hospital and primary care services. In attempting to increase the feasibility of this plan, some of the key considerations are:

1. Extending prevention programmes and getting them to work is critical to reduce long term morbidity and costs. A simple example is PMTCT. If this programme was functioning properly, it would radically reduce paediatric aids cases.
2. Innovative financing arrangements such as partnerships with the key donors (Global Fund to Fight AIDS, TB and Malaria and PEPFAR) as well as partnerships with the private health sector, business and a range of other stakeholders is crucial.
3. Attention should be placed on increasing the affordability of medicines.
4. To enhance efficiency, attention must be given to strengthening the primary health care infrastructure so that the location of care can be shifted out of hospitals into quality primary health care services, especially at the community health centre level. This will also improve the accessibility of the service to patients.
5. Improved monitoring and evaluation is essential to show value for money for the large amount of resources being allocated to the programme. In addition, weaknesses in existing monitoring and evaluation systems makes it very difficult to adequately cost the NSP because of uncertainty around baseline performance and outputs.

Attention needs to be given to programmes to improve adherence to treatment; poor compliance and associated rapid development of resistant strains would lead to increasing reliance on more expensive lines of treatment.

**Total Costs**

**Table 1** and **Table 2** outline the costs of the key interventions contained in this report, grouped according to priority areas (e.g. prevention), goals (e.g. reduce HIV transmission) and interventions (e.g. post exposure prophylaxis) contained in the NSP.

In **Table 1**, low cost scenarios are summarized, with the key difference relating to the assumption of only 60% of new AIDS cases receiving ART by 2011. In **Table 2**, high cost scenarios are summarized, where 80% of new AIDS case receive ART by 2010.

When considering these costs, the following points should be borne in mind:

- Home based care and ART treatment will avert the inpatient care costs that would have been incurred for patients in the absence of these interventions
- Some estimates need to be revised once Operational Plans have been developed
- Costs relating to the creation of an enabling political, social and regulatory environment and monitoring and evaluation systems have not been included
- During the Operational Plan, it will also be important to pay attention to the needs of disabled and other special needs groups

The key driver of costs is adult antiretroviral treatment, at approximately 40% of the total cost. The second most expensive programme (7% of the total) relates to the support of orphans and vulnerable children thus emphasizing the importance of safeguarding families through delaying maternal and paternal mortality.

**Table 1: Summarized total costs for the low cost scenarios (million Rands, 2005/06 prices)**

| | | | Year | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Priority area** | **Goal** | **intervention** | **2007** | **2008** | **2009** | **2010** | **2011** | **% Total** |
| **Prevention** | | | **643** | **792** | **951** | **1,098** | **1,247** | **12%** |
| | **Reduce sexual transmission** | | **642** | **790** | **949** | **1,097** | **1,245** | **12%** |
| | | *Behavioural change interventions* | 300 | 400 | 500 | 600 | 700 | 6% |
| | | *Condom provision* | 145 | 152 | 172 | 180 | 188 | 2% |
| | | *Life skills* | 158 | 168 | 177 | 186 | 195 | 2% |
| | | *PEP for sexual assault* | 10 | 10 | 11 | 11 | 12 | 0% |
| | | *STI management* | 30 | 60 | 90 | 120 | 150 | 1% |
| | **Reduce transmission through occupational exposure** | | **1** | **1** | **1** | **1** | **1** | **0%** |
| | | *PEP for occupational exposure* | 1 | 1 | 1 | 1 | 1 | 0% |
| **Care, support and health system strengthening** | | | **4,042** | **5,612** | **6,960** | **8,474** | **10,012** | **88%** |
| | **Scale-up access to VCT** | | **260** | **420** | **423** | **426** | **428** | **5%** |
| | | *HIV testing* | 260 | 420 | 423 | 426 | 428 | 5% |
| | **Maintain health of HIV-infected adults** | | **2,495** | **3,365** | **4,250** | **5,301** | **6,360** | **55%** |
| | | *Antiretroviral treatment for adults* | 1,588 | 2,296 | 3,115 | 4,036 | 5,014 | 40% |
| | | *Food support for adults* | 521 | 586 | 652 | 782 | 912 | 9% |
| | | *Home and Community Based Care* | 386 | 483 | 483 | 483 | 435 | 6% |
| | **Address the special needs of mothers and children** | | **1,007** | **1,267** | **1,447** | **1,627** | **1,823** | **18%** |
| | | *Antiretroviral treatment for children* | 245 | 359 | 488 | 635 | 791 | 6% |
| | | *OVC* | 452 | 561 | 589 | 618 | 649 | 7% |
| | | *PMTCT dual therapy and infant testing* | 310 | 348 | 370 | 374 | 383 | 4% |
| | **Strengthen the health system** | | **280** | **560** | **840** | **1,120** | **1,400** | **11%** |
| | | *Strengthen TB programme management* | 30 | 60 | 90 | 120 | 150 | 1% |
| | | *Increase CHC coverage* | 250 | 500 | 750 | 1,000 | 1,250 | 9% |
| **Grand Total** | | | **4,685** | **6,404** | **7,910** | **9,572** | **11,259** | **100%** |

