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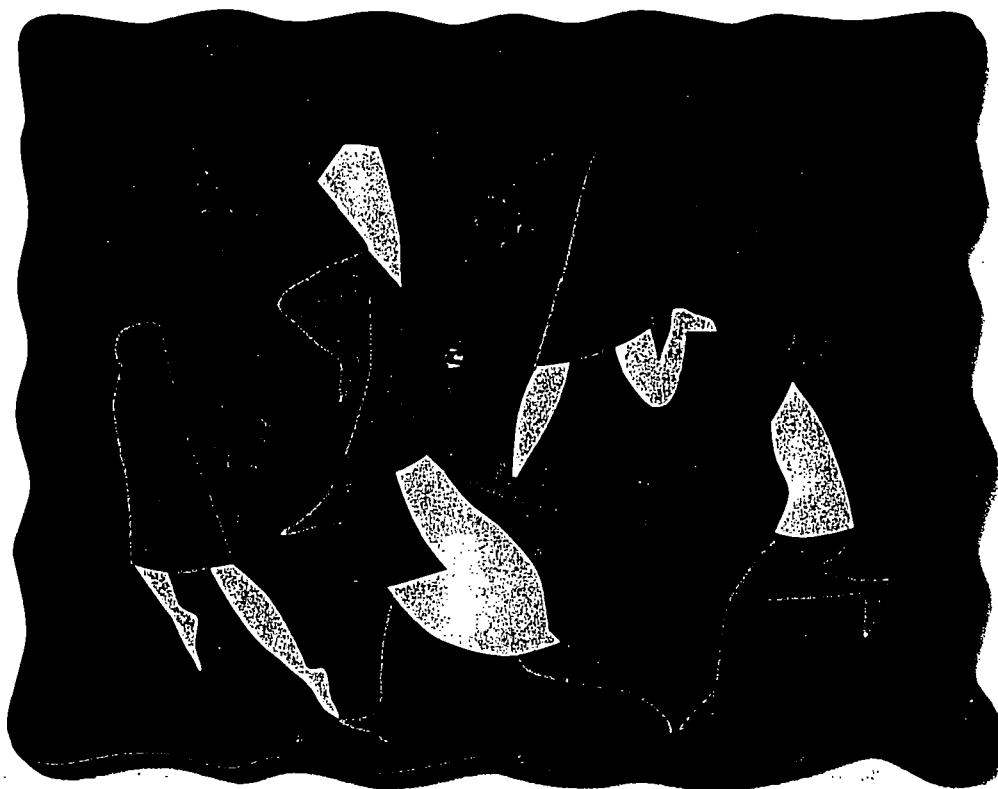
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HIV/AIDS & STD

Strategic Plan for South Africa
2000-2005



foreword

.....

The HIV/AIDS epidemic is the most important challenge facing South Africa since the birth of our new democracy. This challenge therefore, comes at a time when the country is faced with many other competing needs; redressing the imbalances of the past, transformation of our society, as well as integrating our country in the global economy are some of the many challenges.

Failure to respond to this epidemic however, will reverse all the developmental gains, made in the last five years. The Government has therefore made the fight against this scourge a top priority. In so doing, it has chosen a multi-sectoral approach as a lead strategy in combating the HIV/AIDS epidemic.

Many organisations, communities and individuals have contributed a lot in the country's response and their efforts are applauded. There is however, an urgent need to bring in more partners and to consolidate our efforts for maximum impact. This Strategic Plan has been developed with the participation of many stakeholders. Key priority areas have been identified and sectors are expected to plan their interventions in line with these priorities.

The implementation of this Strategic Plan will require enormous resources. Therefore, all sectors including Government Ministries, Non-Governmental Organisations, the private sector, religious organisations, People Living with AIDS and donor organisations are urged to devote resources towards the fight against HIV/AIDS.

South Africans have fought and won many difficult wars before. We have the ability as a country to do the same with this epidemic. Let us 'Break the Silence' around HIV/AIDS. Let us break the AIDS chain.

Dr M Tshabalala-Msimang
MINISTER OF HEALTH

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ATIC	AIDS Training and Information Centre
ART	Anti-Retroviral Therapy
BHF	Board of Health Care Funders
CBOs	Community-based Organisations
CGE	Commission on Gender Equality
CMA	Civil Military Alliance
DENOSA	Democratic Nursing Organisation of South Africa
DOE	Department of Education
DOF	Department of Finance
DOH	Department of Health
DOJ	Department of Justice
DOL	Department of Labour
DOME	Department of Minerals and Energy
DOT	Department of Transport
DOTS	Direct Observed Therapy Short Course
DOW	Department of Welfare
EDL	Essential Drug List
GCIS	Government Communication and Information System
IDC	Interdepartmental Committee on AIDS
IMC	Inter-Ministerial Committee on AIDS
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
IEC	Information, Education, and Communication
IMC	Inter-Ministerial Committee on AIDS
MOH	Ministry of Health
MEC	Member of Executive Committee
MRC	Medical Research Council
MTCT	Mother-to-child transmission
MTEF	Medium Term Expenditure Framework
NAC	National AIDS Council
NACOSA	National AIDS Co-ordinating Committee of South Africa
NGOs	Non-Government Organisations
NPPHCN	National Progressive Primary Health Care Network
PEP	Post-exposure prophylaxis
PWA	People living with HIV infection or AIDS
PHRC	Provincial Health Restructuring Committee
SAIMR	South African Institute of Medical Research
SALC	South African Law Commission
SAMA	South African Medical Association
SAPS	South Africa Police Service
SADC	Southern Africa Development Community
SANDF	South African National Defence Force
STDs	Sexually Transmitted Diseases
SM	Syndromic Management
TB	Tuberculosis
THs	Traditional Healers
UNAIDS	Joint United Nations Programme on HIV/AIDS
VTC	Voluntary HIV Testing and Counselling
WHO	World Health Organisation

Dr M Tshabalala-Msimang

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introduction

During the last two decades, the HIV pandemic has entered our consciousness as an incomprehensible calamity. HIV/AIDS has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy.

According to recent statistics by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), the number of people living with HIV was estimated to be 33,4 million by the end of 1998, a 100% increase compared to 1997. In Sub-Saharan Africa, more than a quarter of young adults are infected with HIV.

Assuming that no cure is found, it is estimated that more than 40 million people globally will be living with HIV by 2000. The impact of the epidemic on the economy is already being felt in most countries. Life expectancy has been significantly reduced as many people in the 15-49 year age group are now dying of AIDS.

Many countries, both in Africa and Asia, have taken urgent steps to curb the epidemic with varying degrees of success. In South Africa, despite our efforts, the HIV infection rate has increased significantly over the past 5 years. This increase in the infection rate calls for a renewed commitment from all South Africans.

1.1 The Purpose of the Strategic Plan

This document is a broad national strategic plan designed to guide the country's response to the epidemic. It is not a plan for the health sector specifically, but a statement of intent for the whole country, both within and outside government. It is recognised that no single sector, ministry, department or organisation is by itself responsible for addressing the HIV epidemic. It is envisaged that all government departments, organisations and stakeholders will use this document as a basis to develop their own strategic and operational plans so that all our initiatives as a country can be harmonised to maximise efficiency and effectiveness.

1.2 The Development of the Strategic Plan

The development of the Strategic Plan was initiated by the Minister of Health, Dr. Manto Tshabalala-Msimang, in July 1999. This was in response to the President, Mr Thabo Mbeki's challenge to all sectors of society to become actively involved in initiatives designed to address the HIV/AIDS epidemic.

It began with a meeting in July 1999 to review the current HIV/AIDS prevention, treatment, and care efforts in South Africa. The meeting was attended by representatives of faith-based organisations, people living with HIV infection and AIDS (PWAs), human rights organisations, academic institutions, the civil military alliance(CMA), the Salvation Army, the media, organised labour, organised sports, organised business, insurance companies, women's organisations, youth organisations, international donor organisations, health professionals and health consulting organisations, political parties, and relevant government departments.

After priority areas for future efforts were discussed and agreed upon, a committee was charged with developing a five-year HIV/AIDS & STDs Strategic Plan. Task teams were

established to review current goals and objectives for the designated priority areas. The priority areas are prevention; treatment, care and support; legal and human rights; and monitoring, research and evaluation.

In addition, the Minister of Health held bilateral meetings with several important sectors including traditional leaders, faith-based organisations and the business sector to obtain their views and to discuss ways to facilitate their active participation.

In September 1999, the Minister of Health and the nine provincial MECs for Health reconfirmed the previous priority areas. This was followed, in October 1999, by a two-day National AIDS Meeting where Provincial AIDS Co-ordinators, the National DOH HIV/AIDS & STDs Directorate, representatives of the AIDS Training and Information Centres (ATICs) and representatives of several other organisations discussed progress in the five-year HIV/AIDS & STDs Strategic Plan.

In October and November 1999 the task teams met to further develop their goals and objectives. They reviewed the National AIDS Plan for South Africa, 1994; the Department of Health White Paper for the Transformation of the Health System; the 1997 Annual HIV/AIDS & STDs review, and reports from the September meeting of the Provincial MECs for Health, and the National AIDS meeting.

In November 1999 a draft document was presented to the Inter-Ministerial Committee (IMC) on AIDS, and additional comments were solicited from all government ministers. The final document was completed in January 2000.



background

2.1 Situation Analysis

The South African picture of the epidemic

The Sub-Saharan and Southern Africa is suffering severely from the HIV/AIDS pandemic. Recent estimate suggest that of all people living with HIV in the world, 6 out of every 10 men, 8 out of every 10 women, and 9 out of every 10

children are in Sub-Saharan Africa. These figures provide sufficient evidence to make HIV/AIDS both a regional and a national priority. Data from the DOH's Annual National HIV Seroprevalence Surveys of women attending Antenatal Clinics (ANC) for the past 9 years provides a good estimate of HIV prevalence and trends over time in South Africa (See figure 1).

Figure 1: The National HIV survey of women attending antenatal clinics of the public health services in South Africa, 1990 - 1999

