



BRIGHAM AND  
WOMEN'S HOSPITAL

## CASES IN GLOBAL HEALTH DELIVERY

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# loveLife: Preventing HIV Among South African Youth

**"Incremental was not good enough. We were going to be big and bold and accept the frayed edges because we had to reach enough young people. It was the right thing to do.**

**I have no regrets about doing that."**

-- David Harrison, loveLife CEO

On December 16, 2005, David Harrison CEO of loveLife, South Africa's largest HIV prevention program, called his leadership team to an emergency meeting after learning the nonprofit organization had lost one-third of its operating budget. The Global Fund to Fight AIDS, Tuberculosis, and Malaria discontinued loveLife's funding, meaning a loss of USD 58 million over the next three years. In its sixth year of operation, loveLife was reaching 80% of South African youth through its media campaigns and 40% through face-to-face positive lifestyle programs. Now, it was a whisper away from closing.

With loveLife's reputation hanging in the balance, managers moved quickly to develop an action plan. Harrison led an assessment of whether the program's original strategy remained pertinent, and if so, whether loveLife's activities and organizational structure were best aligned to support the strategy. If not, what improvements could be made?

## Overview of South Africa

South Africa was the southernmost country on the African continent. In 2000 its population of 44 million lived on 1.2 million square kilometers – an area roughly twice the size of Texas (see **Exhibit 1** for map). From 1948 to 1994, South Africa was governed through a policy of apartheid that institutionalized racial discrimination. Race determined where people could live and go to school, whom they could marry, and if they could vote. The policies marginalized the non-white population and greatly restricted their

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*Sarah Arnquist and Rebecca Weintraub prepared this case for the purposes of classroom discussion rather than to illustrate either effective or ineffective health care delivery practice.*

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access to basic resources for health, education, and other social services.<sup>2</sup> A network of anti-apartheid organizations, including the African National Congress (ANC), led a decades-long fight against the apartheid government that culminated in 1994 with the nation's first multi-racial, democratic election. ANC leader Nelson Mandela became the new democracy's first president.

**Table 1: Basic Socioeconomic and Demographic Indicators<sup>1</sup>**

INDICATOR		YEAR
UN Human Development Index ranking	103 out of 182	2000
Population (thousands)	44 million	2000
Urban population (%)	56.9	2000
Drinking water coverage (%)	93	2001
Poverty rate (% living under USD 1.25 per day)	26	2000
Gini index	57.8	2000
GDP per capita in PPP (constant 2005 international dollar)	6,470	2000
GDP per capita (constant 2000 USD)	3,020	2000
Literacy (total, female, male)	82.4, 80.9, 84.1	1996

## Demographics

About 60% of South Africans lived in urban areas. The population was 80% black, 9% white, 9% colored (legal term for mixed race), and 2% Indian. Across the nine provinces, 11 national languages were recognized, and several tribes retained local power. Nearly 70% of South Africans practiced Christianity, and traditional beliefs were the next most common religion.<sup>5</sup>

In 2000 South Africa was an upper middle-income country. Affluent areas of major cities resembled cities in high-income countries, with smoothly paved highway systems, shining skyscrapers, and sprawling shopping malls. However, poverty remained widespread.<sup>6</sup> Poverty was concentrated in rural areas and in "informal settlements," the underdeveloped slums outside major cities where blacks were forced to live during apartheid.

High unemployment – with about one in four adults lacking work – was a major problem. Unemployment rates were highest among blacks.<sup>7</sup> Young people were also disproportionately represented among the unemployed. In 1998, 2.4 million people (5%) received government-paid, social support grants.<sup>2</sup> Gender inequality, high rates of rape and other violent crimes also were pervasive. One-third of crimes recorded in South Africa involved violence, compared to 15% in the United States and 6% in the United Kingdom.<sup>7</sup>

## South African Youths

According to the 2001 census, nearly 45% of South Africans (16 million) were younger than 20; an estimated 6 million were between ages 12 and 17. About 90% attended school, and one-quarter lived in households with no formal income source.<sup>8</sup> They were exposed to greater benefits and opportunities than their parents but faced many socioeconomic legacies of apartheid.

<sup>1</sup> Source: This data was compiled from the following sources: WHO, UNICEF, UN.

It was common for black children to grow up without fathers contributing to their upbringing socially or financially.<sup>2</sup> Over 40% of black households in 2003 were headed by women without cohabitating men. One of the fastest growing sectors of the unemployed was young people who had finished secondary school but lacked the resources for further schooling or job training. Just 4% of young blacks enrolled in post-secondary education compared to 20% of whites. About 60% of people between ages 18 and 35 lacked jobs in 2002.<sup>7</sup>

Few social development opportunities existed for youths. A 2003 national youth survey found that only 34% of respondents had ever played in a community sports program; 25% had participated in a community club; and 50% had attended a cultural event.<sup>7</sup> Half of 15 to 19 year olds reported drinking alcohol, and 1 in 10 reported using drugs.<sup>9</sup> Half reported being sexually experienced. The median age of first sexual intercourse was 17 years, with 8% reporting their first sexual experience before age 14. Ten percent of women and 2% of men reported being forced to have sex.<sup>9</sup> In 1999, one-third of 19-year-old women had given birth.<sup>10</sup> Teenagers and young adults were the perpetrators and victims of most crimes.<sup>7</sup>

One loveLife manager recalled a conversation with a young boy living in a slum outside Durban. He told her, "I don't care if I die at 60 or 40 because each day is the same."

## Health in South Africa

In 2005 life expectancy for South African men and women was rapidly declining due to the AIDS epidemic.<sup>11</sup> South Africa was among a dozen countries whose child mortality increased after the Millennium Development Goals were set in 1990. Infant mortality increased from 44 to 52 per 100,000 between 1990 and 2000. Mortality in children younger than five was four times higher among the poorest quintile (88 per 1,000) than the richest (22 per 1,000).<sup>11</sup>

### Health System

South Africa's health system was relatively well-resourced compared to other sub-Saharan countries. It had some of the most advanced medical care and research in the world. The distribution of resources, facilities, and providers was inequitable and inefficient, however. Blacks suffered significantly poorer health and had worse access to health care services than whites.

The Health Minister led the National Department of Health (National Health Department) and worked directly under the President to set national health policy. The nine provincial health departments developed provincial policy within the national framework. In the post-apartheid era, the National Health Department aimed to improve equity by restructuring the health system and establishing a district-level, free primary care system that included health prevention and promotion.<sup>12</sup> One in three health districts, however, could not provide the complete, standard national primary care package. There was a severe shortage of skilled personnel in the public sector,<sup>2</sup> exacerbated by high staff turnover and increased workloads from the HIV epidemic.<sup>12</sup>

The private health system was concentrated in major urban areas. In 2005 per capita spending in the private sector was seven times greater than the public sector — USD 1,170 per beneficiary compared to USD 160. Seven million people (15%) had private health insurance while 40 million people (64%) depended entirely on the public sector. The remainder used both.<sup>2</sup>

**Table 2: Health Indicators<sup>2</sup>**

INDICATOR		YEAR
Average life expectancy at birth (total, female, male)	58,61,55	2000
Maternal mortality ratio (per 100,000 live births)	124	2002
Under five mortality rate (per 1,000 live births)	73	2000
Infant mortality rate (per 1,000 live births)	52	2000
Vaccination rates (% of DTP3 coverage)	72	2000
Undernourished (%)	5	2002
Adult (15-49 years) HIV prevalence (per 100,000)	20	2000
HIV antiretroviral therapy coverage (%)	15	2005
Tuberculosis prevalence (per 100,000)	515	2000
DOTS coverage (%)	77	2000
Malaria cases (per 1,000)	0.77	2000
Government expenditure on health as a % of total government expenditure	10.7	2005
Government expenditure on health per capita (international dollar, USD)	293, 179	2005
Total health expenditure per capita (international dollar, USD)	223, 101	2000
Total health expenditure per capita (international dollar, USD)	751, 458	2005
Physician density (per 10,000)	8	2004
Nursing and midwifery density (per 10,000)	41	2004
Number of hospital beds (per 10,000)	28	2005

## HIV/AIDS

In 2000 South Africa had the world's largest HIV epidemic, with an estimated 4.2 million people infected. One in five adults (ages 15-49) was HIV positive. In 1999 an estimated 250,000 people died from AIDS, and there were 420,000 AIDS orphans.<sup>13</sup> Health officials projected that by 2008 more than a million people would die annually from AIDS<sup>14</sup> (see **Exhibits 2 and 3** for graphs of HIV infections). South Africa also had the most tuberculosis and HIV coinfections worldwide.

HIV transmission occurred mainly through heterosexual sex, seconded by mother-to-child transmission. Young people drove the epidemic, with an estimated 60% of new HIV infections occurring in people between 15 and 25 years.<sup>10</sup> Women ages 15-29 were three to four times more likely to be HIV positive than males in the same age group, and blacks were six to seven times more likely than whites to be infected.<sup>15</sup> HIV prevalence varied by province, with adults in KwaZulu-Natal, the most severely affected province, more than three times as likely to be infected as those in the Western Cape, the province with the lowest HIV prevalence.<sup>15</sup> Residents in urban slums were twice as likely to be infected as those in formal areas.<sup>15</sup>

<sup>2</sup> Source: This data was compiled from the following sources: WHO, UNICEF, UN.

