development Assistance for Health (DAH)</td>
<td>15.64%</td>
<td>26.80%</td>
<td>2.86%</td>
</tr>
</tbody>
</table>

### 4.7. Comparison of BOD and health financing trends: do they align?

The perspectives below are based on the analysis of the data presented above:

- The trends in the burden of disease in SA suggest that NCDs as a group have become the leading cause of mortality and morbidity, overtaking communicable diseases and other diseases of poverty in SA. TB as a specific disease, is the leading natural cause of mortality, with HIV/AIDS ranking fifth. The drop in HIV/AIDS as a cause of mortality and morbidity is largely because of the increasing availability and uptake of ARVs. HIV/AIDS (and its sequela including TB) however remains a leading cause of years lived with disability, and unsafe sex the leading risk factor.
- The rise in morbidity and mortality due to NCDs is largely due to high levels of risk factors and the aging of the population but is also compounded by underdiagnosis and poor quality of care for NCDs. The prevalence of these conditions is also rising in people living with HIV/AIDS on antiretroviral therapy. High rates of injuries remain the fourth major group contributing to morbidity and mortality.
- The available information on the current funding focus of GHI’s, namely the GFATM, is that despite their very small contributions to overall health financing in the country, it is no longer aligned with the changing burden of disease profile in SA, and with the further increases in NCDs will increasingly fall out of sync with the burden of disease. Currently, TB receives 13.4% of GFATM financing, but is a major cause of mortality in SA. Maternal and child health receive some GHI funding, largely linked to HIV/AIDS, TB, and reproductive health. However, NCDs, injuries and mental health appear to receive no or very little (one or two projects support improving diagnosis of chronic diseases) funding from GHI’s.
- There is little evidence that GHI funding has fully targeted the social and commercial determinants of health which contribute to NCDs, injuries, as well as communicable diseases and other diseases of poverty. The GHI’s funding for HIV/AIDS and TB has included very limited support for health systems strengthening overall, and the underlying weaknesses in the health system have persisted despite the improved diagnostic and treatment modalities for HIV/AIDS and TB.
- SA has committed to achieving universal health care for all and is implementing major reforms in the form of the NHI system to support these efforts. However, some of the challenges to achieving universal health care (UHC) are the poor quality of care delivered and ongoing inequities in health and the health system. Thus, increasingly policy and planning are focusing on addressing the health system weaknesses to not only improve access to care, but also the quality of care to improve the prevention of and treatment outcomes of all the diseases which contribute to morbidity and mortality in SA.
5. GHIs in South Africa

Only three GHIs under study operate in SA, and as indicated above PEPFAR is a major development funder.

5.1. The GFATM to Fight AIDS, TB, and Malaria

SA received its first funding from GFATM in 2002, with an initial grant focusing on supporting efforts to combat NCDs, particularly addressing the high HIV/AIDS burden. Further grants (2004–2011) were provided to scale up HIV prevention, and access to treatment. SA is included in several multi-country grants being implemented across groups of countries in the region. It also receives funding as part of the GFATM’s COVID-19 Response Mechanism, which supports countries to mitigate the impact of COVID-19 on programs to fight HIV, TB, and malaria, and initiates urgent improvements in health and community systems. In terms of total funding, SA is one of the leading countries for GFATM investments. SA has also mobilized and managed an enormous flow of domestic resources over the last decade.

In SA, the GFATM focuses on strengthening key HIV prevention activities which include those for key and vulnerable populations, TB diagnosis, and promotes and protects human rights and sex/gender equality. During the COVID-19 pandemic, GFATM through its COVID-19 Response Mechanism (C19RM) provided grant flexibilities and funding support (grant savings of USD12.3 million) and USD52.2 million of C19RM were provided in 2020 to support community COVID-19 responses and for HIV prevention and TB screening, with 87% absorption as of mid-2021. More funds were awarded in September 2021 (USD161 million).

In 2022, the GFATM and SA signed four HIV and TB grants totalling up to US$547 million for 2022-2025. GFATM grants to SA for 2022-2025 are designed to leverage opportunities within the country to further strengthen partnerships to deliver quality health services to all. The engagement between GFATM and SA emphasizes a multisectoral approach, with close ties to the government, CSOs, and other partners.