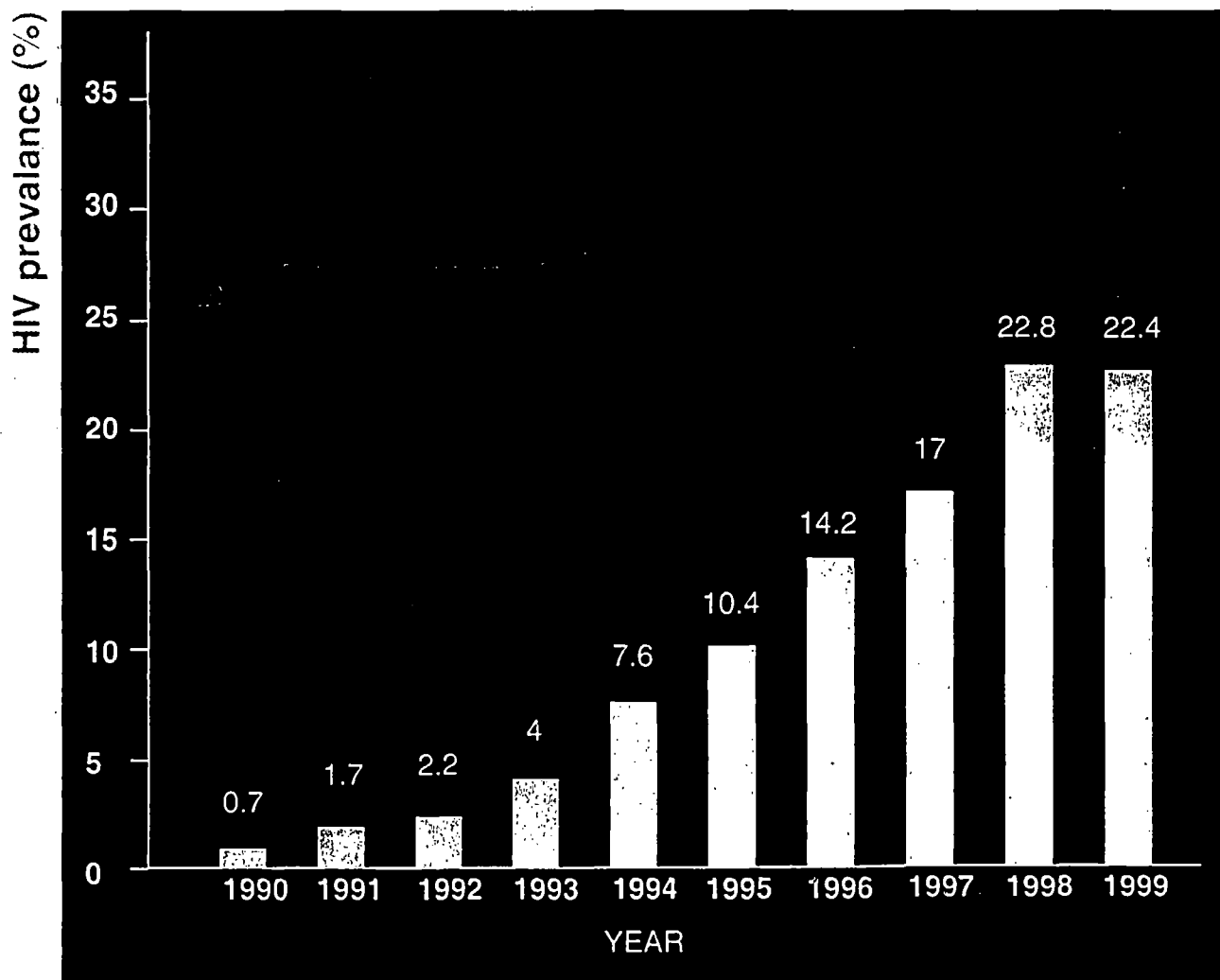
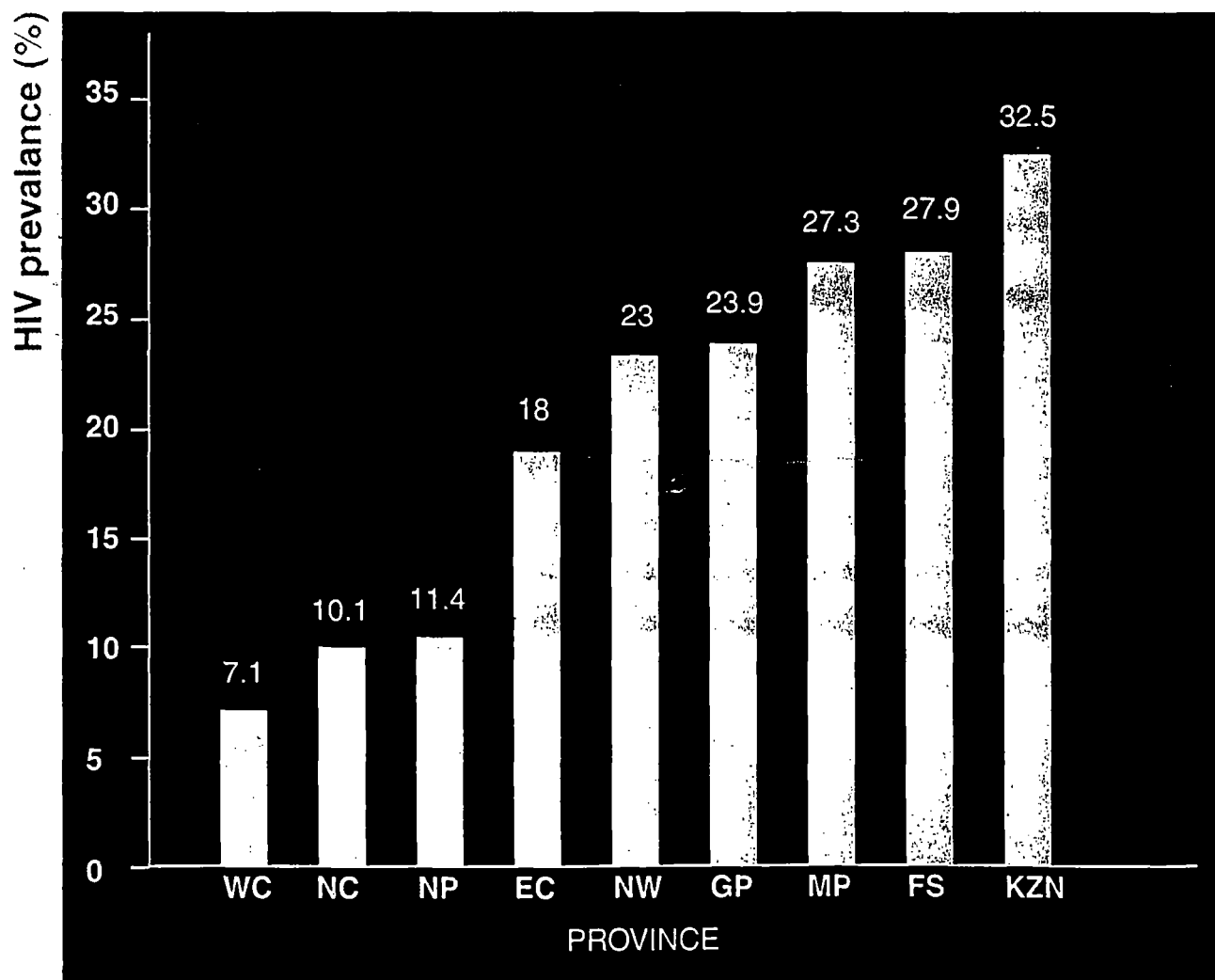


Figure 2 presents HIV prevalence in women attending antenatal clinics by province in 1998. This data reveals geographic disparities in the distribution of the HIV/AIDS epidemic in South Africa.

Figure 2: HIV prevalence in pregnant women attending public antenatal clinics by Province, South Africa, 1999



*Key: KZN = KwaZulu-Natal Province; MP = Mpumalanga Province; FS = Free State Province; GP = Gauteng Province; NW = North West Province; NP = Northern Province; EC = Eastern Cape Province; NC = Northern Cape Province; WC = Western Cape Province

**See Annexure A for map*

Additional information from the survey reveal that:

- The HIV epidemic in South Africa is one of the fastest growing epidemics in the world
- Young women aged 20-30 have the highest prevalence rates
- Young women under age 20 had the highest percentage increase compared to other age groups in 1998 compared to 1997.

This and other data clearly indicate that the HIV epidemic is severely affecting the young, black, and economically poor populations of South Africa.

Currently there are approximately 4.2 million South Africans living with HIV. It is estimated that in 1998 over 1,600 people were infected with HIV each day – this translates to more than 550,000 people infected each year. It is estimated that by the year 2005, there will be 6 million South Africans infected with HIV and almost 1 million orphans under the age of 15 whose mothers will have died of AIDS.

AIDS is currently not a notifiable disease in South Africa and voluntary reporting seriously underestimates the number of people with AIDS. It is estimated that there were approximately 165,000 people living with AIDS and 120,000 AIDS deaths in 1998. Projections indicate that by 2002 a quarter of a million South Africans will die of AIDS, and that this figure will rise to more than a million by 2008. Average life expectancy is expected to fall from approximately 60 years to 40 years between 1998 and 2008.

Major causes and determinants of the epidemic in South Africa

The immediate determinants of the epidemic include behavioural factors such as unprotected sexual intercourse, multiple sexual partners, and biological factors such as the high prevalence of sexually transmitted diseases.

The underlying causes include socio-economic factors such as poverty, migrant labour, commer-

cial sex workers, the low status of women, illiteracy, the lack of formal education, stigma and discrimination. The national HIV/AIDS & STD Strategic Plan must address all these immediate determinants and underlying causes.

Tuberculosis and HIV/AIDS

Closely linked to the HIV/AIDS epidemic, is Tuberculosis (TB) which is fuelled by HIV infection. TB is also the most frequent cause of death in people living with HIV. In South Africa, approximately 40-50% of TB patients are infected with HIV. In some hospitals in South Africa, the HIV prevalence in TB patients has been recorded as over 70%.

Sexually Transmitted Diseases

There is compelling evidence of the importance of STDs as a major determinant of HIV transmission. There are approximately 11 million STD episodes treated annually in South Africa, with approximately 5 million of these managed by private general practitioners. Even without the HIV epidemic, STDs pose an important public health problem.

2.2 Response Analysis

A detailed description of the country's response to the HIV/AIDS epidemic is beyond the scope of this plan. However, a summary of the key responses and constraints include the following:

- In 1992 the National AIDS Co-ordinating Committee of South Africa (NACOSA) was launched with a mandate to develop a national strategy on HIV/AIDS. Cabinet endorsed this strategy in 1994. The goals of this plan were to (a) prevent HIV transmission; (b) reduce the personal and social impact of HIV infection, and (c) mobilise and unify, provincial, international and local resources.
- South African National STD&HIV/AIDS Review was conducted in 1997 in line with the goals outlined in the NACOSA plan. This review indicated the following strengths in South Africa's response to the epidemic:

- There is a high level of commitment from the Health Ministry
- Collaboration initiated by the DOH at various levels to ensure an interdepartmental and inter-sectoral response
- NGOs and CBOs have been highly motivated and active *albeit* operating with limited resources
- Adequate drug supply and accessibility for STD management is good in most clinics
- Improvements in TB services.

The following constraints were noted:

- Major restructuring of national and provincial departments has delayed the appointments of personnel. Both human and financial resources at all levels were limited.
- District structures have not been established.
- Lack of structured referral systems and continuity of care, home based care, and terminal care facilities.
- Lack of integration of STD & HIV/AIDS and TB care.
- Lack of visible commitment outside the DOH to effective interdepartmental implementation of the programme.
- There is continued high levels of discrimination and human rights abuses of people affected by and infected with HIV/AIDS.
- Lack of provincial policies, guidelines or management protocols for comprehensive care and counselling.
- Health promotion materials are not always available in the vernacular and are not client sensitive or user friendly.

Following this review of both the strengths and weaknesses in addressing the HIV/AIDS epidemic, the following recommendations were made:

- Increase resources and build capacity at provincial and district levels to manage, organise, and implement the HIV/AIDS & STD Programme. Provincial authorities should designate co-ordinators responsible for STD & HIV/AIDS in every province and district
- Ensure secure political leadership from the Deputy President and to increase political

commitment and public leadership

- Strengthen interdepartmental and intersectoral response to the epidemic
- A concerted effort by all stakeholders needs to be made to protect human rights, counter discrimination and reduce stigmatisation
- Support and strengthen People living with HIV infection or AIDS (PWA) initiatives and increase full involvement of PWAs in programme design, implementation, and evaluation
- Increase collaboration between the HIV/AIDS & STD and TB programmes.

Subsequent to the 1997 Review, some of the recommendations have been addressed by the following actions:

- Appointing HIV/AIDS Coordinators in each province and supporting regular training and meetings to facilitate programme implementation
- Establishing an Inter-Ministerial Committee on AIDS. This Committee consists of Ministers and Deputy Ministers and meets on a monthly basis to discuss HIV/AIDS and provide political direction and policy guidance to the HIV/AIDS & STD Directorate
- The launch of the Partnership against AIDS by the President in 1998 to broaden and formalise the participation by all sectors in response to the epidemic
- The development of an HIV/AIDS policy by the Department of Education (DOE) for learners and educators. This makes HIV/AIDS education a component in the curricula of all secondary schools
- The development of other national policies including, the Syndromic Management of STDs and post-exposure prophylaxis (PEP) following occupational exposure to HIV
- The establishment the South African AIDS Vaccine Initiative in 1998. This initiative seeks to develop an effective, affordable preventive vaccine for universal use in South Africa and SADC countries by 2005
- The establishment of the South African National AIDS Council (SANAC), a multi-

toral body that will oversee the national response to the epidemic and the implementation of the Strategic Plan. The SANAC facilitates collaboration between government and all other sectors

- The establishment of a national interdepartmental HIV/AIDS committee that developed HIV/AIDS workplace policies and minimum HIV/AIDS programmes for all government departments
- The development of a Strategic Framework for a South African AIDS Youth Programme
- Improved collaboration between HIV/AIDS & STD and TB programmes in the area of policy formulation and advocacy.

This Strategic Plan aims to address the recommendations that have not been adequately addressed since 1997, and provides a strategic framework for the country's response to the HIV/AIDS & STD epidemic.

Initiatives in the Southern African Development Community (SADC) Countries

South Africa is the current chair and host of the Health Desk of SADC, which currently has 14 member states: Angola, Botswana, the Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, the Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

A regional response to HIV/AIDS & STDs is essential in curbing the spread, and to this end a SADC HIV/AIDS & STD task force has been formed and has prepared an HIV/AIDS & STD plan for 1999 - 2003. The three broad goals of the programme are to achieve:

- A better co-ordinated and harmonised response to HIV/AIDS & STD among Member States
- A multi-sectoral response to HIV/AIDS & STD
- Improved quality and coverage of the response to HIV/AIDS & STD both at national and regional level.