## ***National Response to AIDS***

South Africa's first AIDS case was identified in the early 1980s. Starting in 1990, the government began tracking AIDS cases through annual antenatal surveillance surveys at public clinics. In 1990 about 1% of pregnant women attending public clinics were HIV positive. While transitioning out of apartheid, AIDS was not a national priority. By 1998, when Mandela first spoke publicly about AIDS, 20% of pregnant women had HIV.<sup>16</sup>

When ANC leader Thabo Mbeki became president in 1999, he launched an era of AIDS denialism. Mbeki and his Health Minister, Manto Tshabalala-Msimang, attracted heavy criticism for following the advice of scientists who denied that HIV caused AIDS and for delaying the provision of life-saving antiretroviral therapy (ART).<sup>17</sup> In 2000 the South African National AIDS Commission (SANAC) formed to coordinate the country's HIV/AIDS efforts. Chaired by the Health Minister, people described SANAC in its early years as "toxic" and "nonfunctional" but also an important vehicle to improve South Africa's AIDS response. In 2002 SANAC became the local Country Coordinating Mechanism (CCM) to oversee the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) grants (see **Exhibit 4** for AIDS timeline).

The National Health Department estimated its 2002-2003 HIV spending was USD 37 million.<sup>18</sup> Spending increased annually thereafter, especially with the influx of foreign assistance (see **Exhibit 5** for government HIV spending).

## ***Testing and Treatment***

Prior to 2000 most voluntary HIV testing and counseling (VCT) was hospital based. Slowly, VCT using rapid tests was integrated into primary care. Mobile testing also became available. By 2002, most South Africans were aware of VCT, but only one in five had ever been tested.<sup>19</sup>

Following a Supreme Court compulsory ruling in 2002, the South African government began a national program for preventing mother to child transmission. In late 2003 Mbeki's cabinet began implementing a plan to provide ART to the millions of people infected.<sup>20</sup> Specialized ART clinics provided the care. People coinfecting with HIV and tuberculosis received treatment at separate sites for each disease. By 2005 there were 179 sites providing ART, and 460,000 South Africans were receiving ART, including 110,000 in the private sector. UNAIDS estimated South Africa was meeting about 28% of the need.<sup>21</sup>

## ***HIV Prevention***

Beginning in 1997, the national government required all provinces to implement a school-based life skills HIV prevention program. It was under-funded, however, and many provinces struggled to successfully implement it<sup>22</sup> (see **Exhibit 6** for description of the major HIV prevention campaigns). In 2000 numerous HIV prevention programs, including national and international nongovernmental organizations (NGOs), existed throughout South Africa. The main prevention approaches included education and awareness campaigns, promoting condom use, and reducing high-risk behavior through peer education programs, primarily at the provincial or local levels. Additional efforts sought to increase access to VCT and improve clinical services for teens.<sup>22</sup>

Limited public and private funding for HIV prevention meant that most programs had small budgets and small catchment areas. The HIV prevention sector was competitive. Community based organizations struggled against the unsympathetic national government, clamoring for funding and credit. Given this situation, the prevention efforts' impact was minimal, and there were calls for new interventions to halt the spread of HIV/AIDS.<sup>22</sup>

## loveLife's Beginning

The Kaiser Family Foundation was a US-based, nonprofit, private operating foundation that focused mostly on US health policy issues. Beginning in 1987, Kaiser's only major international presence was in South Africa. Kaiser was committed to helping South Africa build a more equitable national health system. It aided in gathering health data to establish the nation's first reliable, non-racial health benchmarks. Kaiser also worked with the National Health Department to institute the antenatal surveillance system. By 1997 data demonstrated an entrenched and burgeoning HIV/AIDS epidemic, said Dr. Michael Sinclair, Kaiser's South Africa program director. Sinclair recalled:

That galvanized us to engage in discussions with the South African National Department of Health about the evidence that the epidemic was clearly way larger than anyone had thought and that the existing prevention efforts did not seem to be having much impact. The outcome of those discussions was an agreement that we would engage in a process of consultation and planning with the idea of coming back to the government with a plan on how we might go about curbing the epidemic.

Between 1997 and 1999, Sinclair, a South African with political connections inside the ANC from his involvement in the anti-apartheid movement, directed a working group from the South African government, civil society and business sector to collect their input on the problem and unaddressed needs. Kaiser spent about USD 2 million on the two-year planning process during which it commissioned research into international prevention programs, demographic modeling, and a national survey about young people's knowledge and attitudes on HIV. The knowledge and attitudes survey indicated that South Africans knew about HIV and how it was transmitted, but open discussion about sex or sexuality was discouraged, even between parents and their children.

A consensus emerged that a large-scale prevention effort should focus on young people because the bulk of the South African population was under 20 years and young people were at greatest risk given the relatively high level of sexual activity among this age group. The working group decided the program should target young people before they began having sex on a regular basis. The working group felt the program should address the identity issues for young blacks around being the first generation of South Africans to grow up free from apartheid and living in poverty surrounded by violence and gender inequality, with limited educational or employment opportunities. The working group believed only a large-scale response could slow the infection rate. Thus, Sinclair recalled, "The basics of the plan were to target young people with a focused, brand-driven approach and to go to a very large scale almost immediately without piloting because of the urgency of the situation. The goal was to cut the rate of infection among 15- to 20-year-olds in half within five years. We were bold and ambitious early on, knowing we obviously might not fully achieve our goals."

loveLife would target youths ages 12 to 17 with a media campaign and interactive life skills programs that aimed to produce benefits beyond HIV prevention, such as decreased teenage pregnancy and sexually transmitted infections, and to confront deeply ingrained attitudes toward sex and gender inequality. Specifically, loveLife hoped to:

1. Get South Africans talking about HIV and its underlying sexual dynamics
2. Reinforce communication with peer-led programs that inspired young people to develop a sense of purpose, belonging, and identity with an HIV-free future; that enabled them to understand the risk of HIV and to decide that risk was not worth taking; and that equipped them with skills to avoid the risk
3. Embed the loveLife messages within institutional responses, including youth development and leadership programs, education and sports programs, and youth-friendly health service

## ***The Memorandum of Understanding***

Kaiser negotiated with the South African government to partner in creating a large-scale youth HIV prevention program. President Mbeki signed a memorandum of understanding establishing a public-private partnership under which Kaiser would, together with other private funders, commit to supporting loveLife's operations for 10 years on the assumption that the government's contribution to the budget would grow over that time. Sinclair explained:

This was an unprecedented approach, but the basic notion was that to impact a large-scale problem, we needed a large-scale response. We were trying to institutionalize the program from the outset and change the focus of HIV policy at that time and also the flow of public resources. loveLife was not going to be a short-term endeavor, and it was crucial to the long-term viability of the effort to get government to make loveLife a line item in the national budget.

The 10-year commitment also gave loveLife some leverage. As CEO David Harrison described, "It gave us the platform to approach government and say, 'Kaiser is in this for the long haul, so here is the plan....'"

## ***The Consortium***

To facilitate a rapid scale up, Kaiser created a consortium in 1999 among four existing health service organizations with nationwide reach and strong reputations. The Health Systems Trust (HST), a South African nonprofit think tank, would manage the finances. The Planned Parenthood Association of South Africa (Planned Parenthood), an affiliate of the international reproductive health NGO, would implement youth outreach programs. The Reproductive Health Research Unit (RHRU), a health sciences research unit of the University of Witwatersrand in Johannesburg, would conduct research and monitoring and manage the adolescent-friendly clinical services. Kaiser contracted with the NGO Advocacy Health Initiatives to create and direct the media and communication programs. The consortium partners were guided by a memorandum of understanding that outlined their responsibilities and funding arrangements.

The consortium, represented by each partner's director, first met in March 1999 and regularly thereafter. The partners were responsible for designing and implementing the loveLife programs. Harrison – a 35-year-old South African doctor who previously worked at Health Systems Trust and had just completed a master's degree in public policy at the University of California, Berkeley – came on board in July 2000 to lead the consortium. Technically, he was employed by Health Systems Trust, but his title was loveLife chief executive officer. Harrison worked from a central coordinating office in Johannesburg, where he oversaw legal and financial contracts between the partners and with subcontractors related to media programs, the call center, merchandise production, and warehouse distribution system. He also was directly involved in program design and implementation and responsible for mobilizing new funding and government support (see **Exhibit 7** for organogram).

All of loveLife's funding flowed through the Health Systems Trust and then to the consortium partners. The budgeting process worked as follows: Each year consortium partners agreed on the next year's activities, their roles, and their goals based on loveLife's estimated income. Then, each partner prepared its respective budget and negotiated with Harrison, who had the final say. Every quarter, the partners prepared financial management reports for HST to compile into a single report for funders. HST retained the right to commission independent audits of the consortium partners and the biggest suppliers.

Harrison led with an entrepreneurial spirit; he made decisions quickly and expected fast results. loveLife's partners worked at the furious pace Harrison's office set. As Harrison described, "The rollout was incredible. It was hectic and required long hours – 16 hours a day sometimes – but our mindset was that you've got to have sufficient scale to have a massive impact."

The pace combined with coordination problems between the national and provincial levels led to periodic stock outs of program supplies and weak support to implementers. Communication among lower-level staff across the partnering organizations was limited. Messages and new initiatives from the national office surprised ground-level managers who had to perform “damage control” as a result. Uneven program quality early on was a tradeoff Harrison could accept in exchange for rapid expansion.

Kaiser remained highly involved in loveLife’s operations. “We monitored closely at every level and worked very close operationally on every aspect,” Sinclair said. In addition to requiring financial audits and progress reports, Sinclair regularly visited the program sites and helped program leaders develop their strategy. Sinclair recruited an international technical advisory group of public health and HIV experts to advise loveLife and a National Advisory Board to serve as program ambassadors. The Board included prominent business people, religious leaders, and politicians, including President Mbeki’s wife, Zanele Mbeki, who served as the chairwoman.

## ***Funding***

Kaiser committed USD 100 million to loveLife over 10 years during which Kaiser’s funding would taper as the government’s funding increased. Kaiser’s Board of Directors required Sinclair to find additional donors to match its investment at a 3-1 ratio (see **Exhibits 8 and 9** for loveLife’s revenues and costs).