Of the GHIs under review, only the GFATM provides support at a large scale in SA and through a process supported by the South African government. As per its mandate, proposals are received via the Country Coordinating Mechanism (CCM) which is described as a partnership comprising all key stakeholders in the country’s response to HIV and TB. The CCM does not ‘handle [GFATM] financing itself’ but submits proposals to the Fund based on local needs. It is co-chaired by the Chief Operating Officer of the South African National AIDS Council (SANAC) and a member of civil society. There are four principal recipients, of which the NDOH is one as are several NGOs. The NDOH is thus both a member of the CCM and a principal recipient.

The situation is different with respect to the GFATM compared to Unitaid and Foundation for Innovative New Diagnostics (FIND). Decisions on the proposals to be funded are guided by the National Strategic Plan, which is co-developed between government and civil society. As noted above, the country proposals to the Fund are coordinated by the CCM which also determines which organisations will receive the funds. Once approved, funds flow to these principal recipients who in turn may appoint sub-recipients.

In 2022, an Audit Report for the GFATM grants and grantees (Principal Recipients and sub-
The findings highlighted the important and critical role that the GFATM played towards reducing mortality from AIDS and TB. Key successes cited were that the GFATM’s Secretariate provided prompt funding to its Principal Recipients and rapidly developed guidance; progress in supporting HIV pre-exposure prophylaxis and HIV self-testing and patient retention strategies and prevention practices; and through developing systems and structures for good procurement and supply chain practices.

The report also, however, highlighted several important health systems issues which have slowed progress towards attaining grant impact. These included significant delays in the implementation of a registration and reporting system, and HIV case finding and linkage to care challenges requiring improvements in the design and implementation of prevention programmes. Delays in the delivery of key strategies and interventions for TB due to factors related to the recruitment of implementation partners, the COVID-19 pandemic and local labour strikes were other factors. Inefficiencies and implementation challenges related to personal protection equipment and diagnostics were highlighted, and gaps in supply chain management processes were reported. A series of agreed-upon actions were proposed with clear targets, responsible people and due dates set to address the aforementioned challenges. Overall, the findings underscored the critical health systems challenges SA faces particularly in the areas of programming, governance and financial management, which require strengthening to ensure maximal impacts of GFATM efforts in the country.

5.2. Unitaid

Unitaid has not directly funded the SA government but funds NGOs with significant research and implementation experience. Importantly, as of 2022 Unitaid has engaged South African government as well as the South African Health Products Regulatory Authority (SAHPRA) to align their strategy with the priorities of the government and SAHPRA in the form of memoranda of understanding (MOUs). Unitaid has funded demonstration projects in the country, examples of which include HIV self-screening, Human papillomavirus (HPV) testing for cervical cancer and the use of thermal ablation for the removal of precancerous lesions.

5.3. FIND

In SA, FIND supports the development of cost-effective and high-quality tests primarily for common infectious diseases (TB, malaria, and HIV/AIDS). FIND collaborates with the National Health Laboratory Services, academic research institutions, healthcare providers, industry partners, and NGOs, and SA participates in multi-country studies. FIND has funded a review of laboratory services provided at PHC services to assess gaps in point-of-care and near point-of-care diagnostic services. Importantly, FIND is in the process of drafting its country strategy for SA with the aim of supporting local diagnostic manufacturing.

5.4. PEPFAR

Although not under review in this case study, it is important to highlight the role that PEPFAR plays in SA. PEPFAR funding is through the Country Operational Plan (COP) which is discussed
and approved annually (2-year COPs were implemented as of 2023). The process of approving the COP is through consultation between the United States Government (USG) and SA governments and civil society organizations. Unlike other GHIs, funding from the USG is via country-to-country or government-to-government agreements facilitated by Department of International Relations and Cooperation with the funds coming through the National Treasury. Additionally, the US Ambassador and Minister of Health (MOH) participate in a governance structure which oversees the PEPFAR programme. This structure is currently undergoing review. The PEPFAR programme largely funds HIV/AIDS activities through implementing partners (NGOs) who bid for work after United States Agency for International Development (USAID) and Centers for Disease Control and Prevention (CDC) issue requests for proposals. There is an element of health systems strengthening activities typically the funding of training (HIV/AIDS clinical guidelines, monitor and evaluation), as well as supply chain and laboratory strengthening. Apart from funds from PEPFAR, separate funding streams are to the National Department of Health (NDOH) from Centers for Disease Control in the form of a co-operative agreement. These funds are also directed to HIV-related activities, but spending is through the NDOHs procurement systems. The NDOH usually participates in the evaluation of proposals. The United Nations Programme on HIV/AIDS (UNAIDS) country office is mandated to co-ordinate UN agencies with respect to the HIV programme. UNAIDS supports both government departments as well as CSOs, including through SANAC. The United Nations (UN) agencies and PEPFAR participate in the drafting of the National Strategic Plan for HIV, TB and sexually transmitted infections (STIs) and use it to guide their investments and support.