These initiatives will be important in ensuring that

South Africa and its regional partners have a more co-ordinated response to the HIV/AIDS epidemic. SADC thus forms an important link in the mechanisms and structures available to the country.

structures in south africa to address HIV/AIDS



The expanded national response will be managed by different structures at various levels. It is envisaged that each government ministry will have a focal person and team with a responsibility will be to plan, budget, implement and monitor HIV/AIDS interventions. It is also recommended that all other sectors including parastatals, NGOs, the private sector, faith-based organisations, youth, and women will also have dedicated HIV/AIDS focal persons. (See diagram 1 on page 9):

The following presents a brief overview of important structures at national and provincial levels and their specific role and functions relating to HIV/AIDS.

- **Cabinet**

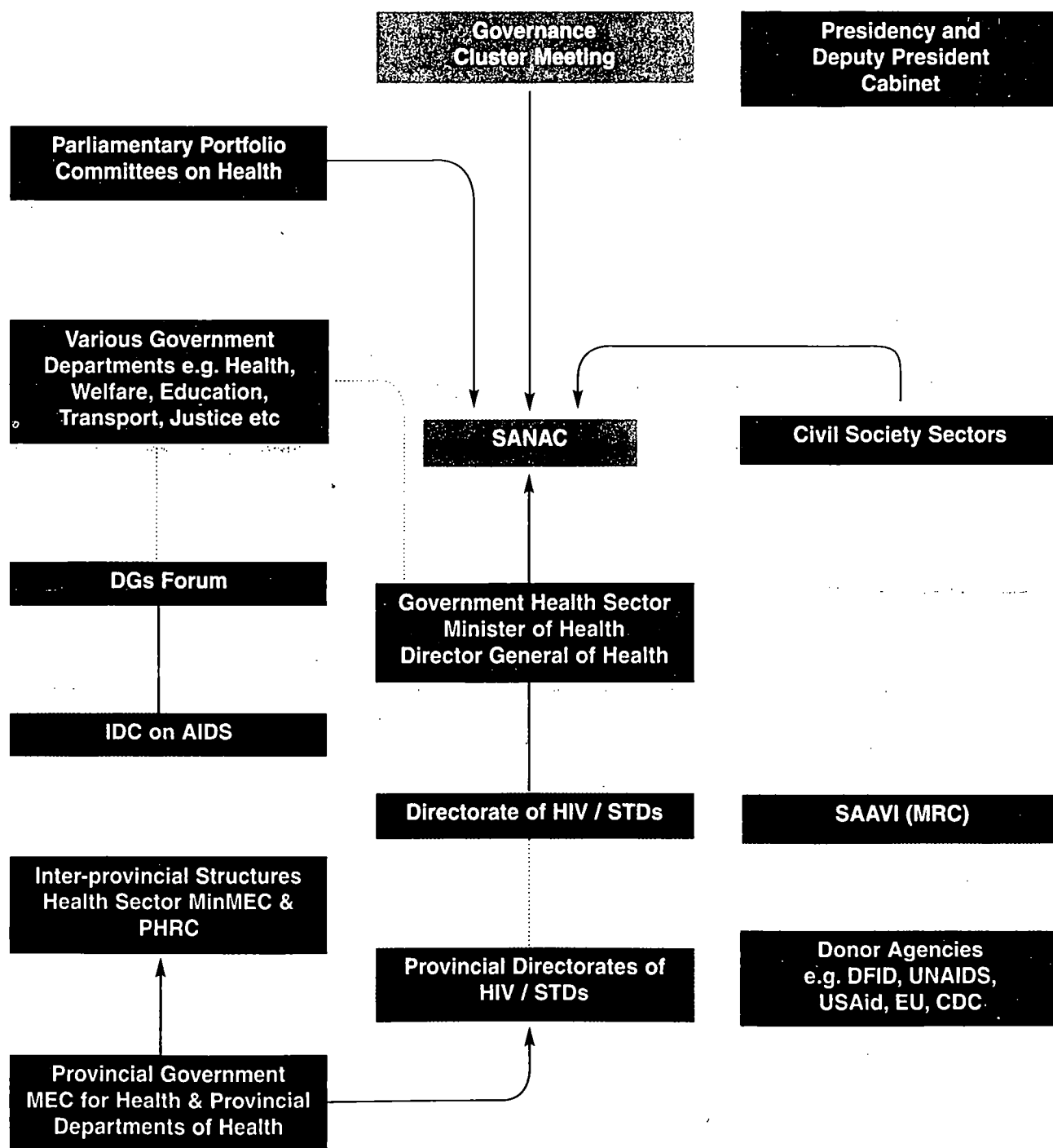
The Cabinet is the highest political authority in the country. The Cabinet meets weekly, but HIV/AIDS issues are not regularly discussed at this level, as all Cabinet members plus all Deputy Ministers and members of the Department of Health meet monthly in the Inter-Ministerial Committee on AIDS (see page 10).

- **South African National AIDS Council (SANAC)**

SANAC is the highest body that advises government on all matters relating to HIV/AIDS. Its major functions are to: (a) advise government on HIV/AIDS & STD policy, (b) advocate for the effective involvement of sectors and organisations in implementing programmes and strategies, (c) monitor the implementation of the Strategic Plan in all sectors of society, (d) create and strengthen partnerships for an expanded national response among all sectors, (e) mobilise resources for the implementation of the AIDS programmes, and (f) recommend appropriate research.

This body is chaired by the Deputy President, and consists of 15 government representatives and 16 civil society representatives (see list on page 10).

Diagram 1: Relevant National and Provincial Structures



- **Government**

Ministers of Health; Education; Welfare and Population Development; Agriculture; Arts, Culture, Science and Technology; Transport; Labour; Finance; Provincial and Local Government; Defence; Minerals and Energy; Correctional Services; the Deputy CEO of the Government Communication and Information Systems; the Chairperson of the Portfolio Committee on Health; and the Chairperson of the Select Committee on Social Services.

- **Sectors to be represented**

One representative from each of the following sectors: Business; People living with HIV/AIDS; Non-government organisations; Faith-based organisations; Trade Unions; Women; Youth; Traditional healers; Traditional leaders; Legal and Human Rights; Disabled People; Celebrities; Sport; Media; Hospitality Industry; and Local Government.

- **Technical Task Teams**

The Technical Task Teams, established by the Ministry of Health, will assist SANAC in its deliberations and decisions. These teams comprise experts in the following five areas: a) Prevention; b) Care and Support, c) Information Education and Communications (IEC) and Social Mobilisation, d) Research, Monitoring, Surveillance and Evaluation; and e) Legal issues and Human Rights.

- **Inter-Ministerial Committee on AIDS (IMC)**

In 1997, the South African Cabinet formed the IMC. The IMC consists of all Ministers and Deputy Ministers and is chaired by the Deputy President. This committee meets on a monthly basis to review the country's response to the HIV/AIDS epidemic. Issues of strategic importance are discussed and political guidance is given to the HIV/AIDS and STD Directorate and the IDC.

- **Interdepartmental Committee on AIDS (IDC)**

This committee consists of representatives from all government departments who co-ordinate HIV/AIDS activities. The IDC meets monthly to

review government programmes and to fulfil requests from the IMC. Goals of the IDC include facilitating the development of HIV/AIDS workplace policies in all government departments, ensuring that all departments allocate financial resources to HIV/AIDS; and developing minimum HIV/AIDS programmes for all the departments.

- **MinMEC**

The MinMEC consists of all Provincial Health MECs and the national Minister of Health. The MinMEC meets every six weeks, and is the body that approves national policies and guidelines. HIV/AIDS is a standing item where reports on national and provincial programmes are discussed.

- **Provincial Health Restructuring Committee (PHRC)**

This committee consists of all Provincial Heads of Health and meets on a monthly basis to discuss the strategic issues of national and provincial importance. HIV/AIDS is a standing agenda item where reports from the IMC, National HIV/AIDS & STD Directorate and Provincial HIV/AIDS Co-ordinators are discussed. Once the PHRC has discussed and approved documentation, it is referred to the MinMEC for political approval.

- **Directors-General Forum**

This forum consists of Directors General from all the National Government Departments and meets regularly. HIV/AIDS is a standing agenda item where reports from the IMC are discussed.

- **HIV/AIDS and STD Directorate, Department of Health**

HIV/AIDS issues are brought to the attention of the above national bodies by the Department of Health's Directorate of HIV/AIDS & STDs. This Directorate prepares briefing documents for these national forums, and attends meetings to provide further information to assist decision-making in these national committees and bodies.



guiding principles

The following principles for HIV/AIDS and STD prevention, treatment and care efforts for South Africa were previously adopted in the National AIDS Plan for South Africa, 1994 - 1995, and the Department of Health's White Paper for the Transformation of the Health System in South Africa, 1997. They are reaffirmed.

- People with HIV and AIDS shall be involved in all prevention, intervention and care strategies
- People with HIV and AIDS, their partners, families and friends shall not suffer from any form of discrimination
- The vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent infection
- Confidentiality and informed consent with regard to HIV testing and test results shall be protected
- Education, counselling and health care shall be sensitive to the culture, language and social circumstances of all people at all times
- The Government has a crucial responsibility with regard to the provision of education, care and welfare of all people of South Africa
- Full community participation in prevention and care shall be developed and fostered
- All intervention and care strategies shall be subject to critical evaluation and assessment
- Both government and civil society shall be involved in the fight against HIV/AIDS
- A holistic approach to education and care shall be developed and sustained
- Capacity building will be emphasised to accelerate HIV/AIDS prevention and control measures
- STDs prevention and control are central elements in the response to HIV/AIDS.

HIV/AIDS and STD strategic plan for south africa 2000 - 2005



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The primary goals are to:

- Reduce the number of new HIV infections (especially among youth)
- Reduce the impact of HIV/AIDS on individuals, families and communities.

The following general strategies will be stressed:

- An effective and culturally appropriate information, education and communications (IEC) strategy
- Increase access and acceptability to voluntary HIV testing and counselling
- Improve STDs management and promote increased condom use to reduce STD and HIV transmission
- Improve the care and treatment of HIV positive persons and persons living with AIDS to promote a better quality of life and limit the need for hospital care.

The Strategic Plan is structured according to the following four areas:

- Prevention
- Treatment, care and support
- Human and legal rights
- Monitoring, research and surveillance.

In addition, the youth will be broadly targeted as a priority population group, especially for prevention efforts.

A national set of primary indicators and surveillance data for the country

South Africa needs a set of key indicators that can be used to track the overall response of the country to the epidemic. This means not only tracking the course of the epidemic over the next five years, but also tracking changes in attitudes, social values, health care practices, socio-economic conditions and behaviours that act as predisposing factors of the epidemic.

The following list of indicators is proposed as a combination of various indicators, that collectively can be used to judge how well the country is doing in terms of tackling the HIV epidemic.

Where necessary, mechanisms to collect the required data will be developed.

General trends of the epidemic

- Prevalence of HIV amongst antenatal clinic attendees (using national sentinel surveillance procedure)

Youth

- Prevalence of HIV amongst antenatal clinic attendees below the age of 18 years (using national sentinel surveillance procedure)
- Teenage pregnancy incidence and rate

Prevention

- Proportion of STD cases effectively managed using syndromic treatment in a) the public sector; b) the private sector
- Percentage of sexually active women using condoms
- Proportion of children leaving primary school who are fully informed of the causes and methods of transmission of HIV

Socio-economic indicators predisposing to HIV transmission

- Proportion of household living below the minimum poverty line
- Unemployment rate

Abuse of women

- The number of reported rape cases
- The number of cases of workplace legislation abuse related to employees contracting HIV

Social values, human rights and acceptance in the community

- The number of VTC clients
- The number of homeless children, as a proxy indicator of the capacity of society to care for
- AIDS orphans
- The number of people "coming out" as people living with AIDS

Goals, objectives, strategies and lead agencies

PRIORITY AREA 1: Prevention

- Goal 1: Promote safe and healthy sexual behaviour
- Goal 2: Improve the management and control of STDs
- Goal 3: Reduce mother-to-child transmission (MTCT)
- Goal 4: Address issues relating to blood transfusion and HIV
- Goal 5: Provide appropriate post-exposure services
- Goal 6: Improve access to Voluntary HIV Testing and Counselling (VTC)

PRIORITY AREA 2: Treatment, care and support

- Goal 7: Provide treatment, care and support services in health-care facilities
- Goal 8: Provide adequate treatment, care and support services in communities
- Goal 9: Develop and expand the provision of care to children and orphans

PRIORITY AREA 3: Research, monitoring and evaluation

- Goal 10: Ensure AIDS vaccine development
- Goal 11: Investigate treatment and care options
- Goal 12: Conduct policy research
- Goal 13: Conduct regular surveillance