In July 2000 the Bill and Melinda Gates Foundation announced a donation of USD 7 million to loveLife. The South African government allocated USD 2.2 million for loveLife — about 6% of the country’s HIV/AIDS spending—starting in 2002-2003. The allocation came from a sympathetic Treasury Minister who channeled national poverty reduction funds toward loveLife. The government funding was distributed on a three-year cycle, protecting loveLife from annual negotiations, but the money had to be channeled through the National Health Department, which posed challenges.

As a National Advisory Board member described, “Our Treasury would allocate us money that would get stuck in the Health Department. It was extremely punitive behavior on the part of the health officials. They just wouldn’t release the money, and it literally meant that loveLife had to pay penalties in overdrafts. It was an ongoing, debilitating battle just to get our money released.”

Encouraged by the South African health minister and national treasury officials, Sinclair and Harrison also sought funding from the Global Fund when it launched in 2002. At the time, South Africa had no functioning Country Coordinating Mechanism<sup>3</sup> to organize the national application process. The Health Minister agreed to support loveLife’s application (a funding requirement) so long as the National Health Department was the principal grant recipient responsible for overseeing program implementation and financing.<sup>4</sup> “That became the albatross around our necks – the demand that it had to go through the government at that stage when there weren’t systems in place, and there was so much animosity toward HIV/AIDS within the Health Department,” Harrison said. In May 2002 the Global Fund approved a grant to loveLife for USD 70 million over five years. The fact that nearly all the First Round Global Fund money went to loveLife frustrated other organizations.

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<sup>3</sup> The Country Coordinating Mechanism (CCM) was a country-level multi-stakeholder partnership that organized and submitted grant applications to the Global Fund. After grant approval, the CCM oversaw its implementation. The CCM included representatives from the public and private sectors, including governments, multilateral or bilateral agencies, NGOs, academic institutions, private businesses, and people living with the diseases.

<sup>4</sup> The Country Coordinating Mechanism designated the principal recipient, which received Global Fund financing directly, and then passed it to other organizations (sub-recipients) that provided services.



## The loveLife Activity System

loveLife targeted South African young people ages 12 to 17 with a media campaign and face-to-face programs led by peer educators called groundBREAKERS.

### *Media Campaigns*

loveLife's architects did not think media alone could change youth behavior, but they thought it could spark discussion about sex and condoms, which they considered a precondition for behavior change. They believed a media campaign could help loveLife establish its brand, thus paving the way for program implementation, and build a social movement around a positive lifestyle that teenagers would want to join. The "movement" would challenge social norms and shape teen culture.

Thus, in September 1999 loveLife launched a media campaign unlike anything ever seen before in South Africa. A loveLife provincial manager recalled:

When the loveLife campaign came out, it was remarkable because South Africa was extremely conservative and religious. People didn't ever talk about sex or condoms. The campaign broke all barriers. And the key to success wasn't just the brilliance of the campaign, but that they drenched it everywhere. The loveLife purple was like CocaCola signs; you couldn't go anywhere without seeing it.

In a deliberate departure from traditional HIV prevention campaigns, loveLife adopted a commercial marketing strategy modeled after Sprite's successful launch in South Africa. It incorporated provocative billboards and sponsored concerts, basketball tournaments, and celebrity endorsements. loveLife launched with a teaser campaign of billboards titled "Foreplay." Then, it painted the country with billboards displaying its trademark purple tagline, "loveLife: Talk about it" (see **Exhibit 10** for illustration). Accompanying the billboards were two youth television shows and a toll-free telephone helpline. loveLife designed the campaign in English to resonate with all South African teenagers and young adults. It did not single out those with the highest risk of infection.

loveLife's campaign received significant negative publicity. Critics wrote editorials disapproving of the graphic approach and filed complaints with the national advertising standards authority. loveLife felt the criticism validated its goal of sparking discussion. loveLife relied on its politically connected National Advisory Board to defend the program publicly and dispel the criticism.

The first year, 70% of loveLife's USD 5-million budget went toward the media campaign, —1,200 billboards, hundreds of painted water tanks, TV and radio programs, and youth magazines distributed through national newspapers. No other HIV prevention campaign compared in scale or lasted all year.

After the first year, media spending comprised about 40% of loveLife's budget. loveLife changed the media campaigns each year to stay fresh and advance a new dialogue. In 2002, for example, a campaign targeted parents with the message, "Love them enough to talk about sex," spoken by prominent figures like Nelson Mandela and Archbishop Desmond Tutu (see **Exhibit 11** for campaign timeline). Corporate media partnerships also helped loveLife maintain its visibility through free print space and air time. loveLife attracted free publicity, as well, with high-profile community events that included visits from local and international celebrities, including former United States President Bill Clinton. By 2001 a loveLife-funded national survey found that 62% of respondents had heard of loveLife.

## **Interactive Programs**

**groundBREAKERS** loveLife created a national volunteer youth service corps for those ages 18 to 25 who committed to one year of service as community mobilizers and peer educators. The young adults, called groundBREAKERS (GBs), received a monthly stipend of about USD 150 along with training in community mobilization, program management, computer skills, and public speaking. Each GB recruited up to five mpinthis (volunteers) to help implement loveLife programs. The youth leaders worked from loveLife's teen-friendly clinics, multipurpose teen centers, and franchised community organizations. GBs led youth festivals and interactive programs to promote the loveLife brand across the country, emphasizing remote areas. The events combined outdoor broadcasting of positive lifestyle messages with theatre, dance, and sports. By the end of 2001, loveLife had recruited 200 GBs, and by 2004, nearly 1,000 GBs, surpassing its goal of 600.

**Youth Centers** In the first year, Planned Parenthood converted five of its youth activity centers into loveLife-branded Y-Centers — large, modern buildings that stood out against their low-income surroundings. By the end of 2002, loveLife had 15 Y-centers. Compared to the other agencies developing similar youth centers, loveLife's centers offered the widest range of recreation and life-skills programs. loveLife's Y-Centers, with help from GBs, combined indoor and outdoor recreation and sports facilities, computer training, radio, sexual health education, life skills, counseling, and clinical services.<sup>23</sup> A 2001 survey of young people living in the youth centers' catchment areas found 72% of teens surveyed knew of the loveLife center nearest them, and 38% had accessed it.<sup>23</sup> Each loveLife Y-Center cost around USD 62,500 annually.<sup>24</sup>

**Clinical Services** Some Y-Centers hired nurses to offer reproductive health services, including contraceptive pills, injections and condoms, as well as STI diagnosis and treatment. Additionally, the Reproductive Health Research Unit led the development of the National Adolescent-Friendly Clinic Initiative (NAFCI), which aimed to increase youth demand for sexual and reproductive health services by improving the quality of adolescent health services at government clinics. RHRU worked with the National Health Department to develop a set of 10 quality standards and create a process for accrediting public-sector clinics for youth-friendly services. NAFCI clinics received loveLife-branded education materials and posters. Additionally, GBs worked with clinic staff to recruit young people for services and make the clinics welcoming. Many NAFCI clinics added recreation areas with basketball courts and "chill rooms" where young people could hang out. The youth-friendly clinic program began with eight pilot clinics in 2001 and expanded to 54 clinics by 2002 and 235 at the end of 2004. With Global Fund money, the goal was to expand to 900 NAFCI clinics over five years. loveLife was also to add 200 clinic chill rooms, 600 GBs, and see a 10-fold increase in youth participation at the clinics.

**Call Center** Thethajunction was an anonymous, toll-free telephone helpline for young people available in all 11 national languages. The hotline number was advertised on all loveLife media and merchandise. People could call with health, sexuality, and relationship questions, as well as for information about loveLife. GBs could refer people with questions about loveLife programs to the toll-free number and use it themselves to ask the experienced counselors questions about how best to help youths in certain situations. loveLife launched a toll-free line for parents in 2002 after realizing adults also frequently called in with questions.

**Sports and Games** With the national United Schools Sport Association of South Africa, loveLife launched its largest program, the loveLife Games to provide youth extracurricular activities through which positive lifestyle messages could be reinforced. The Games was a national inter-school sports and debate competition that prioritized rural areas lacking school and community sports programs. Participating youth received athletic equipment and training and had to complete life skills lessons on subjects like personal motivation and sexual health.

## ***Franchises***

Realizing that establishing a presence in remote communities presented a major challenge, in 2002 loveLife launched a franchise program to recruit existing community-based organizations to adopt the loveLife brand and programs. In return, loveLife provided them with management training, merchandise, and promotional materials (stationery, condom holders, signs, and posters) and paid GBs to assist with their work. Planned Parenthood spearheaded the effort and hired Grace Matlhape, an adolescent mental health practitioner with an MBA, to manage the process. Matlhape oversaw nine provincial franchise managers responsible for managing local relationships, forging new franchise partnerships, and ensuring quality control. loveLife did not provide them operational funding. loveLife had 93 franchises in 2002 and 147 at the end of 2004 (see **Exhibit 12** for graph of scale up).

## ***External Stakeholders***

Several people from the government, news media, and other HIV prevention programs continued criticizing loveLife for 1) focusing only on young people and not using its relatively large budget to address HIV across the entire population; 2) being overly sexual with opaque messages; and 3) not pretesting its media messages scientifically and not collecting baseline data upon which to gauge its impact. loveLife leaders refused to stray from their initial audience, maintaining that young people offered the greatest potential return on investment. They believed making messages more palatable to adults would dilute their effect.

From the start, Kaiser's investment in creating an entirely new entity for HIV prevention frustrated people at other organizations working on HIV/AIDS issues, who felt threatened by loveLife's rapid scale up, brash public image, and unconventional approach. Among loveLife's most vocal critics was Warren Parker, then executive director of the Center for AIDS Development, Research and Evaluation. loveLife was an expensive, top-down campaign that "was absolutely against any cooperation or collaboration," Parker said. "They wouldn't allow other programs to distribute education materials at their youth centers. They wouldn't partner with anyone. They wouldn't listen to criticism, and as a result other organizations were alienated." Furthermore, many South African organizations and the government were not used to the pace at which loveLife operated. "When loveLife said things needed to happen by tomorrow and not in two weeks, it was sometimes viewed as a bully," recalled a consortium partner.

loveLife leaders avoided publicly criticizing the government and did not join the activist organizations demanding changes to government policy, nor did they participate in the National AIDS Council. As a result, loveLife gained a reputation as being aloof from the broader issues. "We had to choose between sitting in all-day meetings or implementing at a new clinic and franchise, and we chose implementing," Harrison said. "We ended up with a lot of people who felt alienated, and some became our most persistent detractors."