5.5. Gavi, the Global Vaccine Alliance
UMIC status Gavi does not work in SA, which has however has been a donor to Gavi since 2007 with its International Finance Facility for Immunisation pledge of $20 million over 20 years.

5.6. Coalition for Epidemic Preparedness Innovations CEPI
In SA, Coalition for Epidemic Preparedness Innovations (CEPI) provides support for vaccine manufacturing and technology transfer activities. In 2022 CEPI collaborated with the Gates Foundation to provide US$15 million to support a 10-year agreement between Aspen Pharmacare Holdings (Durban, SA) and Serum Institute of India Pvt Ltd that will support the expansion of the supply and sourcing of affordable vaccines which are manufactured in SA. It has also supported local research on COVID-19 vaccine strategies for people living with or without HIV.

5.7. The SA government and GHIs: some participant perspectives
The SA Government largely funds its health and social programmes, therefore donor funding is considered additive. Much of the donor funds are for technical support with government procuring and funding commodities (medicines, diagnostics). “Right from the beginning, we put our own domestic resources to run our health system going forward. It’s not same as other countries.” There is no overt co-financing agreement. It should also be noted that the SA government also participates in the GFATM’s replenishment drives (the government though the NDOH contributes). To date the GHIs under review have largely focused on strengthening vertical programmes: HIV, TB, malaria and cervical cancer (Unitaid). FIND and Unitaid have
supported aspects of the diagnostic system as noted above. Some key informants who work closely within government structures have reported that whilst the GHIs acknowledge that more needs to be done to strengthen the health system, very little is done in practice. Similarly, whilst there is acknowledgement that the BOD has started to shift to NCDs (including mental health) there is very little resources allocated to them (apart from cervical cancer as has been mentioned above). The NCDs and mental health are already major issues including for people living with HIV as they age (a major benefit of being on antiviral treatment).

According to a high-level expert, both FIND and Unitaid are in the process of exploring formal agreements with the NDOH to at least ensure that the activities that they fund are aligned to government priorities.
6. Added value of the GHIs to date in South: participant perspectives, views and experiences

From the perspective and understanding of the researchers, the qualitative data collection process and the findings that emerged from the qualitative data analysis, are shaped largely by the contemporary South African context, the collective values held by the participants, the economic system, and the place that GHIs hold regarding provision of health services in SA. As indicated above, donor funding, in which GHI support is included, contributes less than 5% to the public health budget, with the GFATM and PEPFAR being the largest players. Thus, unlike in some African countries, GHIs and other donor services are generally not as ubiquitous or visible in SA (e.g., cars marked with donor logo). Even where NGOs operate, their services are often integrated into that of local health facilities. Therefore, to gain insight into the role played by GHIs in SA, we approached senior government officials, and other senior persons engaged in research and health systems policy making and delivery, both in SA and in global arenas. What we found across the interviews, despite directly probing, was that most participants were aware of the GHIs operational in SA but could not always describe or discuss the specific roles played by the various GHIs investigated for this study. Some of those interviewed, particularly within government, were aware of the role played by the GFATM, but not many were aware of the roles of Unitaid, FIND, or CEPI, with fewer able to discuss the specifics of GFATM.

To the best of our current understanding, this lack of awareness of specificity may be related both to the limited role of GHIs in-country, who and what they fund (e.g., clinical research, biomedical activities), as well as to how they provide funding (e.g., the organization and flow of funding). For example, we found that, other than for GFATM, the remaining GHIs operational in-country directly fund smaller organizations within and outside of the country, to provide services and exploratory research. In other words, they bypass the State. Thus, since formal government financing channels are not used, high-level government officials who were interviewed expressed not being able to describe nor account for the non-State funding flows or the activities that are funded by the GFATM, Unitaid or FIND. At the national level, funds from the GFATM are mainly managed by the relevant NDOH programmes responsible for the activities it supports, which limits the interaction of the rest of the managers with the GHI. SANAC, as the CCM, as described above also play a much larger role compared to other national actors. Furthermore, since some GHI funding is directed at smaller organisations, with smaller projects, persons outside of these organisations, such as the senior academics interviewed in this study, held little knowledge of how these GHIs operated.

Another key finding identified by the researchers has been, that despite there being an appreciation of, and a need for GHI support in the country, particularly with regards to funding provided during the early years of the HIV epidemic, during COVID-19 and for certain priority conditions (e.g. vaccine preventable conditions), GHIs have a limited role in shaping the overall delivery of public health in SA.