PRIORITY AREA 4: Human and legal rights

- Goal 14: Create a supportive and caring social environment
- Goal 14: Develop an appropriate legal and policy environment

5.1 PRIORITY AREA 1: Prevention

GOAL 1: PROMOTE SAFE AND HEALTHY SEXUAL BEHAVIOUR

Objective	Selected Strategies	Lead Agencies
Promote improved health seeking behaviour and adoption of safe sex practices	a) Produce and disseminate IEC material and messages to different stakeholders b) Implement life skills education in all primary and secondary schools c) Increase the number of trade unions who have implemented HIV/AIDS & STD policies and programmes d) Facilitate and support the trucking industry's AIDS High Transmission project	DOE, DOH, NGOs, Trade Unions, DOL, DOH Youth Sector
.....		
Broaden responsibility for the prevention of HIV to all sectors of government and civil society	a) Develop sector-specific policies and plans for the prevention of HIV/AIDS & STDs, focussing specially on the following sectors: the Government sector: Health; Education; Welfare; Local Government; Transport; Justice; Police; Correctional Services; Home Affairs; Civil society sectors: Traditional leaders; Youth; Faith-Based Organisations; Business; Entertainment and Media.	DOH, NAC, All Sectors
.....		
Implement HIV/AIDS prevention for migrants	a) Develop an health programme with an HIV focus as part of the Maputo corridor project b) Facilitate cross-border interventions c) Work in partnership with other SADC countries	DOH, SADC, UNAIDS
.....		
Develop and implement counselling and care programmes for all national government departments	a) Create public awareness of HIV/AIDS & STDs in all government departments b) Identify, train, and support peer educators c) Distribute condoms in all government department buildings	DOH and other government departments
.....		
Improve access to and use of male and female condoms, especially amongst 15-25 year olds	a) Expand condom distribution through non-traditional outlets b) Improve access to condoms in high transmission areas (e.g. truck stops, borders, mines and brothels) c) Increase acceptance, positive attitudes and perceptions, efficacy and use of condoms as a form of contraception among the youth	DOH, All Sectors

GOAL 2:IMPROVE THE MANAGEMENT AND CONTROL OF STDs

Objective	Basic Strategies	Lead Agencies
Ensure effective Syndromic Management (SM) of STDs in the private sector	a) Investigate the dispensing of licences to nurses for STD treatment b) Monitor and regulate the quality of care in the private sector c) Training on SM within the private sector d) Review Medical Schemes regulations to ensure minimum reimbursement for treatment of STDs	DOH, SAMA, Board for Health-care Funders, Health Professions Council of SA
• • • • •		
Ensure effective Syndromic Management (SM) of STDs in the public sector	a) Training in syndromic management undergraduate / basic curricula of all nurses, doctors and pharmacists b) Regular in-service training of HCWs	DOH, SANC, Nurse training institutions, Medical Schools
• • • • •		
Collaborate with traditional healers to improve health seeking behaviour for STD treatment	a) Develop, print and distribute training manuals in various languages b) Conduct capacity building workshops with THs c) Sensitise the health sector regarding traditional medicine d) Consider referral systems between traditional and Western medicine	DOH, Traditional Healer Organisations; CONTRALESA
• • • • •		
Increase access to youth friendly reproductive health services - including STD management, VTC and rapid HIV testing facilities (special focus on youth, women, and migrant workers)	a) Make clinics and HCWs "youth friendly" b) Make schools places where youth can access friendly and supportive counselling services	DOH, DOE, Youth Sector

GOAL 3:REDUCE MOTHER-TO-CHILD HIV TRANSMISSION (MTCT)

Objective	Selected Strategies	Lead Agencies
Improve access to HIV testing and counselling in ANC clinics	a) Develop counselling guidelines b) Train counsellors	DOH, Women's Sector, NGOs
• • • • •		
Improve family planning services to known HIV positive women	a) Train reproductive health providers on HIV/AIDS counselling b) Improve access to comprehensive reproductive health services for HIV positive women	DOH, Women's Sector, NGOs, NPPHCN
• • • • •		
Implement clinical guidelines to reduce the transmission of HIV during childbirth and labour	a) Train all relevant midwives and medical practitioners	DOH, Nursing Training Institutions, Medical Schools

GOAL 4: ADDRESS ISSUES RELATING TO BLOOD TRANSFUSION AND HIV

Objective	Selected Strategies	Lead Agencies
Maintain a safe blood transfusion service	a) Monitor implementation of current guidelines on blood transfusion b) Develop national guidelines on HIV and blood transfusion c) Improve the recruitment of low-risk blood donors	DOH, SA Blood Transfusion Service

GOAL 5: PROVIDE APPROPRIATE POST-EXPOSURE SERVICES

Objective	Selected Strategies	Lead Agencies
Provide services for needlestick injuries and occupational exposure	a) Ensure appropriate policies for needlestick exposure in the private sector b) Ensure the supply of anti-retroviral drugs to treat occupational exposure in public health facilities c) Reduce exposure to occupational exposure through the appropriate disposal of medical waste	DOH, DOL
Investigate options to reduce HIV/STD transmission and pregnancies resulting from sexual assault	a) Review research on use of Anti-Retroviral Therapy (ART) to prevent HIV transmission following sexual assault b) Assess services for women and men following sexual assault	DOH, Research Institutions

GOAL 6: IMPROVE ACCESS TO VOLUNTARY TESTING AND COUNSELLING

Objective	Selected Strategies	Lead Agencies
Increase the number of voluntary HIV testing and counselling sites	a) Introduce counselling service in all new testing sites b) Expand use of rapid testing methods Increase the proportion of workplaces that have on-site counselling and testing services	DOH
Increase the number of persons seeking VTC	a) Promote access to VTC services, especially for the youth	DOH, All Sector

5.2 PRIORITY AREA 2: Treatment, care and support

GOAL 7: PROVIDE TREATMENT, CARE AND SUPPORT SERVICES IN HEALTH FACILITIES

Objective	Selected Strategies	Lead Agencies
Improve treatment, care and support for people living with and affected by HIV/AIDS 	a) Develop guidelines for the treatment and care of HIV/AIDS patients in health-care facilities and the community b) Ensure uninterrupted supply of appropriate drugs for the treatment of opportunistic infections and other related conditions c) Build capacity of health professionals to provide comprehensive HIV/AIDS, STD & TB treatment, care and support d) Establish strong links between health facilities and community-based support programmes e) Improve prevention and treatment of TB and other opportunistic infections	DOH, Training Institutions, PWAs
Establish poverty alleviation projects to address the root causes of HIV/AIDS, STDs and TB 	a) Incorporate HIV/AIDS, STDs and TB as indicators of poverty b) Involve relevant government departments and the private sector in poverty alleviation projects	Agricultural sector, Government departments, NGOs, Business
Ensure appropriate practices in the private sector and medical insurance industry for the care and treatment of HIV positive clients	a) Review international and regional practices relating to HIV and medical insurance b) Lobby the medical schemes industry to review benefits and coverage for HIV positive clients c) Standardise a minimum package of treatment and care for people living with HIV/AIDS in the public and private sector	DOH, BHF

GOAL 8: PROVIDE ADEQUATE TREATMENT, CARE AND SUPPORT SERVICES IN COMMUNITIES

Objective	Selected Strategies	Lead Agencies
Develop and implement models of community/home-based care in all provinces	a) Develop appropriate home-based care implementation guidelines b) Promote the establishment of intersectoral task teams at community level to develop community/home-based care c) Reduce stigma of HIV/AIDS in communities and develop IEC materials targeted at communities	DOH, DOW, NGOs
.....		
Increase acceptability to community/home-based care	a) Use media for more exposure to the issues of home-based care in communities	DOH, DOW, NGOs, Media, all

GOAL 9: DEVELOP AND EXPAND THE PROVISION OF CARE TO CHILDREN AND ORPHANS

Objective	Selected Strategies	Lead Agencies
Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS	a) Promote advocacy of all relevant issues that affect children b) Mobilise financial and material resources for orphans and child-headed households c) Investigate the legal protection of child-headed households d) Provide social welfare, legal and human rights support to protect educational and constitutional rights	DOH, DOW, DOJ, NGOs, Business
.....		
Implement measures to facilitate adoption of AIDS orphans	a) Investigate the use of welfare benefits to assist children and families living with HIV/AIDS b) Subsidise adoption of AIDS orphans	DOW, DOE

5.3 PRIORITY AREA 3: Research, monitoring and surveillance

GOAL 10: ENSURE AIDS VACCINE DEVELOPMENT

Objective	Selected Strategies	Lead Agencies
Support efforts to develop a Clade C HIV vaccine	b) Conduct biological and behavioural research to support the development of an AIDS vaccine b) Support the South African AIDS Vaccine Initiative c) Develop South African ethical guidelines for vaccine research	DOH, MRC, Research Institutions

GOAL 11: INVESTIGATE TREATMENT AND CARE OPTIONS

Objective	Selected Strategies	Lead Agencies
Review and revise policy on anti-retroviral use for reducing mother-to-child HIV transmission	a) Review, monitor and evaluate current research on the use of anti-retroviral therapy to reduce mother to child HIV transmission b) Identify and implement additional areas of research c) Review and update national policies to reduce MTCT	DOH, Academic Institutions, Research Institutions, Women's Sector
..... Conduct research on the cost-effectiveness of other forms of non-retroviral treatment and prophylaxis	a) Review international research b) Facilitate local research	MRC, DOH, Research Institutions
..... Conduct research on the effectiveness of traditional medicines	a) Conduct clinical trials b) Review international research c) Collaborate with traditional healers	Traditional Healers, MRC, DOH

GOAL 12: CONDUCT POLICY RESEARCH

Objective	Selected Strategies	Lead Agencies
Conduct HIV/AIDS studies in selected departments and provinces	a) Commission research	DOH, DOF, government departments
Conduct research to determine HIV incidence	a) Conduct HIV incidence surveys in narrow age groups to approximate incidence	MRC, DOH

GOAL 13: CONDUCT REGULAR SURVEILLANCE

Objective	Selected Strategies	Lead Agencies
Develop mechanisms for long and short-term training to improve the capacities of provincial and district staff to conduct HIV/AIDS&STD related operations research and surveillance.	a) Training for provincial and district staff on research and surveillance in collaboration with research and training institutions	DOH, Academic Institutions
Conduct national surveillance on HIV and STD risk behaviours, especially among youth	a) Conduct behavioural sentinel surveys, with a focus on youth b) Conduct routine STD surveillance c) Conduct surveillance of AIDS morbidity and mortality d) Conduct national HIV infections surveillance in selected populations and groups, including STD and TB clients, hospitalised patients, men, and youth	DOH, HSRC, GCIS, MRC, Youth Sector

5.4 PRIORITY AREA 4: Human and legal rights

GOAL 14: CREATE AN APPROPRIATE SOCIAL ENVIRONMENT

Objective	Selected Strategies	Lead Agencies
Develop a National Inter-Sectoral Campaign on Openness and Acceptance of People Living with HIV/AIDS	a) Promote open discussion of sexual practices in various sectors of society b) Promote VTC c) Target awareness regarding rights and responsibilities of people living with HIV/AIDS in 4 key areas: employment rights, education, health care and social service rights	SANAC, Government Departments, NGOs, all Sectors, SABC
.....		
Create a legal and policy environment which protects the rights of all persons infected and affected by HIV/AIDS by 2005	a) Review existing legislation and ensure the protection of rights of people living with HIV/AIDS b) Develop policy on the management of mentally challenged HIV positive persons c) Review and enact new Children's Law to take into account the needs of children infected and affected by HIV/AIDS	DOJ, DOH, SALC
.....		
Monitor human rights abuses and develop enforcement mechanisms for redress	a) Statutory commissions (HRC and CGE) to set up a discrimination database to collect information on the nature and extent of discrimination against people affected by HIV/AIDS b) Improve access to justice for people infected / affected by HIV/AIDS	DOJ, HRC, CGE

GOAL 15: DEVELOP AN APPROPRIATE LEGAL AND POLICY ENVIRONMENT

Objective	Selected Strategies	Lead Agencies
Develop policy and legislation relating to HIV/AIDS and employment	a) Finalise the code of Good Practice on HIV/AIDS in the Workplace, and accompanying regulations, to enforce workplace HIV/AIDS policies b) Support the development of workplace HIV/AIDS policies	DOL, DOH
.....		
Develop policy and legislation relating to HIV/AIDS, commercial sex workers and sexual assault	a) Develop criminal law mechanisms which protect the rights of victims of sexual violence b) Investigate the provision of Post-exposure prophylaxis PEP to the victims of sexual violence c) Investigate decriminalising commercial sex work	DOJ, DOH, SALC

youth as a target group



As indicated earlier in this document, youth is a specific focus area in the fight against HIV/AIDS as people between the ages of 14 -35 are the most vulnerable to HIV infection. In addition, the youth are an important target group to protect against future HIV infection as they represent both the present and future economic powerhouse of the country.