**Table 2: Summarized total costs for the high cost scenarios (million Rands, 2005/06 prices)**

| Priority area | Goal | intervention | Year 2007 | 2008 | 2009 | 2010 | 2011 | % Total |
|---|---|---|---|---|---|---|---|---|
| **Prevention** | | | **643** | **775** | **990** | **1,207** | **1,427** | **11%** |
| | **Reduce sexual transmission** | | **642** | **773** | **989** | **1,206** | **1,426** | **11%** |
| | | *Behavioural change interventions* | 300 | 400 | 500 | 600 | 700 | 6% |
| | | *Condom provision* | 145 | 135 | 212 | 289 | 369 | 3% |
| | | *Life skills* | 158 | 168 | 177 | 186 | 195 | 2% |
| | | *PEP for sexual assault* | 10 | 10 | 11 | 11 | 12 | 0% |
| | | *STI management* | 30 | 60 | 90 | 120 | 150 | 1% |
| | **Reduce transmission through occupational exposure** | | **1** | **1** | **1** | **1** | **1** | **0%** |
| | | *PEP for occupational exposure* | 1 | 1 | 1 | 1 | 1 | 0% |
| **Care, support and health system strengthening** | | | **4,329** | **6,075** | **7,786** | **9,804** | **11,893** | **89%** |
| | **Scale-up access to VCT** | | **278** | **364** | **451** | **568** | **714** | **5%** |
| | | *HIV testing* | 278 | 364 | 451 | 568 | 714 | 5% |
| | **Maintain health of HIV-infected adults** | | **2,724** | **3,809** | **4,926** | **6,309** | **7,714** | **57%** |
| | | *Antiretroviral treatment for adults* | 1,816 | 2,739 | 3,791 | 5,044 | 6,367 | 44% |
| | | *Food support for adults* | 521 | 586 | 652 | 782 | 912 | 8% |
| | | *Home and Community Based Care* | 386 | 483 | 483 | 483 | 435 | 5% |
| | **Address the special needs of mothers and children** | | **1,047** | **1,343** | **1,570** | **1,808** | **2,064** | **17%** |
| | | *Antiretroviral treatment for children* | 285 | 434 | 611 | 816 | 1,032 | 7% |
| | | *OVC* | 452 | 561 | 589 | 618 | 649 | 6% |
| | | *PMTCT dual therapy and infant testing* | 310 | 348 | 370 | 374 | 383 | 4% |
| | **Strengthen the health system** | | **280** | **560** | **840** | **1,120** | **1,400** | **9%** |
| | | *Strengthen TB programme management* | 30 | 60 | 90 | 120 | 150 | 1% |
| | | *Increase CHC coverage* | 250 | 500 | 750 | 1,000 | 1,250 | 8% |
| **Grand Total** | | | **4,972** | **6,850** | **8,777** | **11,011** | **13,320** | **100%** |

## 14. EFFECTIVE IMPLEMENTATION OF THE HIV AND AIDS AND STI STRATEGIC PLAN:

To achieve effective implementation, the following practical and policy issues will have to be addressed:

### a) Adoption of the HIV & AIDS & STI Strategic Plan by SANAC:

After it has been adopted by SANAC, the HIV & AIDS & STI Strategic Plan 2007-2011 should be used in developing national, provincial and district operational plans as well as sector plans. Yearly operational plans should be based on realistic objectives.