Yet, despite the participants’ limited knowledge of programme specifics of the GHIs, they were very
vocal in expressing their understanding of the role, impact and future possibilities of GHIs, not just in SA, but in countries in the Global South. The latter was informed by their knowledge and experience of the SA landscape, health system challenges and the roles they play both locally and internationally, and their interactions with numerous global actors within health.

Our findings (presented below) synthesize these participant opinions and offer important insight into the contemporary values held by key stakeholders and power brokers in SA. GHIs and other donors, wishing to engage with local actors, will need to be apprised of these insights and values, if they wish to strengthen partnerships with key players within this context. In contrast to the limited understanding of the specifics of GHI activities, several of our participants spoke to the role of PEPFAR. We have therefore included these reflections as they too offer insight into how donors are perceived and experienced within this context. The findings below therefore represent their views.

6.1. Greatest GHI achievements
Participants expressed appreciation for the assistance provided by GHIs to SA, particularly in addressing the HIV/AIDS epidemic over the past two decades and support of the national HIV/AIDS programme and NGOs improved access to relevant prevention, diagnosis, and treatment modalities. Both government officials and academics expressed that GHI support, particularly from the GFATM and PEPFAR, contributed to reductions in mortality rates for HIV/AIDS and TB, as well as to reducing mother-to-child transmission of HIV, ultimately increasing overall life expectancy. Improvements in some infant and child health indicators were also attributed to financial and technical inputs from in-country GHIs, including other DAH funders. Participants expressed that PEPFAR as a major funder of HIV/AIDS and TB in SA has contributed towards many of these achievements and remains an important player in DAH in the country. Despite evidence for improvements in disease-specific health outcomes, it was however felt that there was insufficient supporting evidence (e.g., from peer-reviewed published studies) demonstrating any beneficial impact on the health system and the lives of ordinary people living in SA beyond these diseases.

6.2. Alignment of GHI funding priorities with country health needs and progress towards UHC and strengthening health systems
Our participants were very concerned that whilst there is acknowledgement by GHIs that there has been an epidemiological transition of the BOD within the country towards NCDs (including mental health), very few GHI resources are allocated to these conditions, except for cervical cancer. However, criticism in this area was not only focused on the GHIs, but on how health issues were prioritized within the country too. One senior government official suggested that SA had become HIV-centric, another jokingly suggested that SA had a national department of HIV/AIDS, with health being tacked on, while other diseases were neglected. A national research organization official interviewed suggested that while the focus on HIV was correct, that TB had become the “poor cousin”, and very little focus was given to maternal and child health, injuries, interpersonal violence, disease prevention, and health promotion. Even though participants agreed that the infectious disease focus by the in-country GHIs was understandable and that this needed to change, they were not unanimous in their perceptions as to what lay behind this narrow focus – was it due to the need for the funder to focus on its stated priorities, or was it largely a legacy of the past,
given the burden that HIV had historically placed on the delivery of health services particularly before the introduction of ART.

Across the interviews, participants valued a holistic approach to health, that took social determinants of health, health promotion, commercial determinants of health, and climate change into account. In contrast, the participants expressed concern that GHIs were more focused on disease program funding, which was weighted to biomedical interventions. For example, a senior academic mentioned that GHI support for One Health (an integrated global approach to balancing the health of humans, animals, and the environment) was largely absent.

As expressed by most of the participants, GHI funding for health systems support in SA tends to focus on staff training and community health worker (CHW) programmes and is often seen as an add-on that is poorly integrated into the health system. Strategic national policy imperatives such as the implementation of UHC to address equity was said to receive little or no support from the GHIs. Similarly, even though the in-country GHIs, such as the GFATM, have acknowledged and supported health systems strengthen, many participants including a high-level official who worked closely with the in-country GHIs noted that very little is done in practice. A clear theme across all the interviews was the need for GHIs to shift from supporting a more verticalized approach towards integrated service delivery, and to have a deeper understanding of the broader health system changes and support required to facilitate such a transition.

"Are they [GHIs] fit for purpose? ... I think that the need to focus on particular issues and particular conditions is appropriate and relevant, however in the way that GHIs worked from the beginning... and I think that has changed to some extent over time, but I imagine the driving focus on a particular issue or condition means that they still are a little bit vertical in their approach. Shall we say so? I think that the way that they have functioned has addressed certain needs, but it hasn’t addressed the broader situation of countries, health systems, and how those health systems can themselves be strengthened to address those needs over time.”