In this section the strategies that relate to youth will be replicated to emphasise the need for all sectors of society to focus a significant amount of their resources and energies on this age group.

Objective: Promote improved health seeking behaviour and adoption of safe sex practices

- Produce and disseminate IEC material and messages to different stakeholders
- Implement life skills education in all primary and secondary schools

Objective: Broaden responsibility for the prevention of HIV to all sectors of government and civil society

- Develop sector-specific policies and plans for the prevention of HIV/AIDS & STDs, focussing specially on the following sectors: ... youth, women and children.

Objective: Improve access to and use of male and female condoms, especially amongst 15 - 25 year olds

- Expand condom distribution through non-traditional outlets
- Improve access to condoms in high transmission areas (e.g. truck stops, borders, mines and brothels)
- Increase acceptance, positive attitudes and perceptions, efficacy and use of condoms as a form of contraception among the youth

Objective: Increase access to youth friendly reproductive health services - including STD management, VTC and rapid HIV testing facilities

- Make clinics and HCWs "youth friendly"
- Make schools places where youth can access

friendly and supportive counselling services

Objective: Increase the number of persons seeking voluntary HIV testing and counselling services

- Promote access to VTC services, especially for the youth

Objective: Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS

- Promote advocacy of all relevant issues that affect children
- Mobilise financial and material resources for orphans and child-headed households
- Investigate the legal protection of child-headed households
- Provide social welfare, legal and human rights support to protect educational and constitutional rights

Objective: Implement measures to facilitate adoption of AIDS orphans

- Investigate the use of welfare benefits to assist children and families living with HIV/AIDS
- Subsidise adoption of AIDS orphans

Objective: Conduct a national surveillance on HIV and STD risk behaviours, especially among youth

- Conduct behavioural sentinel surveys, with a focus on youth
- Conduct national HIV infections surveillance in selected populations and groups, including youth



Implementing the HIV/AIDS & STD Strategic Plan is essential to ensure the achievement of the national goals. Broad principles for implementation include appropriate activities and practices and cost effective for South Africa. Activities should be based on known evidence based practices.

Key critical areas for effective delivery include:

A. Authority and political will at all levels

B. Structures:

- Delivery and implementation
- Co-ordination

C. Resources:

- Financial Resources
- Human Resources
- Technical Resources

D. Capacity:

- HIV AIDS & STD understanding
- Management
- Monitoring and evaluation

E. Communication:

- National = Provincial & Provincial = National
- Provincial = Provincial
- Provincial = District = Community
- Government = Civil society

7.1 Effective implementation of the HIV/AIDS & STD Strategic Plan

To achieve this, the following issues will be addressed:

- **Approval of the HIV/AIDS & STD Strategic Plan by national bodies such as the Inter-Ministerial Committee on AIDS (IMC), SANAC and National HIV/AIDS & STDs Directorate, followed by provincial and local structures**

The HIV/AIDS & STD Strategic Plan should be used in developing national, provincial and district operational plans. Yearly operational plans have to be based on realistic objectives. These should be developed taking into consideration existing financial and human resources, the capacity thereof, the process of recruitment as well as the political commitment in each of the provinces. The setting of national goals will allow for inter-provincial comparisons and ensure a measure of unity regardless of the relative autonomy of the

provinces. The provinces should then take these national goals and objectives and present them to key role players within each province to ensure that all buy into what would be a Provincial Strategic AIDS Plan.

- **Improve structures for delivery**

This involves reviewing and developing where necessary structures at all levels, from national to community. The concept of appropriate national structures such as the IMC, IDC and NAC should be considered for duplication within provinces, keeping in mind the importance of delivery within communities.

The most important structures to create to guide the implementation of the Strategic Plan are:

- SANAC, with duplicate bodies in each province
- Interdepartmental Committees on HIV/AIDS in every province. One of the functions of the Interdepartmental Committees within provinces would be to define each government department's unique and generic responsibility within the HIV/AIDS & STD Strategic Plan.

Equally important is the establishment of appropriate structures at district level to ensure the implementation of the HIV/AIDS & STD Strategic Plan. It is thus recommended that District HIV/AIDS Committees be established. The district structures should include community-based committees that represent major role-players within the relevant community in the field of HIV/AIDS.

These committees should include local government to ensure the integration of HIV/AIDS & STDs and TB issues and development plans. It is vital that this include non-health issues as part of HIV/AIDS & STD planning, such as transport and poverty alleviation.

- **Establish acceptable standards for provinces with respect to resources**
Financial Resources

It is important to ensure that adequate funding

is available at national and provincial levels within the healthcare environment to ensure delivery. One method is to establish an agreed resource standard for all provinces to directly place financial resources into HIV/AIDS. This is currently (in 1999/2000 prices) set as R10 per person per year or a total of R400 million per year for the whole country.

Related activities include:

- Audit financial resources for HIV/AIDS activities within Provinces over the preceding three years
- Compare resources between provinces on a per capita and per HIV infected population
- Agree on standards or conditions by national bodies such as MinMEC, PHRC for allocating dedicated HIV/AIDS funding from national bodies
- Cost the HIV/AIDS & STD Strategic Plan and Programmes
- Agree on the continued funding by the national DoH of activities and products - such as condoms - that have a major cross provincial impact.

Funds for HIV/AIDS should be devolved to provinces from the national government only on condition that certain standards are met. These include the:

- Presence of an Interdepartmental Committee on HIV/AIDS
- Commitment to "ringfence" funds for direct HIV/AIDS activities within provinces
- Commitment to distribute funds according to the HIV/AIDS & STD Strategic Plan
- Commitment to spend over 80% of the funds in one financial year
- Commitment to roll funds over into the new financial year without risk of penalty
- Commitment to prioritise the process of HIV/AIDS spending within the provinces
- Commitment to ongoing national and provincial communication
- Regular review of the implementation of HIV/AIDS Plans

- Establishment of realistic goals and objectives that can be implemented within provinces and districts
- **Human Resources**
It is vital for the success of the Strategic Plan that adequate human resources are available to ensure delivery. The constraint on action is arguably capacity rather than funding. The current ratio suggested is one dedicated employee per 100,000 population. To evaluate the availability of human resources, it will be necessary to audit the existing human resources at national, provincial, regional and district levels. This audit should assist in establishing standards of personnel at district, regional and provincial levels of management.
- **Regularly review the implementation of the Strategic Plan**
The HIV/AIDS Strategic Plan must be reviewed every 12 months at national and provincial levels, with quarterly reports to be submitted to provincial and national structures.

The National DOH has overall responsibility for the implementation of the Strategic Plan within the provincial structures. Specific measurable targets and indicators will be developed for each objective and reported in annual operational plans. The Strategic Plan will be monitored by these objectives and supplemented with additional monitoring including national, provincial and local behavioural surveys. These surveys will measure changes in HIV related risk behaviours including condom use, delay of sexual initiation among youth, HIV incidence, and the number of sexual partners.

Establish a mechanism of constant and consistent reporting by provinces to national structures and vice versa. Information from the regular review should be used to serve as a communication tool between provinces of successes, as well as to other stakeholders to provide guidelines on activities to be involved in.

7.2 The Role of Sectors

The HIV/AIDS & STD Strategic Plan provides a broad framework for government, NGOs, business, labour, women and all sectors of society. Each sector should develop more specific plans based on their role, activities and their specific strengths. Sectors are encouraged to establish technical AIDS committees. These committees will advocate, manage and co-ordinate, the implementation of HIV/AIDS activities within that sector.

The sectoral AIDS committees will also be responsible for liaison with other sectors and the Directorate: HIV/AIDS & STDs. The recommended role of the sectors will be as follows:

- Identify determinants of the spread of HIV/AIDS & STDs specific to the sector
- Identify strengths and weaknesses with respect to HIV/AIDS & STDs
- Identify obstacles to the response within the sector
- Integrate HIV/AIDS & STD's activities in their yearly plans
- Formulate specific HIV/AIDS sectoral plans and budget for their implementation
- Mobilise resources for interventions
Document best practice within the sectors and share information
- Prepare and submit quarterly reports to SANAC

All Ministries, including the MOH, will submit quarterly reports to SANAC on their HIV/AIDS activities.

7.3 Monitoring and Evaluation

The effective implementation of the activities outlined in the Strategic Plan will largely depend on the availability of human, financial and institutional resources. The sustainability of the response will depend on an efficient monitoring process in the areas of policy development, institutional strengthening and service delivery.

Monitoring will ensure that activities are being implemented according to the plan and that each implementing agency and all partners contribute to the accomplishment of policy aims. This activity should be seen as mutually beneficial for the implementing agencies to assess their performance and seek corrective measures, and for government to formulate appropriate policy.

Effective monitoring and evaluation tools will be developed and customised for each intervention. These tools will identify strengths and weaknesses in the response programmes and activities, and areas that need the redirection of resources. The cost effectiveness of selected interventions will be determined through special operational research.

7.4 Concluding Remarks

The HIV/AIDS & STD Strategic Plan is a living document and will be subjected to regular critical review. This will be undertaken at the national, provincial and district levels with input from all stakeholders. A mid-term review will be conducted and the Strategic Plan modified in accordance with the findings.

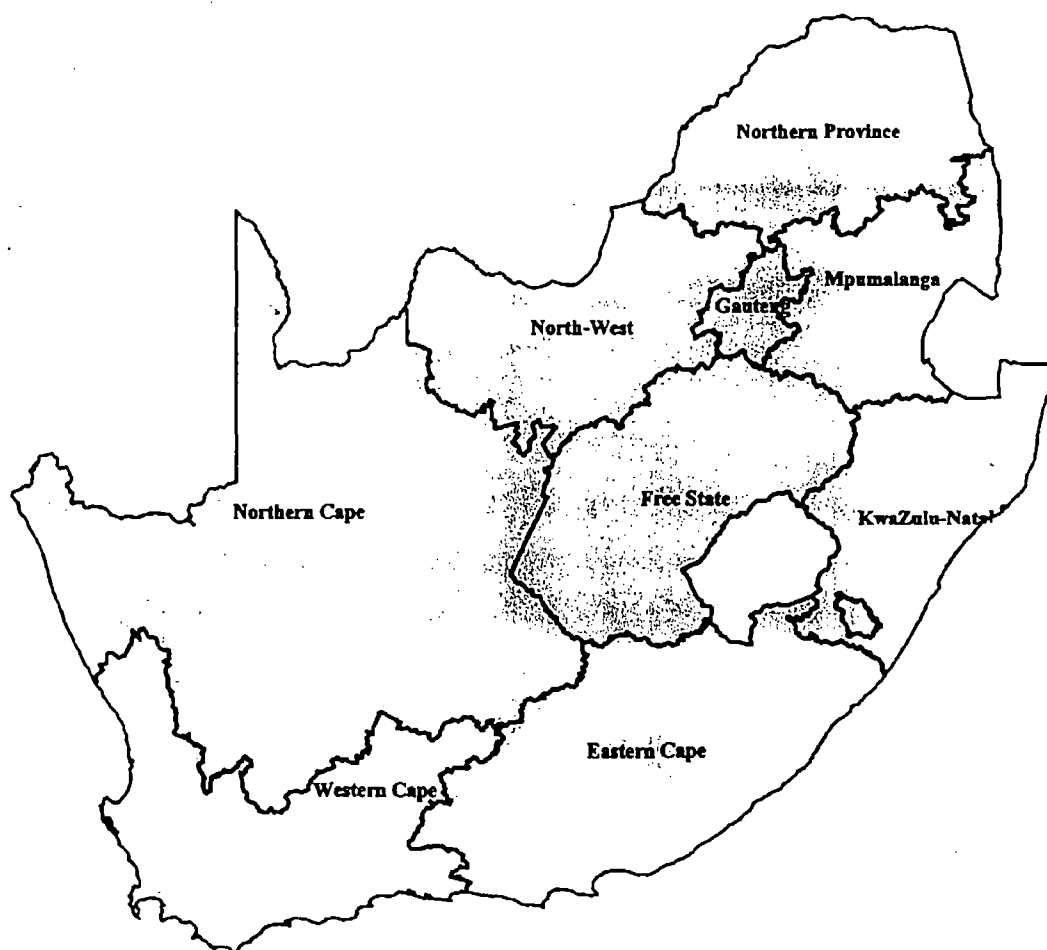
Acknowledgements

The development of this "HIV/AIDS & STD Strategic Plan for South Africa: 2000 - 2005" would not have been possible without the immeasurable assistance from countless individuals and organisations. Our thanks goes to every individual 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.