## ***Monitoring***

In 2002 and 2003, loveLife devoted 6% and 7%, respectively, of its budget to monitoring and evaluation. In the following years, the monitoring unit received less than 2%. The electronic system tracked inputs (e.g., number of GBs, events, and training workshops) and outputs (e.g., partner organizations and youth participation by age and sex). The GBs were the primary data collectors. They were supposed to log every loveLife activity they performed and count all participants. Frequently, however, the data was incomplete and late. It took about two months at the end of each quarter for all the data to be turned in and analyzed.

Provincial managers were described as “mini CEOs” responsible for program implementation, human resources, financial management, and local stakeholder relations. Managers could log onto the intranet monitoring system to track progress and compare their targets against other regions at any time. However, use of the database outside the national office to guide decision making was irregular. The national team tried to instill an organizational awareness for using data to guide management decisions by incorporating monitoring into all staff trainings. Awareness increased over time, but monitoring remained one of loveLife’s challenges, partially due to the difficulty in recruiting managers with experience using data systems.

The monitoring director recalled:

The database was good; it just needed to be used consistently. If you don’t have management support for monitoring, you can pack up and go home. It has to start at the top and filter all the way down to the implementation-site level and occur day in and day out. Ideally, the regional and provincial managers would take ownership of the data collection and use that to start their meetings and give feedback every single day.

## ***Impact Evaluation***

In the first two years loveLife funded small-scale surveys to assess its market penetration and message recall among teenagers. In early 2002 it gathered a group of international experts to create a more rigorous evaluation plan. The result was a national surveillance survey to capture youth HIV prevalence and knowledge of and participation in loveLife. Additionally, in-depth studies examining loveLife’s impact in communities with Y-centers and NAFCI clinics would be done. The first youth survey in 2003 was considered loveLife’s baseline and would be followed by subsequent surveys every two years. As loveLife was the only nationwide HIV prevention program, this was the first attempt in the nation to evaluate a large-scale prevention program’s effects.

The first survey results, released in April 2004, confirmed previous data estimates: 10.2% of 15- to 24-year-old South Africans were infected with HIV, and most were women. Prevalence was three times higher after age 19. Young people living in urban informal areas were most at risk. Median age of first sex was 17, and 52% reported using a condom the last time they had sex. Among those having sex in the past 12 months, 27% had more than one sexual partner.<sup>25</sup>

The survey provided new data to better understand youth sexual behaviors, knowledge of HIV, and attitudes about life. loveLife would use this information to refine its programs. Eighty-five percent of youths reported hearing of loveLife; 65% knew of four or more loveLife products or services; and 34% reported participating in the face-to-face programs. Most interaction was through reading loveLife’s printed magazine. Among young people who had heard of loveLife, 92% said it was good for South Africa, and 24% reported doing something as a result of the program, including talking or seeking information about sex. HIV prevalence among youths who had participated in loveLife was 40% lower than among those who had not.<sup>25</sup> Regarding the relationship between exposure to loveLife and HIV risk, the authors concluded that sexually experienced participants of loveLife programs were significantly less likely to be HIV infected.

Methodology limitations and study biases, however, made it impossible to prove a causal link. The external authors concluded, “Determining the impact of a diverse national prevention campaign such as loveLife is difficult, and changes in HIV prevalence over time will result from the combined effect of many prevention initiatives.”<sup>9</sup>

## The Five-year Mark

In 2004 loveLife hit its five-year mark. The 50% reduction in youth HIV incidence was not achieved. Even Harrison recognized this goal was extremely ambitious and was not surprised that loveLife had to extend the goal another five years. loveLife also set goals to increase condom use from 50% to 80% and reduce the proportion of young people with multiple sexual partners from 27% to 20% in one year (see **Exhibit 13** for loveLife’s goals).

At the five-year mark, loveLife’s income totaled USD 24.2 million. Kaiser funded 47%, the South African government 19%, the Global Fund 25%, and other private foundations 8%. Kaiser’s funding paid for the media programs, and as Harrison said, was also “the glue in the cracks and the venture capitalist when other conditional funding did not cover initiatives we thought were critical to moving loveLife forward. The latter role was critical in giving us flexibility to make things happen fast.”

Harrison spent considerable time trying to get loveLife’s money from the National Health Department. The frequent late payments meant cash-flow problems for the consortium partners. Sipho Dayel, Planned Parenthood CEO at the time, explained:

The payment delays from the government in terms of the Global Fund money made it difficult to pay staff and suppliers. As one of the key people who carried the largest number of employees, I can tell you that working on loveLife was a nightmare. A few times we were unable to pay staff salaries on time, and in some instances we couldn’t pin down a date for payment. That began to create insecurity, and the challenge was maintaining employee motivation. loveLife didn’t account for the fact that government operated more slowly than it did; it refused to slow down.

Tensions between consortium partners were high in 2004, particularly regarding funding and organizational identity. That year, the Health Systems Trust ended its management of loveLife finances. loveLife became a legally independent, nonprofit trust through which all money now flowed. Harrison’s role as CEO remained the same, but he was no longer an HST employee. Other consortium partners felt that loveLife’s central office now had too much control. The majority of Planned Parenthood’s employees worked on loveLife projects, but Dayel explained he was still accountable to his own Board of Directors. To maintain the purity of the loveLife brand, Planned Parenthood and RHRU were not allowed to display their own logos at the facilities they operated, which their boards did not appreciate. “I took serious beatings in my own board meetings by members who were not convinced by loveLife,” Dayel said.

## Introducing the “loveLifestyle” Curriculum

Harrison and the loveLife team began 2005 optimistic they could further diversify funding to grow the GB program and expand into new communities. They refined loveLife’s strategy based on the survey results showing 15% of the target age range was not aware of loveLife and 65% had not participated in its programs. Reaching these young people became the organization’s top priority; it would focus on those most at risk: poorer, less educated, and unemployed young people primarily living in urban slums and rural areas. Harrison also decided loveLife should more overtly address poverty, violence, and gender norms given their impact on individual behavior. loveLife planned to increase interactive program spending from 60% to 67% and shrink media and brand promotion spending from 34% to 27%.

loveLife expanded GB training to include information on adolescent and gender rights. GBs also received training on how to identify teenagers eligible for social security grants and connect them to social services. Additionally, loveLife worked to link graduating GBs and volunteers to education and employment opportunities. In a shift from its initial strategy, loveLife managers decided schools were a vital youth-access point. The loveLife national office created “loveLifestyle” health education modules for GBs to teach in the classroom and afterschool programs, including sports and debate. GBs now were expected to implement at a set number of schools per year, and they and their managers were assessed based on their progress against those targets. loveLife began using school implementation as a proxy for youth coverage.

The loveLifestyle program modules focused on three elements: a hip, future-focused attitude; a healthy lifestyle promoting physical health and fitness and peer-pressure resistance; and safer sexual behavior including delaying sex, having one partner, and always using condoms. All modules were 16 weeks, run twice-yearly on dates set by the schools. The GBs running the programs referred participants to loveLife’s the adolescent-friendly clinics and other programs.

In 2005 a scaled back version of the afterschool sports program, the loveGames, officially became part of the South African government’s school sports and youth development strategy. The communication campaign continued using television, radio, newspapers, and billboards to promote messages of self-motivation, encouraging teenagers to embrace their differences and challenge social norms.

## ***Decentralization***

To facilitate expansion into schools and remote areas and improve consistency, loveLife launched an organizational restructuring in 2005. Managers realized that as loveLife rapidly scaled to employ 400 people (excluding GBs), the Y-centers, franchises, NAFCI clinics, and loveLife games each developed separate management structures. This led to duplication, miscommunication, and logistics and supply problems. They needed to streamline the organization by restructuring and strengthening operational systems including human resources, information technology, and distribution logistics. As one provincial manager recalled:

As wonderful a leader as David [Harrison] was, he needed to have good managers to ensure that systems were in place. I don’t think that was there when loveLife started off, and there were hard lessons to be learned from that. For us managers on the ground, it took energy away from other things that we should’ve been doing to sort through the crisis management.

Harrison agreed:

As the organization matures, you get all the challenges of a big organization. You have more and more tiers holding it together, and maintaining the integrity of the brand and inspiring people becomes more challenging. You have to have systems in place to support that complexity to ensure your brand is smart and sharp, which is absolutely pivotal to success.

loveLife decentralized the management of nine provincial offices into 32 regional offices. All staff members reapplied for regional-level jobs, and in the process, loveLife eliminated 60 positions. The strongest employees were made regional directors responsible for managing the network of 145 loveLife franchises, 17 Y-centers, and 250 NAFCI clinics. These sites became “hubs” from which GBs reached out to schools and the community. The loveLife national office enhanced its field support and revamped the training programs, communication, finance, and project management.

The regional offices’ first step in early 2005 was identifying the neediest communities by mapping HIV prevalence, loveLife sites, similar organizations, and schools. This exercise helped managers prioritize

loveLife's expansion and identify potential partners. Managers tracked the number of participating schools, the number of participants (by age and gender), and the number of loveLifestyle program graduates in their area.

## The Global Fund Crisis

The NAFCI clinic expansion relied on Global Fund funding. loveLife received USD 12 million for the first two years, and based on a satisfactory performance during the first phase (2003-2005), leaders planned to receive funding for the next three years. In May 2005, however, loveLife learned that the Global Fund Secretariat<sup>5</sup> recommended against continuing loveLife's funding into the second phase. The Secretariat said loveLife was underperforming on the agreed-upon targets.