"Funding causes fragmentation in health system – separate staff, financing channels, reporting – managers focus on performance and reporting for donor programmes and others receive less attention”

"Past decades there has been a focus on UHC, and past few years on PHC. But the donor funding landscape has not yet gotten behind UHC, because it is still fragmented, funding vertical programmes.”

“So at the end of the day, we might say, well, as government, we’ve got the power because we say whatever they do must be aligned to our priorities, but they also hold the power because they decide what is worth funding and what is not worth. So somehow we need to find each other. You know, we need to find a middle ground...”.

While participants described a deep appreciation for the contribution of GHIs and other donors to specific disease areas like HIV/AIDS, they were really very concerned that this focus, though needed, would further entrench verticalized service delivery. One senior academic argued that
GHIs, bilateral organizations, and donors, tend to focus on adding inputs within a timeframe, during which they want to achieve value for money and demonstrate to their funders that they have made an impact, but “those are external pressures that then do not create adequate spaces for domestic ownership of how to strengthen the health system over the longer term”. Given SA’s background, and the effort that continues to be exerted to strengthen the national health system, the tension between what is perceived as a GHI or donor’s need to invest in single programmes or diseases, versus the strongly held value of offering an integrated service, is an important insight to acknowledge in future engagement between national and global stakeholders.

Our analysis suggests that for participants, GHIs play a crucial role, but there is concern that GHI funding priorities are no longer aligned with the current BOD, health systems strengthening needs, or progress towards UHC, with little support for population-level disease prevention and health promotion.

7. Challenges with the current global health system: participant perspectives, views and experiences

7.1. Programmatic and health system

The GHI’s vertical disease-focused approach was felt to be too narrow and not aligned with the country’s needs. This vertical approach and GHI requirements caused fragmentation of the health system, and undermined efforts of services to deliver holistic and integrated person-centred health care. Some however felt that funders do not trust government systems, thus leading to duplication of systems, particularly of information, financial management, and procurement systems, which increased the work burden on health managers. “Lack of trust in governments, often result in bypassing country government and bureaucracies to recipients.” Participants felt that the current approach also deepens inequity across diseases, patient groups, and provinces, since more advantaged areas and large better-resourced urban NGOs are favoured over community-based organisations in poorly resourced areas. Often local technical expertise is bypassed in favour of international experts from the global north who lack contextual knowledge of the South African BOD, health systems and communities.

7.2. Financing

Although some GHI funding is channelled through the national government and treasury, much of the GHI funds by-pass government, and are channelled through NPO principal recipients and academic or research institutions. Therefore, government cannot account for all in-country GHI funds, as recipients do not necessarily report to the relevant levels of government. In addition to fragmenting service delivery, this also had implications for accountability and sustainability. Those who worked within government expressed concern that they were not able to account for all donor funding. Participants were not all in agreement on this issue. Some, particularly those who worked within government, felt that there should be more channelling via government, while at least one participant outside of government felt that this should not be done. A reason for the former view was that if government could account for all the funding,
then they would be in a better position to channel these funds in a more equitable manner (e.g. to more under-resourced provinces which often are not able to advocate for funds, nor support or implement without significant technical support).

“To take advantage of the funding, or to engage with GHIs requires strength, health systems strength. This means that some weaker provinces can’t take advantage of this, but stronger provinces can.”

Another view held by some was that the use of funding for implementation was not a strategic or sustainable use of resources (e.g. payment of CHW salaries or drug procurement) with some officials responsible for implementation stating that Global Health funding should not be used to buy commodities or finance key resources as this creates a disincentive for government to fund these services through allocations or domestic resource mobilisation.

7.3. Performance indicators and reporting mechanisms

High-level participants suggested that there was no formal in-country mechanism mandating GHIs to also report findings or challenges to government when reporting to its stakeholders. An example was provided where GHIs would present reports of activities or communicate in-country challenges directly to their organizations and funders, and yet high-level policymakers within important government structures were not made aware of these concerns. This was seen as a lost opportunity to engage in joint problem-solving or to collectively understand what some of the underlying reasons may be. The overall effects of GHIs and DAH, participants argued, was also not sufficiently evaluated both by the GHIs and independent researchers to determine the real-world impact on the health system and the health of communities. Such evaluation would be appreciated particularly by participants from government.