### b) Establish and Improve Structures for Delivery:

In a similar fashion to the process undertaken by SANAC there is a need to review and develop structures at all levels, from national to community where necessary. Provinces should consider duplicating appropriate national structures, such as SANAC, at provincial and local level. It is vital to establish appropriate structures at district level and it is recommended that District HIV and AIDS Committees be established. These district structures should include all the role players in the field of HIV and AIDS within relevant communities, particularly local government in order to ensure coherence in dealing with HIV and AIDS, STIs and TB issues and making development plans. It is vital that non-health issues such as transport and poverty alleviation are included in HIV and AIDS and STI planning.

### c) Policy and Legal Issues needing attention:

In relation to two of the key priority areas there are a number of policy and legal issues that require urgent attention in order to assist with the implementation of the NSP. These are set out briefly below:

### HIV Prevention:

Reduction of new HIV infections by 50% is an ambitious target. A supportive policy framework is critical for programme development in this regard.

- Establishing a national culture in which people regularly seek voluntary testing and counselling for HIV will necessitate a paradigm shift in the traditional approach to VCT. In particular it requires a policy where HIV testing is offered by health providers to specified groups of people attending health services, as well

as the identification of new strategies for the provision of counselling and testing outside of health facilities.

- At the end of 2006 research results confirmed that circumcised males have a significantly lower risk of HIV infection. A mechanism is needed to determine how best to translate such evidence into policy and programmes.
- There is overwhelming evidence that better efficacy is achieved with dual therapy in PMTCT and this regimen is known to be highly cost effective. Policy on the regimen used in PMTCT needs to be updated accordingly.
- A number of higher risk groups, such as sex workers, continue to face legal barriers to accessing HIV prevention and treatment services, because of the criminalisation of their activity. An audit of criminal laws, and their amendment with a view to ensuring non-discrimination and harm reduction, is recommended.

**Treatment, Care and Support:**

In the section below the cost of medicines is identified as the largest overall component of treatment, care and support. The price of medicines and their cost effectiveness can be impacted upon by (a) adopting polices that will contribute to adherence and (b) lowering prices. In this regard the NSP recommends the introduction of a chronic diseases grant that will promote adherence by supporting people with long term medical needs.

In addition it will be necessary to examine and amend the medicines regulatory framework to ensure access to a sustainable supply of affordable essential prevention and treatment commodities. This can be done by:

- Amending the Patents Act to permit compulsory licensing in accordance with Revised Guideline 6 of the *International Guidelines on HIV/AIDS and Human Rights* and the WTO's *Declaration on the TRIPs Agreement and Public Health* and decision on the *Implementation of paragraph 6 of the Doha Declaration on the TRIPs Agreement and public health*
- Addressing the underlying problems that prevent the Medicines Control Council from registering fast-track medicines timeously

Policy and regulatory frameworks are also needed to support implementation of innovative human resource strategies, for example 'task-shifting' (see section below).

**d. Financing the NSP:**

Weaknesses in existing monitoring and evaluation systems make it very difficult to adequately cost the NSP because of uncertainty around baseline performance and outputs. Nonetheless, the cost implications of the NSP are extremely large, in some options exceeding 20% of the health budget. This is without considering the costs arising from the effect of the epidemic on hospital and primary care services.

This poses challenges for both the affordability and sustainability of the plan, around what efficiencies might be possible and difficult resource allocation choices within the health sector and between sectors. In ensuring the feasibility of this plan, some of the key considerations are:

- Extending prevention programmes and getting them to work is critical to reduce long term morbidity and costs. A simple example is PMTCT. If this programme was functioning properly, it would radically reduce paediatric AIDS cases.
- Innovative financing arrangements such as partnerships with the key donors (Global Fund to Fight AIDS, TB and Malaria and PEPFAR) as well as partnerships with the private health sector, business and a range of other stakeholders is crucial.
- Attention should be placed on increasing the affordability of medicines.
- Improved monitoring and evaluation is essential to show value for money.
- Attention needs to be given to programmes to improve adherence to treatment; poor compliance and associated rapid development of resistant strains would lead to increasing reliance on more expensive lines of treatment.