Annexure A: Map of South Africa

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



THE WHITE HOUSE
WASHINGTON

November 3, 2000

MEMORANDUM TO THE PRESIDENT

FROM: Sandra L. Thurman, Director, Office of National AIDS Policy, and Presidential Envoy for AIDS Cooperation

SUBJECT: Response to Your Inquiry Concerning AIDS in Africa

In response to your question regarding what more we can do for people living with AIDS in Africa, here is a brief overview of our recent advances, as well as a few additional opportunities for moving this agenda forward in the remaining months of this Administration.

Resources: As you said in your speech to the U.N. Security Council in September: “Unfortunately, the U.N. has estimated that to meet our goals [to establish basic prevention and care programs for HIV/AIDS], we will collectively need to provide an additional \$4 billion a year. We must join together to help close that gap.”

To that end, the Foreign Operations FY2001 Appropriations bill contains two key improvements. First, the bill includes \$315 million for the global AIDS program at USAID. It is likely that when the remaining appropriations bills are completed, we will have secured an additional \$115 million for the CDC, and \$10 million each for the Departments of Labor, Defense, and Agriculture – all now part of our multi-sectoral response to the AIDS pandemic. In total, over the past two years, we will have more than tripled our global AIDS prevention and care efforts to \$461 million – more than the entire world was spending in FY98. Second, the full funding for debt relief in the bill will free up much needed resources that HIPC countries in sub-Saharan Africa and elsewhere can redirect into HIV/AIDS programs.

Securing these significant funding increases not only demonstrates leadership on the part of this Administration, but gives us the credibility needed to leverage additional action from other stakeholders including:

- challenging our G-8 partners to build on the progress made in Okinawa by pledging significant new resources toward closing the global AIDS resource gap (joining us in doubling or tripling their investments);
- utilizing the upcoming EU and the APIC summits to raise the AIDS issue and to accelerate and enhance the global AIDS mobilization;
- working with multi-lateral lending institutions as well as HIPC governments to encourage the redirection of debt service to AIDS prevention and care activities; and,

- working with Congress, prior to adjournment, to find additional resources for the U.S. contribution to the newly authorized multi-lateral AIDS trust fund to be established at the World Bank (a major Congressional Black Caucus priority).

Leadership and Visibility: We have consistently stated that the global battle against AIDS will take all sectors of all societies working together. It is for this reason we have sought to not only mobilize governments, but corporations, unions, foundations, NGOs, IFIs, etc. We believe that the religious community has a pivotal role to play and a great deal to offer – most of which has yet to be tapped. To that end, as the final deliverable of our LIFE Initiative, we are planning to bring together an extraordinary group of religious leaders from around the world for a summit on AIDS at the White House on World AIDS Day – December 1st. This would provide a timely and critically important opportunity to reframe the dialogue on AIDS as a moral and ethical imperative, and enlist powerful and vital allies. U.S. invitees include Reverend Jesse Jackson, Reverend Leon Sullivan, Ambassador Andrew Young and Dr. Elie Wiesel. Your participation in this event would make all the difference.

* only 4 people

April 14th
Mtg - 3:00

C-SIA

Dr M E Tshabalala Msimang, Minister of Health

~~Ms K P Miasstry, Assistant to the Minister~~

~~Dr S F Drysdale, Hlabisa Hospital, KwaZulu Natal~~

Dr Z L Mkhize, MEC for Health, KwaZulu Natal

Ambassador Sheila Sisulu

Advocate Mohamed Cassimjee

AIDS IN SOUTH AFRICA



Overview

- In sub-Saharan Africa, more than 11,000 additional people become HIV+ each and every day. In South Africa alone, 4.2 million people are already HIV+ and at least 1,600 people a day are newly infected.²
- UNAIDS reports that half of all HIV+ people in the 9 southern African countries hardest hit by the pandemic live in South Africa.
- The number of reported AIDS cases in South Africa has risen 33% since the end of 1997.³
- By 2010, 25% of South Africa's adult population is expected to be HIV+; AIDS deaths will peak about 5 years later at 256 AIDS deaths per 100 normal deaths.⁵
- According to the Actuarial Society of South Africa (ASSA), the country's total population by 2015 will be 23% lower than it would have been without AIDS.⁶
- UNAIDS reports that during the last 8 years, HIV prevalence in South African prenatal clinics has increased more than 21-fold, and that the 1998 national prevalence rate among pregnant women was 23%.
- By 2008, 1.6 million South African children will have been orphaned by AIDS.⁷
- A new UNAIDS Report estimates that in South Africa, AIDS is set to claim the lives of around half of all 15 year olds.⁸

Development

- In the next few years, AIDS will reduce life expectancy in South Africa by a third, from 68 to 45 years⁹. By 2010, infant mortality is expected to increase by 40%.¹⁰
- AIDS as a security issue. Recent reports confirm that 40% of the South African military is already HIV positive. US military officials have raised this as a serious stability concern.¹¹
- A South African anti-crime institute has linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. Without appropriate intervention, many of the almost 2 million children projected to be orphaned by AIDS in South Africa will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs for survival. This not only affects social stability but also dramatically increases their risk of HIV.¹²

¹ New UNAIDS Report.

² Africa Facts 2, ONAP.

³ USAID Country Profile.

⁴ UCB.

⁵ Ing Barings, South African Research, Economic Impact... April 2000, Page 1.

⁶ Ing Barings, Page 6

⁷ UCB.

⁸ UNAIDS Press Release, 6/27/00

⁹ Africa Facts 2, ONAP.

¹⁰ UCB.

¹¹ Africa Facts 2, ONAP.

¹² Africa Facts, ONAP.

Economic Impact

- The economically active population (25 -50 years old) will be the worst affected, with infections rates expected to reach 26% in just a few years. South Africa's unskilled and semi-skilled workforce will be most heavily impacted, though skilled and professional workers follow close behind.¹³
- Between 2000-2015, The South African labor force is expected to average 10% lower due to AIDS.¹⁴
- In a country already battling a skills shortage, AIDS will only exacerbate the problem by decreasing the work force, lower labor productivity, lower labor income, and increase demand for health services both in the private sector and in government supports.¹⁵
- By 2010, the demand for health services could be over 11% higher than it would have been without AIDS.¹⁶ The cost of treating one AIDS case already exceeds the GNP per capita by more than \$1,000. In KwaZulu/Natal, the entire provincial health budget is spent on AIDS-related illnesses.¹⁷
- A recent report predicts that South Africa's Real GDP will be .4% lower by 2006 than it would have been without AIDS. As the country generates 45% of sub-Saharan Africa's total GDP, the lower growth and higher risk profile for South Africa will not bode well for financial markets and may deter foreign investors.¹⁸
- At a meeting with African trade and finance ministers, Professor Jeffrey Sachs, director of the Harvard Institute for International Development, stated that, "a frontal attack on AIDS in Africa may now be the single most important strategy for economic development."¹⁹

Response

- After a slow start, in 1994 South Africa became the first sub-Saharan country to develop and gain Cabinet approval for a comprehensive HIV/AIDS policy.²⁰
- Though the failure of past actions continue to challenge the South African government in their ability to respond successfully, renewed leadership has and will continue to help break the silence surrounding AIDS. Both Archbishop Desmond Tutu and Nelson Mandela have spoken out publicly on HIV/AIDS issues including condom use and safe sex.
- The private sector has begun to respond. Since 1993, the South African power company Eskom, has guaranteed full ill-health and pension benefits to employees with AIDS and their families. It also provides clinical services, counseling and therapy, supports educational programs, both in the workplace and in the public arena, and is engaged in funding vaccine research.
- USAID, UNAIDS (still working on donor involvement info...)

¹³ Ing Barings, Page1.

¹⁴ Ing Barings, Page 10.

¹⁵ Ing Barings, Page 1.

¹⁶ Ing Barings, Page 15.

¹⁷ USAID Key Talking Points.

¹⁸ Ing Barings, Page 2.

¹⁹ Africa Facts 2. ONAP.

²⁰ UCB.

Country Brief

SOUTH AFRICA

06/01/00

Socio-Economic Data

Total population (thousands), 1997	43,336	UNPOP
% of population urbanized, 1996	51	UNPOP
Annual population growth rate, 1980-1995	2.3	UNPOP
Infant mortality rate (per 1,000 live births), 1996	50	UNICEF/UNPOP
Maternal mortality rate (per 100,000 births), 1990	230	WHO/UNICEF
Life expectancy, 1996	65	UNPOP
Adult literacy rate, 1995	M 82, F 82	UNESCO
Per capita GNP (US\$), 1995	3,160	World Bank

Status of the Epidemic

Prevalence – Year	Trend
16.7 – 1998	Rapid growth with all age groups in surveillance sites showing between 15 and 65 percent growth between 1997 and 1998. Highest growth rate was in the under 20 age group.

National Response

National AIDS Programme

- The HIV/AIDS and STD Directorate is located within the Ministry of Health which is the lead ministry in the response to the epidemic;
- An Inter-Ministerial Committee on AIDS was established in 1998 to provide political direction and policy guidance to the national AIDS programme;

National Strategic Planning

- The development of the national strategic plan occurred during the months of July- November 1999;
- The plan, still in draft form, is a five-year plan;
- The priority areas include prevention, human rights, care and support, research monitoring and evaluation, youth and policy implementation.

Political Commitment

- The President launched the Partnership against AIDS in 1998 to broaden and formalise the participation by all sectors in the response to the epidemic;
- The President also launched the South African National AIDS Council on 1 December 1999. It is a multisectoral body that will oversee the national response to the epidemic and the implementation of the Strategic Plan.
- The current Minister of Health initiated the development of the strategic plan;

Country Brief

- It was in response to the statement by the newly elected President calling all South Africans to action in the fight against AIDS. He challenged all sectors of society to be actively involved in the response to HIV/AIDS.

Multisectoral Involvement

- Initial efforts in the South African response to HIV/AIDS were implemented mainly by non-governmental organizations and the Ministry of Health;
- There has been gradual involvement by other government departments and civil society;
- Participants in the recent national strategic planning process included representatives from faith based organisations, people living with HIV/AIDS, non-governmental organizations, human rights organisations, academic institutions, the civil military alliance, the media, organised labour, organised sports, business, insurance companies, women's organisations, youth organisations, international donors, medical and health professionals, medical and health consulting organisations, political parties and other relevant government departments;
- The Response Analysis calls for all provincial authorities to designate co-ordinators responsible for STD/HIV/AIDS at the province and district levels.

UN Theme Group on HIV/AIDS

Chair:

UNICEF Representative

Members:

UNICEF, UNESCO, World Bank

UNDP, WHO, UNFPA,

Participants: ILO, UNHCR, UNIC, IOM and UNAIDS/ICT

Support from UN System Agencies for HIV/AIDS activities in 1998-1999

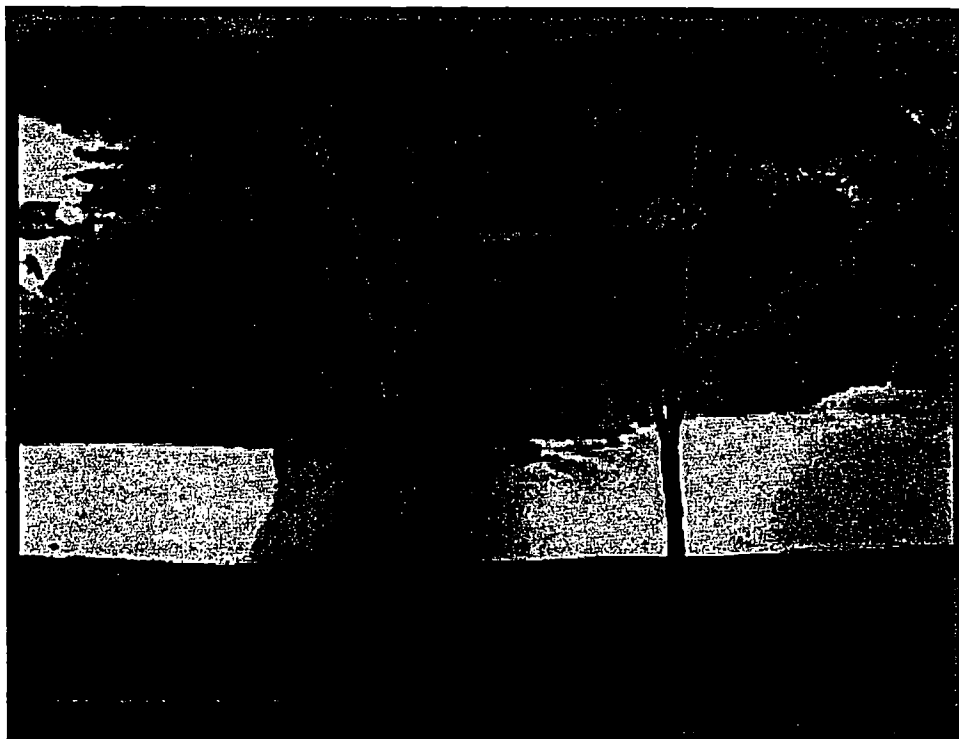
<i>Organization</i>	<i>Amount US\$</i>
WHO	80 000
UNDP	200 000
UNFPA	10 000
UNESCO	5 000
UNAIDS	683 450
Total	978 450