“So I think if we use the word research quite broadly...so sort of in-country evaluation of implementation of different programs and activities is vital and preferably led by in country teams, so that the evaluation is both done in ways that are tuned to local realities and itself supports the development of that capacity. So I think, that the importance of such evaluation is, ... giving hopefully, relatively real-time feedback on experience that can then be fed back into programming ways of working. And that’s different from large scale cross-country evaluations that are undertaken to serve only global headquarters or global discourse”.

Overall, participants felt that the reporting focused on disease “tick boxes” and failed to assess the whole-system effects. There was also insufficient coordination, integration, and alignment of the large number of different indicators and parallel reporting systems of GHIs. This undermines the country HIS, with health managers prioritizing reporting for GHIs over reporting in the routine HIS. “Administrative burden placed on (staff) is really bad - separate reporting and separate management on every single one of these donor programs is untenable.”

Those who worked within government structures spoke about the added burden of taking staff, who had other responsibilities, out of service to attend to the numerous funding applications, planning and reporting requirements. One high-level official with vast experience working with numerous GHIs and other donors over decades reported that the GFATM administrative requirements were burdensome and a disincentive to working with the organization.
7.4. Governance, coordination, alignment, and accountability

Despite efforts by the GFATM, many participants felt that across the in-country GHIs there was insufficient in-country coordination and resource mobilisation mechanisms to align with the country’s health plans and priorities. One however reported that GHIs such as FIND and Unitaid have taken steps to align more closely with the strategic direction and needs through engaging with the NDOH. Furthermore, separate country mechanisms were required by each GHI and DAH, increasing the country efforts and fragmenting accountability. For example, participants felt that GHI and DAHs lacked transparency, joint decision-making, and inclusivity. Participants who were knowledgeable about how decisions are made at high levels within GHIs through direct experience or interaction with these actors reported that GHI boards and decisionmakers did not sufficiently include recipient country voices in decision-making, and large power imbalances existed between recipient countries, communities, the GHIs, and their funders (i.e., countries, philanthropists). It was also felt by the participants with experience working at global levels that, in those spaces, civil society was not active or sufficiently strong to ensure accountability, and that GHIs and government did not engage sufficiently with community voices in decisions on funding priorities. Some specific examples were that civil society representatives were often those who represented the views of their constituents and not the population at large.

“NGO’s on boards don’t necessarily represent communities within recipient countries – have own agendas.”

Some participants spoke of people being “professional Board members” with some members being “recycled”. Researchers knowledgeable with the dominant global health discourses also expressed these views. Other comments were more general, pointing to the potential that civil society holds in keeping GHIs accountable, but that they were either not knowledgeable or mobilized enough in this regard. “accountability is not for the donors or the partners, but it’s about the people that we serve on the ground”. Governance challenges at the provincial government level (responsible for service delivery), were due to health leadership and management constraints, as well as GHIs bypassing provincial governments and working directly with NPO’s. Both national and local government officials reported the need for better mechanisms to support more rural and under-resourced provinces with implementation through capacity building of officials and frontline managers and through technical support. These decisions should be made through discussions between the in-country GHIs and local and national government.

8. Proposals for Change

8.1. Views and perceptions of stakeholders on the effectiveness of GHIs and the main programmatic and health system challenges

An overwhelming number of respondents expressed the view that GHIs needed to shift beyond the current disease focus to address country BOD and health systems priorities. The importance of strengthening the foundational elements of the health system to reduce fragmentation in the
health system, bolster PHC and attain quality UHC, with a stronger focus on health prevention and promotion, was stressed by most. A few proposed identifying and supporting intersecting factors with more focus on primary prevention, early diagnosis, and getting people into care for common diseases to support a more integrated approach to addressing the BOD. More effort should go into incorporating other in-country (traditionally non-health) sectors into funding priorities and activities, to address climate change and other social determinants of health.

Many proposed that GHI’s focus on resourcing on what one participant referred to as “catalytic” programmes and technical support for the design and development of innovations and interventions aligned with the country priorities and policy initiatives. In this context, catalytic activities place a strong emphasis on (a) the provision of technical assistance to build governments’ general technical capacities, and (b) supporting government with activities that require technical or expert skills. Technical assistance should also focus on supporting a wider range of activities (e.g. in NCDs and mental health), strengthening Information and Communication Technology (ICT) and e-health capabilities, and a strong focus on health promotion and disease prevention. Capacity building should extend beyond those who work within the funding priorities to all who play a role in delivering health services thereby strengthening the whole system.