It is important to plan to ensure that adequate funding for ensuring delivery is made available at national, provincial and district levels. One method is to establish an agreed percentage of financial resources that all provinces must place directly into HIV and AIDS programmes. The best mechanism of ensuring predictable and sustainable provision of financial resources is the conditional grant that is available through the division of revenue.

**d) Human Resources:**

A number of important systems level innovations will be necessary to implement and scale up the interventions outlined in this NSP. The biggest threat to the implementation of the NSP is the unavailability of skilled personnel. Human resources shortages, however are not a pretext for paralysis. Innovative ways have been used to mobilise local communities for the provision of services. These strategies have been successful in promoting greater access to services. Some examples include the use of community development workers, community care givers, lay counsellors in health facilities.

Task shifting involves the delegation of activities to less qualified cadres and includes, for example training of primary health care nurses (rather than doctors) to initiate antiretroviral treatment, lay counsellors (rather than nurses) "pricking" patients for rapid HIV tests, lay counsellors (instead of social workers) for orphan support activities. The regulatory and policy barriers to achieving this need to be removed and the process set in motion to provide the necessary training. Such policy decisions would require a supportive systemic environment, in order minimise the risk of compromising quality of services. In this regard, defining roles and responsibilities, targets setting, planning identifying vulnerable groups, removing barriers to access, building integrated networks, and strategies of prevention care and support as well as inter-sectoral collaboration are some of the core responsibilities at district and local level.

In this respect initiatives to develop integrated local government responses to HIV and AIDS through the Department of Provincial and Local Government and to strengthen the managerial capacity and functioning of health districts are central to the implementation of the NSP.

Finally, the ability to engage in and sustain partnerships , formal (contractual) or informal between a range of actors – patients and providers, public and private sectors, governmental and non-governmental players, and various sectors is a major determinant of success of the NSP. This applies as much to national processes in bodies such as SANAC, as to provincial and local interactions. The mobilisation of community institutions such as churches, schools and traditional authorities and coordination between health and social development sectors is at the base of social protection for orphaned and vulnerable children. Similarly, high levels of adherence and

the success of treatment programmes in many places is attributed to effective collaborations between people living with HIV, their organisations and health and social services. Partnerships allow for the rapid diffusion of new ideas and best practises, not only horizontally between local areas and provinces but also vertically between emerging experiences on the ground and policy and decision making spheres.

## 15. WAY FORWARD

Effective coordination across the sectors is key to the successful implementation of this NSP. The SANAC secretariat will be strengthened to ensure that all sector responsibility for their role as leading agencies in the implementation of the Plan. Government departments, sectors of civil society, provinces and other implementing agencies will be assisted in the development of their strategies and operational plans. Responsible policy-making bodies should ensure that all the identified gaps are address in order to support implementation of the Plan. All the necessary resources will be mobilised.

The HIV & AIDS & STI Strategic Plan provides a broad framework for government, NGOs, business, organised labour, women's and organisations and all sectors of society in responding to HIV and AIDS and STIs. Each sector should develop more specific operational plans based on its role in society, its activities and its specific strengths. Sectors are encouraged to establish technical AIDS committees, guided by and according to the requirements of SANAC structures.

## 16. CONCLUDING REMARKS

The HIV and AIDS and STI Strategic Plan 2007-2011 is seen as a dynamic document that will be subject to regular critical review. This will be undertaken at the National, Provincial and District levels with inputs from all stakeholders. A mid-term review will be conducted and the Strategic Plan modified in accordance with the findings.

## 17. ACKNOWLEDGEMENTS

The development of this *"HIV & AIDS & STI Strategic Plan for South Africa: 2007 – 2011"* would not have been possible without the immeasurable assistance from countless individuals, organisations and all those who participated in the various sector summits. Our thanks goes to all who took the time and effort to assist in the development of the document, be it through drafting sections or reading and commenting several times to improve the quality. Special thanks go to the task team members (Annexure A), who worked tirelessly to ensure excellent quality of this very important document.

**Annexure A: Map of South Africa**

The following map represents the nine provinces that make up South Africa.