South Africa

Economic Impact of AIDS in South Africa

A dark cloud on the horizon

APRIL 2000



- **South Africa is faced with a worsening AIDS epidemic, which will have a profound impact on the country's economic outlook.** We forecast HIV infection rates to peak at almost 17% by 2006 for the population as a whole. AIDS-related deaths will peak about five years later at 256 AIDS deaths per 100 normal deaths.
- **The economically active population will be worst affected, with infection rates forecast to reach 26%.** The lion's share of the infections and deaths will be borne by the unskilled and semi-skilled part of the workforce, with infection rates likely to top the 30% mark. Nevertheless, the skilled and highly skilled will also be profoundly affected, with infections forecast to reach 23% and 13% respectively. South Africa is already battling with a skills shortage, which will be further exacerbated by the AIDS epidemic, raising remuneration and replacements costs for companies.
- **The epidemic impacts on the economy in various ways.** It leads to a smaller labour force, lower labour productivity, cost pressures for companies, lower labour income, and increased demand for health services from the private and the public sectors.
- **In our non-alarmist scenario, we believe GDP trend growth is forecast to be on average 0.3-0.4 percentage points pa lower than in a no-AIDS baseline.** CPI inflation will pick up due to cost pressures on companies that are passed on. This will exert some upward pressure on interest rates. Capacity utilisation and investment holds up fairly well, as the lower labour supply and productivity encourage a switch towards technology away from labour and narrow the gap between potential and actual output.
- **The costs of the AIDS epidemic are likely to cause a domestic savings squeeze – and this could potentially set off a vicious spiral.** Domestic savings as a percentage of GDP are expected to be on average 2 percentage points lower than in a no-AIDS scenario. In order to support investment demand in the economy, South Africa would need to attract foreign savings to plug the gap. Should foreign inflows not materialise, a savings-investment crunch will ensue, pushing interest rates markedly higher and further slowing GDP growth than is expressed in our AIDS baseline case.
- **The lower growth and higher risk profile for South Africa will not bode well for financial markets and may well deter foreign investors.** We look at relative risk exposure of sectors in terms of two factors – firstly, their reliance on a workforce that has a high infection risk and, secondly, their reliance on skilled workers, the replacement cost of whom is much higher than of the unskilled. Aggregating those two factors, we find that transport & storage and catering & accommodation are the sectors most exposed to the AIDS risk, while machinery, communication and metals fare relatively better. An important finding is, however, that service industries, such as finance and business services (including IT), rank in the middle field, as their reliance on skilled personnel makes them more vulnerable to a rising remuneration bill.

Figure 1

% POINT DIFFERENCE IN GROWTH RATES BETWEEN THE AIDS AND NO-AIDS SCENARIOS

	2001F	2002F	2003F	2004F	2005F	2006-10F	2011-15F
Real GDP	-0.3	-0.2	-0.2	-0.2	-0.3	-0.4	-0.3
Employment*	-1.5	-2.1	-2.8	-3.7	-4.7	-8.3	-14.1
Unemployment	-0.3	-0.3	-0.4	-0.5	-0.6	-0.9	-1.2
Real household disposable income*	-1.3	-1.7	-2.1	-2.4	-2.8	-4.4	-5.8
Real PCE	-0.3	-0.4	-0.3	-0.4	-0.5	-0.8	-0.8
Real govt consumption	0.1	0.1	0.1	0.1	0.1	-0.1	-0.2
Real GDFI	-0.1	0.1	0.2	0.2	0.1	-0.1	0.0
Real inventory investment (Rm difference)	-130	-698	-935	-852	-1,116	-4,014	-4,676
Real exports	0.1	0.1	0.1	0.1	0.1	0.1	0.0
Real imports	0.4	-0.2	0.2	0.0	-0.1	-0.3	-0.5
Current account balance/GDP**	-1.0	-1.2	-1.4	-1.7	-1.7	-2.4	-2.4
Trade weighted nominal exchange rate*	-0.7	-1.3	-1.4	-1.8	-2.1	-3.0	-3.9
Budget deficit/GDP**	-0.3	-0.3	-0.4	-0.5	-0.6	-0.8	-0.9
CPI inflation rate	0.7	0.2	0.4	0.3	0.4	0.4	-0.1
Prime lending rate**	0.0	0.0	0.0	0.1	0.2	0.3	0.6

Difference between YoY growth rate of AIDS and no-AIDS scenarios

** Real % difference between AIDS and no-AIDS scenarios, not YoY growth rate differences*

*** % point difference*

Source: WEFA

The uncertainty over the impact of the AIDS epidemic on the South African economy causes some discomfort with regard to the country's investment risk profile in the future. In order to shed some light on the effects of the AIDS issue, we have attempted to model some of the possible channels through which the epidemic impacts on the economy. We approached the problem in two steps,

Our goal was to model the possible macroeconomic effects of AIDS

- Firstly, we modelled the demographic changes that are likely to occur, using the Actuarial Society's (ASSA) demographic model, and produced infection and mortality profiles by skills levels and for selected sectors. The results were discussed in our first report 'The Demographic Impact of AIDS on the South African Economy', dated 17 December 1999.
- Secondly, we conducted long-term economic forecasts to take into account the AIDS effect. Clearly, the demographic projections, which we updated for this second part of the study, formed the backbone to the analysis. In addition, we formulated assumptions on costs to consumers, companies and government. The results are presented in this report.

As little work had actually been carried out before with regard to econometric modelling of the epidemic, the research took several months. The further we went in our endeavours, the more gaps we discovered in the existing data on the demographic profile of the disease, government policy and estimated expenditure, changing household consumption and expenditure patterns and the costs arising for companies. It is therefore important to emphasise the imperfect nature of the information.

However, our work was greatly helped by informal cooperation with AIDS experts and other modellers. We were able to host a workshop in January that included the World Bank, the Department of Finance and the Bureau for Economic Research (BER) in Stellenbosch to discuss the modelling approach and the validity of the assumptions. A follow-up workshop was held at the BER in early March, which also included, among others, Professor Dorrington, who is responsible for the ASSA demographic model, and Metropolitan Life. We benefited greatly from the discussion and would like to thank all participants for their comments and inputs. Over the coming months, we will probably see different angles to the economic analysis of AIDS explored by other participants, which should add further to the debate on the impact of AIDS.

Most importantly, we would like to thank WEFA for helping us model the long-term demographic trends and the macroeconomic outlook.

RECENT INTERNATIONAL TRENDS

According to the UNAIDS December 1999 figures, some 33.6m people worldwide are currently living with HIV – 32.4m adults and 1.2m children. Some 70% of the global total of HIV infected live in sub-Saharan Africa. Life expectancy at birth in southern Africa, which was 59 years in the early 1990s, is set to drop to just below 45 years between 2005 and 2010.

Figure 2

REGIONAL HIV/AIDS STATISTICS AND FEATURES, DECEMBER 1999

Region	Epidemic started	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV in 1999	Adult prevalence rate ¹ (%)	Women as a % of HIV+ adults	Main modes of transmission ² for adults living with HIV/AIDS
Sub-Saharan Africa	Late 1970s-early 1980s	23,300,000	3,800,000	8.00	55	Hetero
North Africa & Middle East	Late 1980s	220,000	19,000	0.13	20	IDU, Hetero
South & South East Asia	Late 1980s	6,000,000	1,300,000	0.69	30	Hetero
East Asia & Pacific	Late 1980s	530,000	120,000	0.07	15	IDU, Hetero, MSM
Latin America	Late 1970s-early 1980s	1,300,000	150,000	0.57	20	MSM, IDU, Hetero
Caribbean	Late 1970s-early 1980s	360,000	57,000	1.96	35	Hetero, MSM
Eastern Europe & Central Asia	Early 1990s	360,000	95,000	0.14	20	IDU, MSM
Western Europe	Late 1970s-early 1980s	520,000	30,000	0.25	20	MSM, IDU
North America	Late 1970s-early 1980s	920,000	44,000	0.56	20	MSM, IDU, Hetero
Australia & New Zealand	Late 1970s-early 1980s	12,000	500	0.10	10	MSM, IDU
Total		33,600,000	5,600,000	1.10	46	

¹ The proportion of adults (15-49 years of age) living with HIV/AIDS in 1999, using 1998 population numbers.

² MSM (sexual transmission among men who sleep with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

Source: WHO

Following the publication of our 17 December 1999 report 'The Demographic Impact of AIDS on the South African Economy', the Actuarial Society of South Africa (ASSA) on whose model our forecasts were built, updated some of its assumptions flowing into the model. We have amended our forecasts to reflect these latest revisions.

THE ACTUARIAL SOCIETY OF SOUTH AFRICA (ASSA) NATIONAL AIDS MODEL

The Actuarial Society of South Africa (ASSA 600, Dorrington, 1998) model was developed to forecast the South African population and the impact of AIDS on its various segments. This version of the ASSA model is currently set up to reflect the entire population in South Africa, which is divided into three distinct age groupings: young (0-13 years old), old (60 years and older) and adult. On reaching their 14th birthday, individuals are allocated into the various other risk groups according to the assumed proportions of the population as a whole. It is assumed that none of the perinatal infections will survive to age 14. The adult group is divided into four subgroups, differentiated by their level of exposure to the risk of a heterosexual epidemic.

- PRO – Individuals whose level of sexual activity is such that their HIV prevalence is similar to that of sex workers and their clients
- STD – Individuals whose level of sexual activity is such that their HIV prevalence is similar to that of people being treated for sexually transmitted diseases at STD clinics
- RSK – Individuals with a lower level of sexual activity but who are still at risk from HIV
- NOT – Individuals who are not at risk of HIV infections

A pattern of contact is assumed both within and between risk groups. Instead of modelling the various factors involved during a single sexual encounter, the model uses an average 'force of infection' to determine the spread of HIV. The force of infection is a combination of 'number of sexual partners', 'number of new contacts' and 'ease of infection'. The age and sex of the specific force of infection is then derived by incorporating the relevant sexual activity index for age and sex. Although the sexual activity curve is arbitrarily chosen, it is chosen such that the shape of new HIV infections matches known data.

Figure 3 shows the further assumptions that feed into the model.

Figure 3 ASSA AMENDED ASSUMPTIONS

Risk group	Description of risk group	% population	Relative fertility* (%)	Probability of HIV+ infection per year
PRO	Sex workers and clients	1	40	0.85
STD	Treated for sexually transmitted diseases	20	70	0.47
RSK	Normal HIV risk	40	100	0.09
NOT	No HIV risk	39	117	0.00
General		Value		
Infant AIDS mortality (%)		30		
Median term to death of HIV+ (14+ yrs)		10		
Proportion of perinatal infection (%)		25		
Proportion of infected via breast-feeding (%)		10		
Proportion of male births (%)		51		
Relative male to female infectivity		2:1		
Imported infectivity (male PROs)		300		
Imported infectivity (female PROs)		450		

* To RSK group

Source: Dorrington, ASSA 600, A User's Guide

We start our analysis at the most aggregated level, ie, at the level of the total population, and present our results of a baseline AIDS-inclusive population forecast and a no-AIDS population forecast. The no-AIDS scenario is recreated by adding back to the current (AIDS-inclusive) population forecasts the AIDS deaths while adjusting for their fertility and mortality. The ASSA model is operated from a 1985 base year in 15-year cycles, and it should be noted that in our baseline case, we have not changed any of the ASSA assumptions in the second cycle that runs from 2000 to 2015. We assumed that sexual behaviour such as that implied by Figure 3 does not change and that no medical advances are made during as well as between the cycles.

GENERAL POPULATION FORECASTS

The modelling results are shown in Figure 4. It can be seen that for 2000 the ASSA model suggests that without AIDS the population would be 1.1% higher than under the current AIDS-inclusive scenario. This differential is forecast to rise to 23% by 2015.