Some examples include:

- Assistance with planning, researching, determining, and designing innovative solutions (e.g., for existing or new programmes to improve healthcare access, health outcomes, and integrated patient-based health information platforms).
- Public and other health system expert support (e.g., health technology assessment, economic evaluations, Information and communication technologies for health), including technical work to design and cost benefits packages for the NHI within the resource scope; design costs should include consultations with communities, local and regional capacity for developing, producing and distributing drugs, medical technology, and other medical supplies.
- Training to build health leadership, management and staff capacity in key areas beyond disease programmes.
- Research and evaluation of the overall impact of GHI on population health and health systems performance.

Another important theme that was identified was that GHIs should leverage and strengthen in-country technical expertise in government and at local academic and research institutions to ensure sustained local technical support. “We have to be able to make sure that in their conceptualization in the design and in their approaches in how this global health initiatives are being done, we have to make sure that we recognize the capabilities and the assets contained in the global South.” This could be through partnerships between the GHIs and the latter, through funding provided so that they can provide the technical support or conduct research to generate local evidence to inform future GHI directions, to assess their effectiveness and
impact, and to inform health systems responses. Thus, it was expressed that more support is needed for strengthening systems levers such as leadership and governance of the SA health system and building learning health systems that can integrate and sustain lessons learned for greater health systems resilience. It was felt that these system-wide approaches which focused on the ‘software’ of the health system would benefit the whole system and would enable and enhance the work of in-country GHIs, ultimately leading to more sustainable solutions.

8.2. Financing

8.2.1. Coordinate and streamline financing approaches and mechanisms

The perspectives of those working within government structures and those who work closely with GHIs reported that improved prioritization and coordination of funding were needed at all levels, from global to regional and country levels. Some high-level government officials and technical experts suggested that at a global level, GHIs and donors should channel finances through a single GFATM scheme, informed by and aligned with global and country health priorities rather than prioritizing each GHI donor’s agendas. Some suggested that there should be consideration of establishing an alternative funding system such as a BRICS (Brazil, Russia, India, China and South Africa) bank, or that the World Bank and WHO should play a much stronger role in either coordinating, managing, or supporting such an entity. There should be stronger country and regional representation, including community voices (not national or international NGOs who don’t necessarily represent communities), on GHI Boards or within decision-making structures, as suggested in the section above.

These high-level government officials for the most part also held the view that appropriate in-country coordination mechanisms were needed between government and other stakeholders to improve GHI coordination and alignment of funding with the in-country disease burden and health system priorities. Some perspectives included that all donor funds should flow through the government financial systems and not directly to service providers. The motivations behind these suggestions were that government could track funds and participate in decision-making, in partnership and with accountability to its country coordinating mechanism, and should then be responsible for distributing funds, with more funding channelled through provinces and flowing to district service delivery levels. These procedures should remove in-country duplication of efforts and resources and improve local accountability for the management and use of GHI funding. These officials also suggested that in-country GHIs should include more flexibility on how some of their funds are spent. An example was provided that about 5–10% of GHI and DAH funding should be used for any ad-hoc or urgent matters that might arise and that this amount should be negotiated upfront. This will enable the country to respond to pressing needs or crises that arise, particularly while domestic resources are being mobilized.

8.3. Performance indicators and accountability mechanisms

8.3.1. Streamline monitoring, evaluation, and reporting systems

A very common theme was that there is a need to harmonize reporting across GHIs and other funders, using a common indicator set focused on measuring process and output indicators to assess performance and health systems challenges, as well as indicators that reflect the whole
 system’s impact of GHIs. It was strongly suggested that GHI reporting systems should build on and strengthen the routine health information system, using GHI financial and technical resources to innovate, further develop, and support the use of an integrated, national, electronic patient-based health information system. Donors can assist with technical support in developing appropriate measurement systems for improvement.

8.3.2. **Strengthen evidence generation for accountability**

As suggested in the section above, many participants said that routine monitoring and reporting should be complemented by research studies and reviews on questions deemed relevant to the country’s priorities. The combined evidence should be shared on publicly accessible platforms for greater transparency and accountability. Government officials felt that regular reporting should be provided to stakeholders in-country, with reports to donors also sent to the relevant government department, and to the government-led coordinating mechanisms. This information should be shared through multistakeholder dialogues to better understand reasons for performance, lessons and best practices, review priorities, and consider new directions. Across the participants, suggestions were made that health service providers and communities should be included in such dialogues and fora as equal partners and play a stronger role in decision-making, alongside national senior program managers, large NGOs, and politicians, with the goal of ensuring accountability and promoting transformative change and equity at all levels.