The currency exchange-rate fluctuations had decreased the grant's operating value by 40% and hampered clinic chill room construction, loveLife's major unmet goal. After two years, loveLife built only 86 of the 200 targeted chill rooms. loveLife insisted some indicators were not supposed to apply until Phase 2, but even so, that it had missed just four of the 14 contractual targets, and two were at 87% and 73% progress. "The Secretariat has now moved the goalposts by introducing an expanded set of indicators to gauge initial performance," loveLife wrote in response.

The Global Fund's Board of Directors also objected to the Secretariat's recommendation and ordered a financial audit of loveLife. The accounting firm KPMG reviewed loveLife's finances and reported concerns about its financial sustainability and practice of borrowing across donor funds to meet program costs (see **Exhibits 14 and 15** for Global Fund stakeholders and funding disbursement timing).

In July the Secretariat again issued a "no-go" recommendation, stating the program had "limited prospects for success" of meeting its goal of a 50% reduction in youth HIV incidence by 2009. Again the Global Fund Board objected, and the Secretariat commissioned an independent review by the technical review panel<sup>6</sup>.<sup>26</sup> The no-go recommendation against funding loveLife based on "serious performance, management, financial and sustainability problems" also implicated the National Health Department, as it was the principal recipient.

The no-go recommendation was a "bolt from the blue," loveLife leaders said, because no quarterly reports had foreshadowed it was failing. Many Global Fund progress reports, however, had documented the National Health Department's inefficiencies and repeated payment delays. Due to these delays, loveLife managers had to juggle funding streams to continue operating. Harrison requested the South African Auditor-General review loveLife's finances. The review was largely positive.

Kaiser officials worked with Harrison's team to respond to the Global Fund objections. Kaiser paid for Harrison to fly more than 100,000 kilometers and visit 11 of the 19 Global Fund board members to share loveLife's side of the story. Harrison asked for a technical review panel to visit and evaluate loveLife's programs in South Africa. The Global Fund Board requested another review in September, but the review panel never visited loveLife's programs.

At the end of the year, loveLife managers felt they had adequately refuted all the Secretariat's concerns and were hopeful for a favorable vote at the December meeting. After spending the last eight months fighting to save the program he built, Harrison left for a holiday feeling relieved.

<sup>5</sup> The Secretariat was the Global Fund's administrative body responsible for day-to-day operations. The Board was responsible for grant approval.

<sup>6</sup> The technical review panel reviewed eligible grant proposals for technical merit according to soundness of approach, feasibility, and potential for sustainability and impact. Based on this review, the review panel made funding recommendations to the Board.

## ***Consortium Dismantlement***

After years of struggling to make the consortium work, Harrison used the Global Fund crisis to dismantle it. In September 2005, loveLife became a single organization with its own board of trustees. Harrison recalled:

loveLife had outgrown the consortium model, and it was operationally inefficient. We had been making that point for several years, but there was always the money and political space to keep it operating in an inefficient way, but with the Global Fund decision that changed. loveLife management used that extreme pressure to say that if loveLife was going to continue to exist at all, it had to break away from the consortium and become its own organization.

In 2005 Planned Parenthood employed 250 people who worked on loveLife programs, representing more than 75% of its total staff. Matlhape left Planned Parenthood to become deputy CEO of the new loveLife Trust. Most of her staff followed, leaving Planned Parenthood a shell. Many of the 40 RHRU employees working on NAFCI and monitoring and evaluation also moved over to loveLife. Now, everyone working on loveLife programs reported to a single organization.

## ***The Final No-go***

On December 16, 2005, Harrison's holiday was cut short. Ongoing funding required a 60% majority in favor, and the Global Fund Board's vote was tied – eight to eight. loveLife lost USD 58 million and one-third of its operating budget. Harrison recalled, "There was no clear avenue forward, but I was absolutely clear that we were not shutting loveLife down in the middle of a crisis."

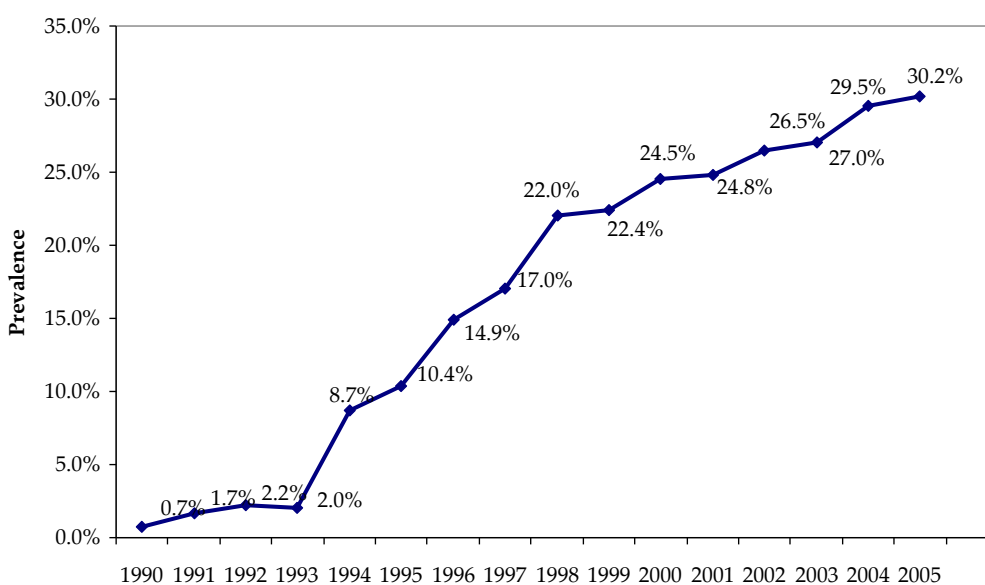
loveLife's leaders worked quickly. Within a week, they drafted a new, five-year strategic plan to send to employees and the news media that emphasized loveLife would not end. The immediate next steps were to reduce the staff and try to fill the funding gap. Harrison and Matlhape divided duties. "My job was to negotiate with the government to open up the political space and inspire people," Harrison said. "Grace's [Matlhape's] job was to fire people."

To guide their decisions, managers worked closely with the Board of Trustees and Kaiser staff. They asked themselves: "Was loveLife's strategy supported by the best available evidence? Would loveLife get the highest returns by continuing to focus on 12- to 17-year-olds, or should it expand its focus? Could loveLife sustain a comprehensive approach, and if not, what would be the impact of scaling back the teen-friendly clinics component?"



**Exhibit 1** *Map of South Africa*

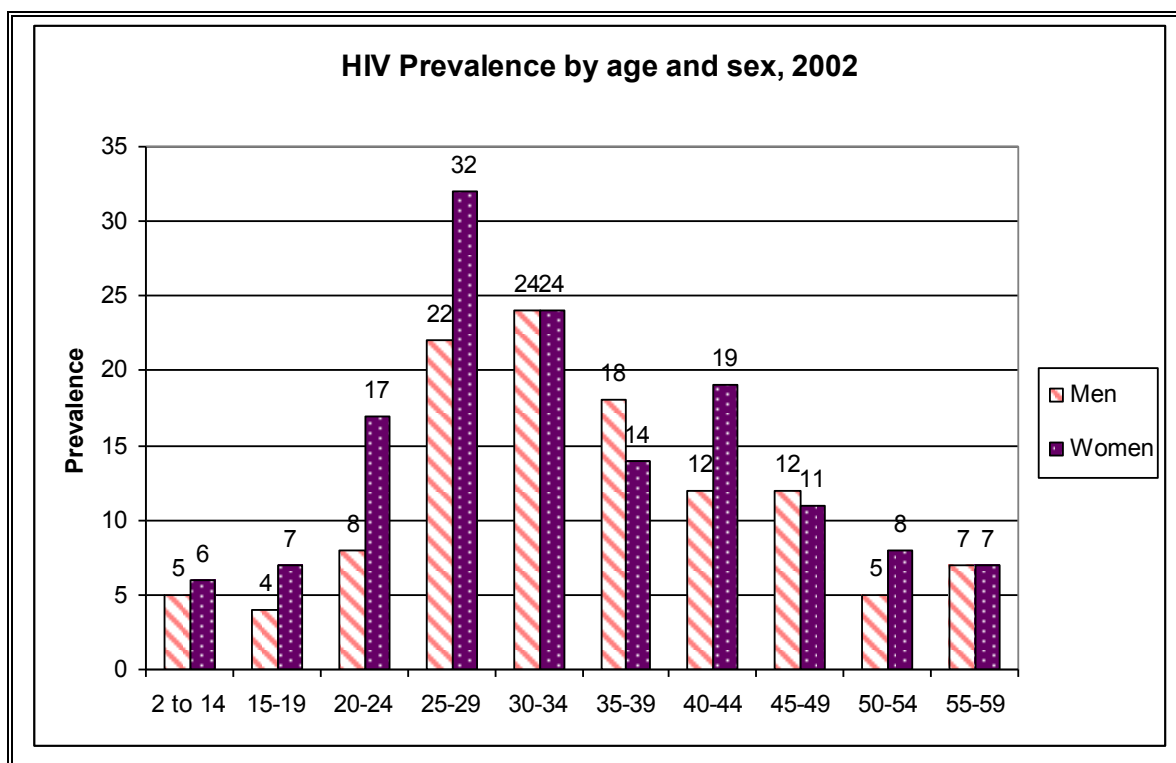
Source: Adapted from public domain.

**Exhibit 2** *HIV Prevalence of Women Attending Public Antenatal Clinics*

Source: South Africa National Department of Health.

