THE SOUTH AFRICAN NATIONAL STRATEGIC PLAN: WHAT DOES IT MEAN FOR OUR HEALTH SYSTEM?

W D Francois Venter, *FCP (SA)*
Reproductive Health and HIV Research Unit, Department of Medicine, University of the Witwatersrand

South Africa has a new and highly ambitious guiding document to comprehensively deal with HIV over the next 5 years, the National Strategic Plan (NSP)[1] (Table I). The country has an HIV problem resulting in huge mortality and morbidity, with an associated tuberculosis crisis, a growing orphan population, and a range of well-documented adverse social and economic impacts.[2]

In 2000 the South African government, under siege internationally for its denialist President and combative Health Minister, hurriedly unveiled its 5-year programme for HIV. The plan was vague and committed the government to very little of substance, and its soft wording contrasted with the strong and clearly defined advocacy campaigns around prevention of mother-to-child transmission (PMTCT) and antiretroviral therapy (ART) provision, nutrition and unscientific supplements. In 2003, the release of the ART component of the Operational Plan for Comprehensive HIV and AIDS Care, Management, and Treatment resulted in the provision of antiretroviral treatment throughout the country over the next 4 years.[3]

The original Plan expired in 2005, but it was only when the absence of an updated version was highlighted in the media, that the Department of Health began responding by drawing up a new Plan. An initial very rough draft, released after some consultation with special interest groups in the middle of 2006, rapidly attracted civil society interest and mobilisation, as well as strong media interest.

PROCESS OF WRITING

The subsequent consultative process, ostensibly co-ordinated through the South African National Aids Council (SANAC) but in reality co-ordinated by health officials and key civil society members with some political guidance from SANAC, engaged in a laborious but highly participatory series of sectoral discussions, engaging labour, gender groups, traditional leaders, the disabled, business and academia, as well as many other sectors, including education and prisons. Ready access to e-mail meant a large number of submissions from a range of organisations and individuals were submitted electronically.

Interestingly, the process of writing was made significantly more complex by recognition that in several areas related to HIV – including poverty, housing and TB – there were existing government policy and targets, and the process of harmonising these with the new Plan was not always possible.

The writing of the final 159-page report was a consensus event by a few key individuals, and the final version was released at the time of writing, in June 2007.

STRUCTURE OF THE PLAN

The structure of the document broadly follows the original 2000 version, with four key areas:

- Prevention
- Treatment, care and support
- Research, monitoring, and surveillance
- Human rights and access to justice

TABLE I. PRIMARY AIMS OF THE NSP

The primary aims of the NSP are to:

- Reduce the rate of new HIV infections by 50% by 2011.
- Reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all HIV positive people and their families by 2011.

The intention is that 'all government departments and sectors of civil society will use this plan as a basis to develop their own HIV and AIDS strategic and operational plans to achieve a focused, coherent, country-wide approach to fighting HIV and AIDS'.

An introduction and overview sketches the epidemic with all the usual sobering indicators, and has a sanitised description of the various conflicts over the last few years between government and sectors of society. The epidemiology descriptions are a useful summary of the evolution and current status of the epidemic, and the discussion on the drivers of transmission is necessarily cursory but frank. There is a section on the process of development of the Plan, and a description of the formal governmental political process that overviews the AIDS agenda.

The bulk of the document sketches targets in the four key areas, with objectives, interventions, timelines for implementation, and lead agencies. The final section details the significant cost projections, and some key implementation suggestions, including the establishment of district committees.

STRENGTHS OF THE PLAN

Undoubtedly, the strength of the plan relates to the setting of aggressive targets (see Table II). In the old Plan, provinces were left to set their own targets, often with no measure against local prevalence rates or population size. This led to a situation where some provinces, with very high prevalence, had set themselves low targets, which could easily be met. It also allowed for priority setting in the wrong areas, often because managers and policy makers lacked the skills to identify critical concerns. In some instances, politicians used this unfocused approach to follow an unscientific and denialist agenda, channelling resources to interventions that are not evidence based.

TABLE II. SELECTED TARGETS

Target	2007	2011
PEP for sexual assault survivors	30% coverage	90% coverage
% of pregnant women tested for HIV	70%	95%
% of HIV-positive women given PMTCT	60%	95%
Adult population tested annually	7%	25%
New adult initiates on ART	120 000	420 000
% adult initiates started on ART *outside* hospital setting	30%	70%
% adult initiates started by nurses on ART	10%	80%
% HIV exposed children screened by PCR	45%	90%
New child initiates on ART	17 000	40 000
% of TB patients screened for HIV	40%	90%

PEP = post-exposure prophylaxis; PCR = polymerase chain reaction.

South Africa has excellent epidemiological provincial data, and extrapolating these targets set by the new Plan down to a district level will not be difficult. Our unapologetically hard-nosed treasury has held government departments accountable for their budgets against outputs, and it would appear that local health departments will be pushed to achieve targets once they are given adequate funding.