8.4. **Governance, coordination, and alignment**

8.4.1. **Better aligned and streamlined multilevel governance and coordinating mechanisms under a unified approach with a single voice**

Participants felt that changes are required at the level of the GHIs and other global actors (e.g., UN, World Health Assembly). Those who worked at global levels of with many donors felt that across-the-board GHI board members and staff require a deeper understanding of how African health systems are structured and function. GHIs, including in-country ones, should also have greater flexibility to evolve from their original mission in response to global and country shifts in health needs and priorities. More meaningful representation of Low- and middle-income countries (LMICs) is needed “at the table where decisions are made.” This should include the involvement of civil societies and more equitable gender representation. Instead of their own interests or those of their constituents, civil society representatives should be able to represent the views of all local citizens. It is also important for civil societies to be accountable to country stakeholders. Importantly, it was also felt that the capacity of LMIC representatives on GHI boards should be strengthened to engage effectively at this level, given conflicting interests and agendas, unbalanced power relations, and the political nature of these relationships. As one participant suggested, “We have to be able to make sure that in their conceptualization in the design and in their approaches in how these Global Health Initiatives are being done, we have to make sure that we recognize the capabilities and the assets contained in the Global South.”

Many participants reported that at a regional level, both formal structures and informal forums are needed where African countries, agencies, and other key actors can determine collective
priorities, share plans, and agree on what the GHIs and DAH should fund and how they should engage, align, and coordinate with the continent, region, and countries. It was perceived that these structures can be used to develop and/or propose GHI changes that are applicable to multiple countries, i.e., a common voice to strengthen the accountability of GHIs within the region, and to strengthen consensus on relevant regional issues at big global meetings (e.g., the UN General Assembly). Decisions regarding funding should also acknowledge that within Sub-Saharan Africa, people often move across country borders. Migratory patterns should influence proposals for grants and implementation, with a suggestion of “borderless funding” that addresses pertinent healthcare needs at the appropriate local level.

There was a prevailing sense amongst the participants that strong political will and leadership are required at the country level to guide decision-making on GHI funding, coordinate with stakeholders, ensure accountability, and facilitate the effective and efficient use of the available resources in responding to the BOD and health systems priorities of the country. One provincial example was cited where longstanding and close working relationships with donors enabled funding to be used to develop disease-specific technologies (e.g., a health information management system) which grew to incorporate other conditions. In that same province, explicit and intentional engagements with in-country funders resulted in better alignment and focus on local needs. The changes, however, as reported by the official, were because of ongoing discussions and close working relationships, but more importantly political will and provincial commitment to build stronger relationships with funders.

Some proposed suggestions by the participants were that better-coordinating mechanisms are required to:

- Prevent funds from bypassing government and/or creating a mechanism whereby the government can track all GHI and DAH funds allocated to the country. High-level officials questioned whether a substantial proportion of funds should flow via the National Treasury and the NDOH, rather than being allocated directly to NGOs and CSOs. If that was not a viable option, then at the very least mechanisms should be in place to enable the government to keep track of the GHI and DAH funds which bypasses it.
- Consider establishing an integrated funding channel for supporting UHC and PHC to address the multiple funding streams focused on the various diseases, thus representing a shift from disease-specific funding.
- Strengthen joint (GHI and country actors) planning to better support country priorities, reduce duplication of bureaucracies, coordinate and report systems, and support health systems strengthening. The development of long-term, consolidated, and agreed-upon plans may reduce the chances of re-focusing on funding GHI “flavors of the month”. PEPFAR annual consultation process with a wide range of stakeholders was cited by those who participated in it as a very useful and important consultation process.

9. Conclusion

Better joint (GHI and country actors) dialogue and planning to adequately support country priorities, reduce duplication of bureaucracies, coordinate and strengthen reporting systems,
and boost health systems strengthening and the achievement of UHC is required. The development of long-term, consolidated, and agreed-upon plans will be key to reducing fragmentation and the effective use of GHI resources to sustainably strengthen the health system.

A broader and more inclusive coordination mechanisms, led by the government with GHIs and DHAs and all country stakeholders is needed. This will facilitate greater transparency and accountability for GHI and donor funding in-country and ensure more equitable universal healthcare coverage. Such co-creation should also identify strategic approaches to enhance technical expertise locally and to support catalytic innovations to strengthen the health system to deliver better prevention and care for all diseases and patients. Stronger political will, governance and leadership are required at the country level to guide decision-making on GHI funding, coordinate with stakeholders, ensure alignment of efforts and accountability, and facilitate the appropriate, effective, and efficient use of the available resources in responding to the BOD and health systems priorities of the country.

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