**Exhibit 3** *HIV Prevalence Table and Chart*

POPULATION	2002	2005
<b>Total population</b>	11.4% (10-12.7)	10.8% (7.1-9.6)
<b>Adults (15-49)</b>	15.6% (13.9-17.5)	16.2% (14.9-17.7)
<b>Adults in urban slums</b>	28.4%	25.8%
<b>Adults in formal urban cities</b>	15.8%	13.9%
<b>Adult women</b>	17.7%	20.2%
<b>Adult men</b>	12.8%	11.7%
<b>Black adults</b>	18.4%	19.9%
<b>White adults</b>	6.2%	0.5%



Source: South African National HIV Prevalence, Incidence, Behavior and Communication Survey, 2002 and 2005.

## **Exhibit 4**    *South Africa AIDS Timeline*

- 1983    First two HIV cases are identified.
- 1990    Annual HIV surveillance at public perinatal clinics begins to track the disease.
- 1997    The Inter-Ministerial Committee on AIDS is established as the first high-level political body on AIDS with intentions to provide guidance, leadership, and political oversight on HIV and AIDS. Then Deputy President, Mr. Thabo Mbeki, chairs the committee.
- 1998    Nelson Mandela first discusses AIDS in a public speech.
- 1999    Mbeki becomes president and appoints to Minister of Health Manto Tshabalala-Msimang, who questioned whether HIV caused AIDS and supported research into traditional medicines, such as beetroot, garlic, and lemons.
- 2000    The South African National AIDS Council replaces the IMC on AIDS and includes civil society in the overall response to the HIV and AIDS challenge.
- 2000    South Africa hosts the International AIDS Society conference in Durban, where 5,000 scientists sign a petition affirming that HIV causes AIDS.
- 2001    Mbeki's Presidential AIDS Advisory Panel releases a report stating, "Most of the participants agreed that HIV exists, but not all acknowledged that it causes AIDS."
- 2002    SANAC becomes South Africa's Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria. The CCM oversees the grant submission process and monitors the implementation of activities under Global Fund.
- 2002    The Treatment Action Campaign sues the government, claiming the prevention of mother-to-child-transmission policy was unconstitutional. The constitutional court orders the government to provide ART to all HIV-positive pregnant women.
- 2002    The Treatment Action Campaign and *Medecines San Fronteires* begin importing generic drugs from Brazil for pilot ART programs in the slums outside Cape Town.

Source: This exhibit was created by case writers from resources made publically available online.

**Exhibit 5** *South African Government Funding for HIV/Tuberculosis, 2002*

	USD million (% total)
Home-based Care and VCT	11.3 (30%)
PMTCT	2.3 (6.2%)
NGO Funding	3.3 (9%)
South African Vaccine Initiative	0.9 (2%)
HIV/AIDS Communication	5.8 (15.6%)
Condoms	7.0 (18.9%)
National Tuberculosis Control	0.5 (1.3%)
loveLife	2.2 (6%)
Other	3.8 (10%)
<b>Total</b>	<b>37.1</b>

Source: South Africa 2002 Proposal to the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

**Exhibit 6** *HIV Prevention Media Campaigns and Programs Operating in South Africa in the early 2000s*

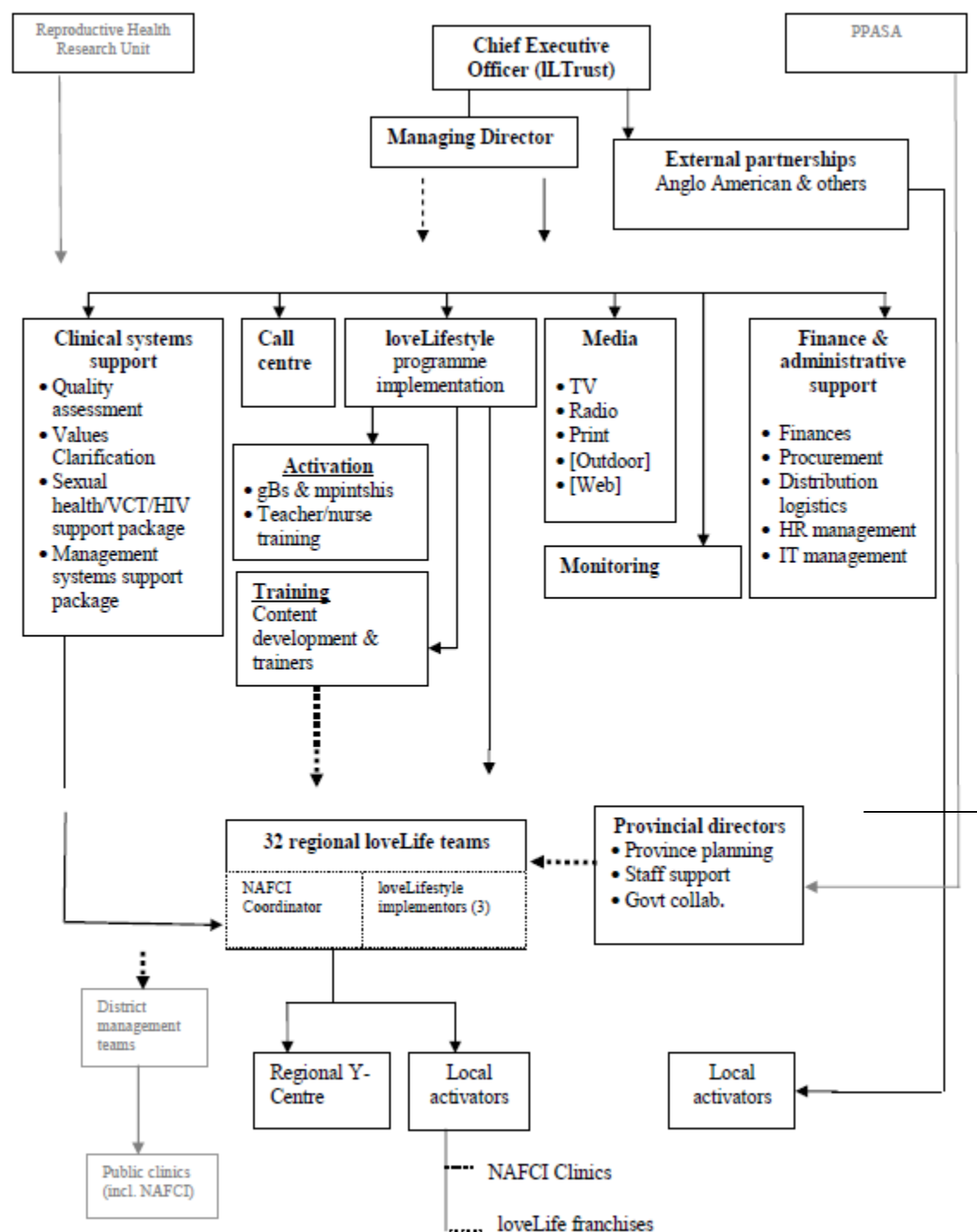
**Beyond Awareness** was a two-year, USD 4.2 million government campaign between 1998 and 2000 that popularized the Red Ribbon for AIDS awareness. It promoted the message “get wise, condomise” and advertised the government’s toll-free AIDS helpline. The campaign focused on different segments of the population over its two years.

**Soul City** started in 1992 and was the oldest South African health communication NGO. Using “edutainment,” it aimed to inform adults about health issues through television and radio shows. About 60% of its content related to HIV/AIDS. Soul City’s revenue in 2000 was about USD 4.56 million.<sup>1</sup> That year, the program launched the Soul Buddyz 26-episode, half-hour television series targeting children ages 8 to 12. Soul Buddyz also included radio series and parenting and seventh-grade booklets that dealt with issues such as children’s rights, AIDS, youth sexuality, accidents, disability, road safety, gender equality, and bullying.<sup>3</sup>

**Society for Family Health** was a South African affiliate of the US-based NGO Population Services International. The social marketing organization focused its HIV prevention campaigns primarily on urban and peri-urban men aged 15 to 40, with an emphasis on recruiting couples for voluntary HIV counseling and testing services. It also ran an HIV prevention program called YouthAIDS in the areas surrounding Johannesburg, Cape Town, and Durban. Youth peer educators spread the message of responsible sexual behavior at schools, parent-child workshops, street campaigns, community centers, transportation hubs, and radio talk shows. Its mobile promotions unit conducted edutainment road shows in five provinces.<sup>4</sup>

**Khomanani Caring Together** was the South African government’s USD 9.5 million communication campaign launched in September 2002 in conjunction with the National HIV/AIDS/STI Five-Year Strategic Plan. Khomanani had six sub-campaigns that ran periodically to target orphan and vulnerable children, youth, health workers, people living with HIV, STIs, and tuberculosis.

Source: This exhibit was created by case writers from resources made publically available online.

**Exhibit 7** *loveLife Organogram up to 2004*

Source: loveLife.