The wide consultative process for the new Plan brings with it unprecedented support from a broad panel of stakeholders. The inclusion of experts from throughout the country has also meant that a variety of ideas were checked against current scientific consensus. The restructuring of the health care system will require creativity and patience from all stakeholders. The consultative process may allow for some of this patience.

There is a strong emphasis on monitoring and evaluation, and adequate and committed resources are suggested for this component. 'Core' indicators are currently being developed, with other measured priorities also reviewed regularly but less often. There is commitment to supporting research, mirrored by a consultative research colloquium at the time of the Plan's launch.

There is significant focus on the specific needs of women and children, as well as special groups such as sex workers. Testing strategies and the specific issues of pregnancy are recognised, with specific indicators measuring the impact of interventions in each group. Continuity of care is also stressed, and regular CD4 measurements for people not needing ART are one of the targets.

The budget for the plan was drawn up under difficult conditions, with many details of the Plan unclear or in the process of being written. However, the Treasury has allocated significant resources to the Health Department, and will no doubt allocate more if the Plan appears to be successful.

WHAT ARE THE CHALLENGES OF THE PLAN?

A more accurate title for the Plan would have been National Strategic Targets, as the Plan gives little guidance on implementation. This may be a necessary tactic to produce a final document, but does leave provinces in a similar position to before, with little guidance on how to implement multiple complex and integrated programmes.

There is no order of priorities within the Plan. This may also be a function of the consensus building process, as well as the fact that in some cases it may truly be difficult to prioritise (how does one weigh poverty reduction against treatment?), but again leaving it up to individual provincial interpretation may lead to key targets not being met. Achieving targets in one area may be seen as permission to underachieve in

another. The implementation process will require clear national leadership and active monitoring.

Multiple government departments are responsible for many of the targets. Achieving buy-in from non-health and social welfare departments has been notoriously difficult. SANAC, tasked with the multi-sectoral response, will have its work cut out to ensure adequate commitment of energy from departments that do not see HIV as their primary focus.

Prevention is a major part of the plan. To an HIV doctor, the ambitious and noble target of reducing infection rates by 50% is, on the face of it, something to be applauded. However, the interventions are disturbingly short on detail, especially considering that current prevention efforts are having little or any impact. Behavioural interventions listed are vague and contain little evidence base. Some of the language within the prevention section borders on rhetoric, and it is unclear why continuing with current approaches would make an impact, especially an impact as great as a halving of incidence. Mechanisms for measuring new infections, which is difficult, are unclear, although the regular HSRC survey, using BED assays, may be one solution.

The XDR outbreak of tuberculosis in Tugela Ferry has triggered a much-needed interrogation of South Africa's TB programme. The NSP attracted strong submissions suggesting that strengthening the TB programme should be integrated within the document. However, there was disagreement, and the position was taken that TB has its own programme that the NSP should support, rather than that the NSP should guide the TB programme. There has been criticism of this approach, especially as the prior separation of TB and HIV has compromised both programmes.

Finally, at the time of the release of the plan, 2007 was half over. The 2007 targets are modest 'stretch targets', and failure to achieve our initial aims would be very demoralising.

SO WHAT DOES THIS ALL MEAN FOR THE SOUTH AFRICAN HEALTH SYSTEM?

Taken individually, HIV testing, PMTCT and ART targets individually would each involve an enormous refocusing of health systems. The targets collectively are phenomenally ambitious, and references to 'stretch targets' peppered all the consultative meetings. However, a radical restructuring in the way that health care is delivered will be required to ensure delivery.

CONCLUSION

The targets throughout the plan are very ambitious. The prevention targets appear to be unrealistic without a more creative and aggressive approach to the issue of behaviour. However, the testing and treatment targets, and the strong commitment to a human rights agenda and societal mitigation and stigma reduction, allows for the planning process to continue on a provincial and local level with firm treatment goals in mind. Government will need all the help it can get, however, and it will be time for civil society, health care workers and policy makers to fully commit to the new Plan.

South Africa has a long history of producing policy papers that look good but fail to facilitate delivery due to lack of implementation. It must not happen with the National Strategic Plan.

REFERENCES

1. HIV & AIDS and STI Strategic Plan for South Africa 2007-2011. Pretoria: Department of Health, 2007.
2. Anderson BA., Phillips HE. *Adult Mortality (age 15-64) Based on Death Notification Data in South Africa: 1997-2004.* Report No. 03-09-05. Pretoria: Statistics South Africa, 2006. www.statssa.gov.za
3 South African Department of Health, Full Report of the Joint Health and Treasury Task Team Charged with Examining Treatment Options to Supplement Comprehensive Care for HIV/AIDS in the Public Health Sector, November 2003. http://www.gov.za/issues/hiv/careplan19nov03.htm (last accessed 5 June 2007).