**Exhibit 8** *loveLife Annual Revenues in USD millions, 1999-2005*

	1999	2000	2001	2002	2003	2004	2005
Kaiser Family Foundation	3.5	7.6	11.0	8.1	12.9	11.5	6.7
SA Government				2.2	4.2	4.7	7.1
Bill & Melinda Gates Foundation			6.9		12.6		
Nelson Mandela Foundation					1.9	1.5	
Anglo American (Mining company)			0.1			0.5	0.8
Global Fund						6.1	2.9
Corporate & Other		0.07	.004	0.08	0.4		1.2
<b>Total USD</b>	<b>3.5</b>	<b>7.7</b>	<b>18.0</b>	<b>10.4</b>	<b>31.0</b>	<b>24.3</b>	<b>18.6</b>
SAR-USD exchange rate	6.14	6.28	7.7	11.4	8	6.6	5.8
<b>Total SAR (in millions)</b>	<b>21.3</b>	<b>48.3</b>	<b>138.7</b>	<b>118.0</b>	<b>248.3</b>	<b>160.0</b>	<b>107.8</b>

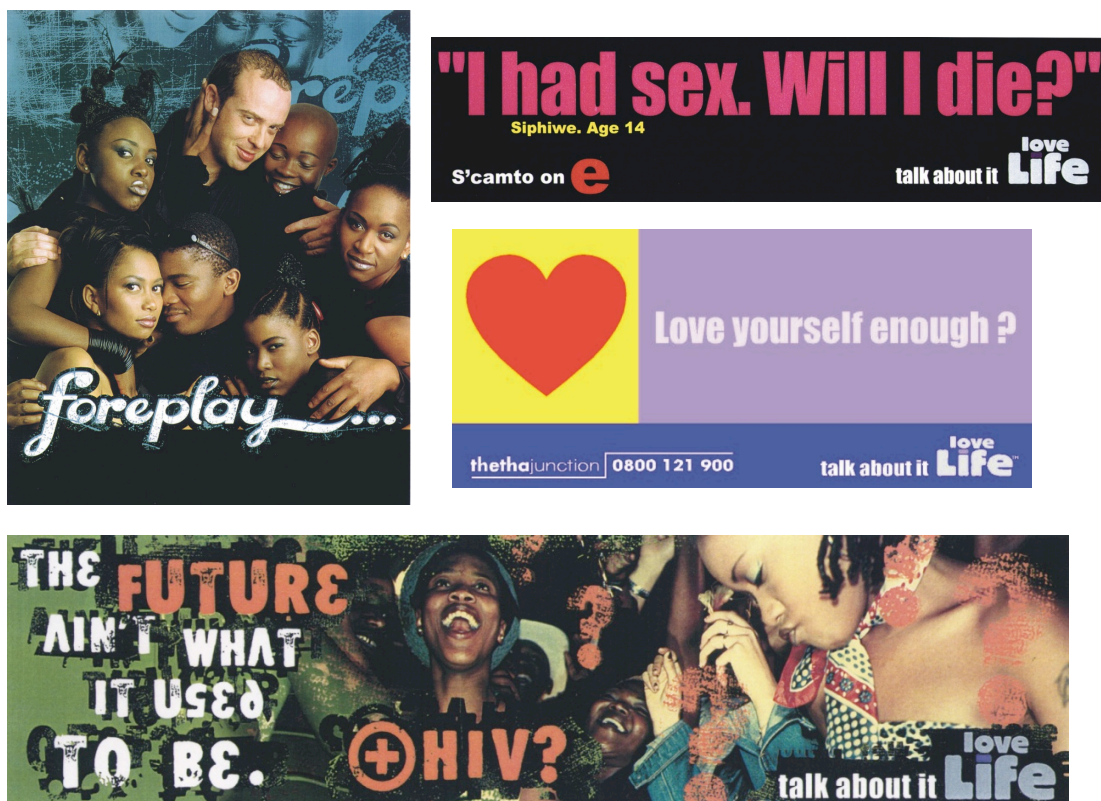
*\*Kaiser donated more in 2002 than 2001, but due to the high exchange rate, when converted, it was less.*

*Source: loveLife Audited Annual Reports.*

**Exhibit 9** *loveLife's Budget Distribution by Program Area, 2001-2005*

	2001	2002	2003	2004	2005
Media	39%	38%	40%	32%	26%
Interactive Programs	53%	47%	51%	60%	67%
Monitoring & Evaluation	2%	7%	6%	2%	1%
Brand Promotion & Marketing	5%	6%	1%	2%	1%
Admin/Management	1%	2%	2%	4%	6%

Source: loveLife.

**Exhibit 10** *Examples of loveLife Media*

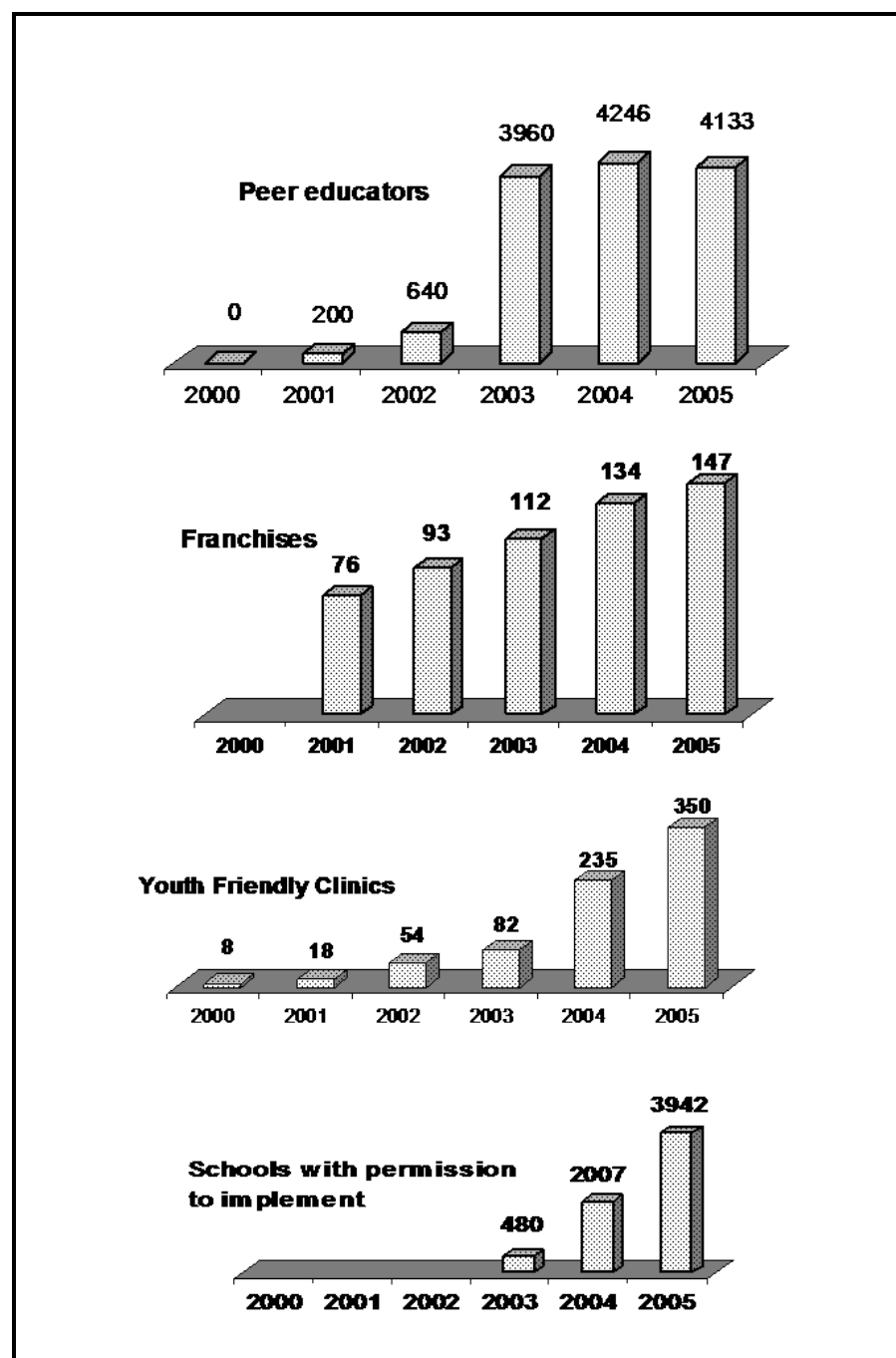
Source: loveLife.

**Exhibit 11** *Timeline of loveLife Communication Themes*

YEAR	The problem	loveLife's Response
1999	We South Africans aren't talking about HIV and the epidemic.	Talk about it.
2000	We aren't connecting HIV and sexual behavior.	It's about sex.
2001	We aren't connecting HIV and their future.	HIV: The future ain't what it used to be. Motivate a new HIV-free future.
2002	We are not taking personal nor collective responsibility.	Shape values of responsibility, love, dignity, and respect.
2003	We know about the ABC, but telling people to ABC does not address the drivers of high risk behavior.	Tackle the drivers of high risk behavior – coercion, peer pressure, sex for money.
2004	In our minds, we need to connect drivers to high risk behavior.	Focus on high risk behavior.
2005	Our actions are shaped by our attitudes – personal and societal.	Focus on attitude to self and to others – a new generation; a new way of thinking.

Source: loveLife.

**Exhibit 12** *loveLife's Scale up*



Source: Created by case writers using data from loveLife.



**Exhibit 13** *loveLife Impact Targets Set in 2004*

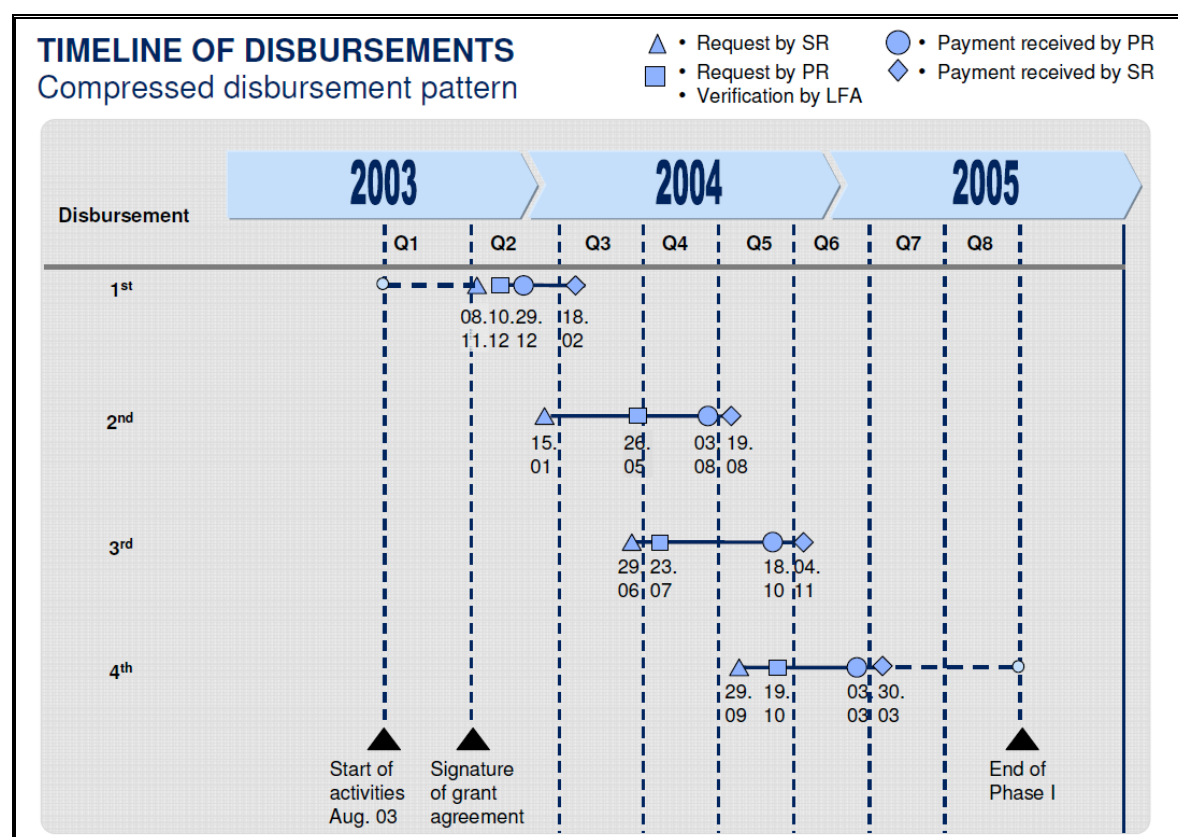
Strategic level	Indicator	Current level*	Goal**	
		2003	2006	2008
<b>GOAL</b> Reduce HIV infection among South African teenagers	HIV rates among 15-19 yr olds: Male Female HIV rates among 20-24 yr olds: Male Female	2.4% 6.9% 7.3% 24.1%	2.0% 4.5% 5.5% 20.0%	1.4% 3.0% 4.0% 15.5%
<b>OBJECTIVE</b> Reduce HIV infection among teenagers from poor and marginalized communities across South Africa	<u>HIV rates among 15-24 yr olds from:</u> Rural informal Rural formal (farms) <ul style="list-style-type: none"> <li>Households without electricity</li> <li>Out-of-school (15-19yr)</li> </ul> <u>Evaluation - Self-reported:</u> <ul style="list-style-type: none"> <li>Perceived risk of HIV: No risk (20-24 yr olds)</li> <li>Predictors of high-risk behavior: Coercion by partner (M:F) Peer pressure to have sex (M:F) Control over sexual choices (M:F)</li> <li>Indicators of high-risk sexual behavior: Condom use at last intercourse (M:F) &lt;1 sex. partners in past year (M:F)</li> </ul> <u>Program Coverage</u> <ul style="list-style-type: none"> <li>Any exposure to loveLife: Rural informal Rural formal</li> <li>Med/high exposure (4 -15 prods) Rural informal Rural formal</li> </ul>	8.8% 13.4% 11.9% 6.9 28% 16%:30% 39%:27% 85%:85% 56%:48% 44%:12% 77% 65% 46% 37%	7.0% 12.0% 10.0% 6.0% 18% 12%:24% 30%:20% 90%:90% 65%:55% 38%:9% 85% 80% 60% 60%	5.5% 9.0% 8.0% 5.0% 10% 8%: 15% 20%:14% 95%:95% 75%:70% 30%:6% 90% 90% 80% 80%

Source: loveLife.

**Exhibit 14** *Key Global Fund Stakeholders in South Africa, 2004*

<b>Global Fund Board</b>	19 members
<b>Global Fund Secretariat</b>	Responsible for Phase 2 decision panel; portfolio management; strategic information and evaluation
<b>Local Fund Agent (LFA)</b>	KMPG South Africa, financial accountant and auditor
<b>Country Coordinating Mechanism (CCM)</b>	SANAC (South African National AIDS Council): 13 government members; 12 civil society members; 3 technical members
<b>Primary Recipient (PR)</b>	National Department of Health
<b>Sub-recipient (SR)</b>	loveLife

Source: The Global Fund to Fight AIDS, Tuberculosis, and Malaria.

**Exhibit 15** *Global Fund Disbursement Schedule*

Source: The Global Fund to Fight AIDS, Tuberculosis, and Malaria.

**Appendix***List of Acronyms and Abbreviations*

ANC	African National Congress
ART	antiretroviral therapy
CCM	Country Coordinating Mechanism
DOTS	directly observed therapy, short course
DTP3	third dose of diphtheria toxoid, tetanus toxoid, and pertussis vaccine
GB	groundBREAKER
GDP	gross domestic product
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HST	Health Systems Trust
NAFCI	National Adolescent-Friendly Clinic Initiative
NGO	nongovernmental organization
PPP	purchasing power parity
RHRU	Reproductive Health Research Unit
SANAC	South African National AIDS Commission
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
USD	United States' dollar
VCT	voluntary HIV testing and counseling

## References

1. Soul City. Economically evaluating the 4th Soul City series. 2001.  
<http://www.soulcity.org.za/research/evaluations/soul-city-series-4/evaluation-cost-effectiveness/view>. Accessed June 20, 2010.
2. Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. *Lancet*. Sep 5 2009;374(9692):817-834.
3. Soul City. *Soul Buddyz Evaluation Summary Report*. 2001.
4. Population Services International. PSI in South Africa. <http://www.psi.org/south-africa>. Accessed June 10, 2010.
5. CIA. World Factbook. 2010; <https://www.cia.gov/library/publications/the-world-factbook/geos/sf.html>. Accessed April 20, 2010.
6. World Bank. World Development Indicators. Washington DC: World Bank; 2008.
7. Morrow S, Panday S, Richter L. Where we're at and where we're going: Young people in South Africa in 2005. 2005.  
[http://www.hsrb.ac.za/research/output/outputDocuments/3474\\_Morrow\\_Wherewereatandwhereweregoing.pdf](http://www.hsrb.ac.za/research/output/outputDocuments/3474_Morrow_Wherewereatandwhereweregoing.pdf). Accessed April 30, 2010.
8. loveLife. Seventh quarterly monitoring report. 2005.
9. Pettifor AE, Rees HV, Kleinschmidt I, et al. Young people's sexual health in South Africa: HIV prevalence and sexual behaviors from a nationally representative household survey. *AIDS*. Sep 23 2005;19(14):1525-1534.
10. Abt Associates. The Impending Catastrophe: A Resource Book on the Emerging HIV/AIDS Epidemic in South Africa. 2001. <http://www.kff.org/southafrica/20000515a-index.cfm>.
11. World Health Organization. World Health Statistics. 2009;  
<http://www.who.int/whosis/whostat/2009/en/index.html>. Accessed April 20, 2010.
12. Bisika T, Buch E, Mathole T, Parsons A, Sanders D. South Africa: The effects of Global Health Initiative funding for HIV/AIDS on the health system. In: Consortium. MPSA, ed. *Interactions Between Global Health Initiatives and Health Systems: Evidence from Countries*. June 2009.
13. UNAIDS. Report on the Global HIV/AIDS epidemic. 2000.  
[http://data.unaids.org/pub/Report/2000/2000\\_gr\\_en.pdf](http://data.unaids.org/pub/Report/2000/2000_gr_en.pdf).
14. South African Department of Health. HIV and AIDS/STD Strategic Plan for South Africa 2000 - 2005. <http://www.doh.gov.za/aids/docs/aids-plan/index.html>.
15. Shisana Olive, Rehle T, Simbayi LC, et al. South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008. 2009. [www.hsrbpress.ac.za](http://www.hsrbpress.ac.za).
16. Rosenberg T. When a pill is not enough. *The New York Times Magazine*. Vol 2006.
17. Kleinert S, Horton R. South Africa's health: departing for a better future? *Lancet*. Sep 5 2009;374(9692):759-760.
18. National Department of Health South Africa. Country Proposal to the Global Fund for AIDS, Tuberculosis, and Malaria. 2002.
19. Kalichman SC, Simbayi LC. HIV testing attitudes, AIDS stigma, and voluntary HIV counselling and testing in a black township in Cape Town, South Africa. *Sexually Transmitted Infections*. 2003;79:442-447.
20. Chigwedere P, Seage GR, Gruskin S, Lee TH. Estimating the lost benefits of antiretroviral drug use in South Africa. *J Acquir Immune Defic Syndr*. Dec 1 2008;49(4):410-415.
21. UNAIDS. Epidemiological Fact Sheet on HIV and AIDS: South Africa. 2008.

22. Harrison A, Smit JA, Myer L. Prevention of HIV/AIDS in South Africa: a review of behaviour change interventions, evidence and options for the future. *South African Journal of Science*. 2000;96:285.
23. Erulkar A. An assessment of youth centers in South Africa. 2001.  
[http://www.popcouncil.org/pdfs/frontiers/FR\\_FinalReports/SouthAfrica\\_Youth\\_Centers.pdf](http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/SouthAfrica_Youth_Centers.pdf). Accessed June 16, 2010.
24. Janowitz B, Cuthertson C, Beksinska M, Cebekhulu QN. The costs of programmes at selected youth centres in South Africa. 2003.  
[http://www.popcouncil.org/pdfs/frontiers/reports/costs\\_%20youth\\_centres\\_SA.pdf](http://www.popcouncil.org/pdfs/frontiers/reports/costs_%20youth_centres_SA.pdf). Accessed June 18, 2010.
25. Pettifor A, Rees H, Steffenson A, et al. *HIV and sexual behavior among young South Africans: a national survey of 15-24 year olds*. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand, 2004.
26. Global Fund Board. Independent Review: South Africa, HIV and TB – Round 1. Eleventh Board Meeting: 28-30 September 2005. <http://www.theglobalfund.org/documents/board/11/gfb1116.pdf>.