Total population will be 23% lower by 2015 than in a no-AIDS case

In the no-AIDS scenario, population growth rates are expected to come down from well over 2% pa to 1.5% by 2015. By contrast, ASSA's recent population projections including AIDS indicate that the growth rate has come down more rapidly since the early 1990s. By 2004, the growth rate is forecast to drop to below 1% and to reach 0% by 2011.

Given the new assumptions on infection rates, propagation, fertility and mortality, HIV+ infection rates are forecast to peak at 16.7% in 2006 and taper off thereafter. The number of AIDS deaths is expected to rise rapidly and should peak with a four to five-year lag in 2010 with 1.8 AIDS deaths per 100 people and 256 AIDS deaths per 100 normal deaths. As shown in our previous report, apart from the 0-9 age group, which reflects the high rate of infant deaths associated with mother-to-child transmissions, AIDS deaths are mainly concentrated in the 25-50 age groups. That means that the labour force is disproportionately more affected than the overall population. The repercussions of this for the economy will be discussed later in the report.

Infection rates are forecast to peak at almost 17%

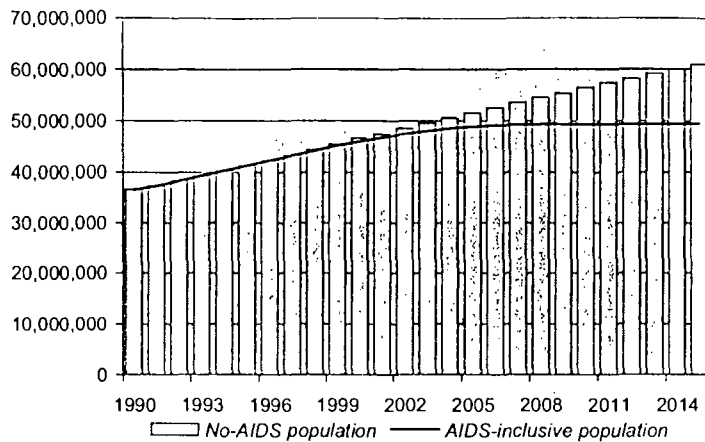
Figure 4 POPULATION FORECASTS OF NO-AIDS AND THE AIDS-INCLUSIVE SCENARIOS

	AIDS-inclusive scenario	Growth (%)	No-AIDS scenario	Growth (%)	No-AIDS/AIDS (%)	HIV+	AIDS deaths	AIDS deaths per 100 normal deaths
1999	45,100,513		45,414,112		0.7	11.58	0.42	57.6
2000	45,951,123	1.89	46,447,874	2.28	1.1	12.99	0.56	76.7
2001	46,725,267	1.68	47,478,275	2.22	1.6	14.17	0.71	99.2
2002	47,407,203	1.46	48,503,417	2.16	2.3	15.12	0.89	124.6
2003	47,984,178	1.22	49,521,688	2.10	3.2	15.83	1.07	151.7
2004	48,448,709	0.97	50,531,745	2.04	4.3	16.31	1.26	178.7
2005	48,800,591	0.73	51,532,490	1.98	5.6	16.58	1.43	203.5
2006	49,047,777	0.51	52,523,054	1.92	7.1	16.67	1.57	224.3
2007	49,205,482	0.32	53,502,785	1.87	8.7	16.62	1.67	239.9
2008	49,293,678	0.18	54,471,262	1.81	10.5	16.45	1.74	249.9
2009	49,333,750	0.08	55,428,279	1.76	12.4	16.22	1.78	254.8
2010	49,345,370	0.02	56,373,740	1.71	14.2	15.96	1.78	255.5
2011	49,344,408	0.00	57,307,533	1.66	16.1	15.70	1.77	253.4
2012	49,342,079	0.00	58,229,435	1.61	18.0	15.46	1.74	249.3
2013	49,345,084	0.01	59,139,066	1.56	19.8	15.25	1.71	244.4
2014	49,356,321	0.02	60,035,874	1.52	21.6	15.09	1.67	239.2
2015	49,375,762	0.04	60,919,128	1.47	23.4	14.97	1.64	234.2

Source: ASSA

Figure 5

POPULATION FORECASTS FOR AIDS AND NO-AIDS SCENARIOS



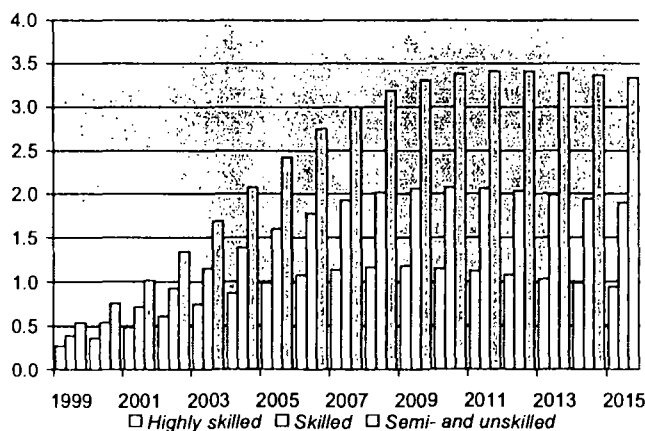
Source: ASSA

EFFECTS ON THE LABOUR FORCE BY SKILLS AND SECTORS

The infection rate among the economically active population peaks at about 25.5% by 2006, well above the 16.7% peak for the total population. As in our last report, we translated the overall infection rate among the economically active into infection rates by skills group. We combined the age, ethnic and gender profiles from the ASSA forecast with provincial information from J Slawski (*AIDS where are we*, 1998 unpublished report for ASSA) and overlaid this information on employment data by skills categories and economic activity from the 1996 population census. When examining the infection rates by skills groups, we find that the HIV+ rate of semi- and unskilled labour is over three times as high as that of the highly skilled. A similar observation can be made with regard to the number of AIDS deaths by skill category. Nevertheless, while the semi and unskilled portion of the labour force is disproportionately affected by the AIDS epidemic, it is important to realise that infection rates among the highly skilled will be substantial as well, exacerbating South Africa's skills shortage. Among the highly skilled, the infection rate is forecast to peak at 13.1% in 2005, compared with 22.8% for the skilled and 32.8% for the semi- and unskilled. Annual AIDS-related deaths among the highly skilled are forecast to peak at 1.2 per 100 workers, while deaths among the semi-and unskilled grouping are expected to peak at 3.4 per 100 workers.

The labour force will be worst affected

Figure 6 PROJECTED AIDS DEATHS PER 100 WORKERS BY SKILLS



Source: ASSA

Figure 7

HIV+ INDIVIDUALS PER 100 WORKERS BY SKILLS LEVEL

	Highly skilled	Skilled	Ratio skilled/ highly skilled	Semi- and unskilled	Ratio semi- and unskilled/ highly skilled
1999	10.2	15.5	1.5	19.9	2.0
2000	11.2	17.5	1.6	22.7	2.0
2001	12.0	19.1	1.6	25.2	2.1
2002	12.6	20.5	1.6	27.4	2.2
2003	12.9	21.5	1.7	29.2	2.3
2004	13.1	22.2	1.7	30.6	2.3
2005	13.0	22.6	1.7	31.6	2.4
2006	12.8	22.8	1.8	32.3	2.5
2007	12.5	22.7	1.8	32.7	2.6
2008	12.1	22.5	1.9	32.8	2.7
2009	11.7	22.1	1.9	32.8	2.8
2010	11.2	21.7	1.9	32.7	2.9
2011	10.8	21.3	2.0	32.5	3.0
2012	10.4	21.0	2.0	32.4	3.1
2013	10.0	20.6	2.1	32.4	3.2
2014	9.6	20.4	2.1	32.4	3.4
2015	9.3	20.2	2.2	32.6	3.5

Source: WEFA

Figure 8

AIDS DEATHS PER 100 WORKERS BY SKILL LEVEL

	Highly skilled	Skilled	Ratio skilled/ highly skilled	Semi- and unskilled	Ratio semi- and unskilled/ highly skilled
1999	0.3	0.4	1.4	0.5	2.0
2000	0.4	0.5	1.4	0.8	2.0
2001	0.5	0.7	1.5	1.0	2.1
2002	0.6	0.9	1.5	1.3	2.2
2003	0.7	1.2	1.5	1.7	2.3
2004	0.9	1.4	1.6	2.1	2.4
2005	1.0	1.6	1.6	2.4	2.4
2006	1.1	1.8	1.6	2.7	2.5
2007	1.1	1.9	1.7	3.0	2.6
2008	1.2	2.0	1.7	3.2	2.7
2009	1.2	2.1	1.8	3.3	2.8
2010	1.2	2.1	1.8	3.4	2.9
2011	1.1	2.1	1.8	3.4	3.0
2012	1.1	2.0	1.9	3.4	3.1
2013	1.0	2.0	1.9	3.4	3.3
2014	1.0	1.9	2.0	3.4	3.4
2015	1.0	1.9	2.0	3.3	3.5

Source: WEFA

Following on from the demographic analysis, we have attempted to model the possible effect of HIV/AIDS on South Africa's longer term economic prospects. For that purpose, we have formulated assumptions based on the information that is currently publicly available. However, one cannot emphasise enough the deficiencies and gaps in the publicly available data. With this in mind, our analysis tries to identify the main channels through which the epidemic will affect the macroeconomy and highlight the sensitivity of the forecast outcomes to the input assumptions on the patterns of the epidemic. To our knowledge, this macro-modelling exercise has not been performed so far, and we hope that in addition to highlighting potential investment implications, we will add to the public debate on the impact of AIDS more generally. We believe that we have drawn a realistic scenario in our assumptions and have refrained from being unduly alarmist.

As the AIDS epidemic is unfolding, it will place severe costs on the economy. The channels we will be examining are the following:

We have identified seven key impact channels

1. A lower labour force
2. Lower labour productivity through absenteeism and illness
3. Cost pressures for companies through higher benefit payments and replacement costs
4. Lower labour income, as employees bear some of the AIDS-related costs
5. Lower population translating into lower expenditure
6. Increased private sector demand for health services
7. Higher government expenditure on health services.

Rising expenditure on healthcare will not only put pressure on the fiscus, but also on households and companies. Overall household demand will be dampened and reprioritised and household savings squeezed. Absenteeism, productivity losses and higher costs for training skilled personnel will place an additional burden on companies. Some of the higher costs will be passed on to the consumer via higher prices, but some will be absorbed in the companies operating surplus and may well come out of corporate savings. Not surprisingly, our analysis concludes that GDP will be lower under the AIDS scenario than the no-AIDS scenario. Price pressure will pick up and with it pressure on interest rates.

LABOUR SUPPLY AND PRODUCTIVITY

The impact of AIDS will be reflected on the labour supply and productivity. The demographic analysis has shown that the infection rates among the South African workforce are higher than for the population as a whole. We can thus expect the labour force to be disproportionately affected by the epidemic. Here we are trying to model the effect of AIDS-related deaths across the various skills groups on overall labour supply. Any change to the overall labour supply in the economy will affect potential output (which is determined by labour and capital supply as well as technology). With unemployment in excess of 30%, South Africa is currently faced with a surplus labour situation. So, in theory, employees who die of AIDS-related causes can be easily replaced by the available pool of unemployed. However, while South Africa has a large pool of unskilled labour available, it already faces a labour shortage at the skilled and highly skilled level. At the higher skills levels, the replacement of employees who have died is more difficult. Since the withdrawal of one unit of highly skilled labour is expected to have a more negative impact on potential output we propose to make an adjustment to the labour supply numbers that accounts for the importance of skill. Assuming that the average wage is a reasonable proxy for skills, we weigh the units of labour by their wage rate relative to the economy-wide average so as to arrive at a weighted aggregate labour supply.

Labour supply is adversely affected by AIDS deaths ...

Figure 9 THE RATIO OF THE AVERAGE WAGE RATE OF SKILL CLASS TO THE ECONOMY-WIDE AVERAGE WAGE RATE		
Highly skilled	Skilled	Semi & unskilled
1.91	1.07	0.65
Source: WEFA's 1997 Social Accounting Matrix		

Figure 9 suggests that highly skilled labour earns on average 1.91x more than the economy-wide average, while semi & unskilled only receives 65%. This set of assumptions generates the following impact on labour supply.

... with the loss of skilled employees weighing more

In the last column of Figure 10 it can be seen that in an AIDS scenario, the labour force is an average 10% lower than in a no-AIDS scenario between 2000-15. Values for the weighted labour supply under the AIDS scenario are shown in column 7. These will feed into the implicit production function of the macroeconometric model to determine forecasts for potential output. Moreover, we add the effect of productivity losses to the forecasts of efficiency units of labour rather than modelling productivity separately.

Figure 10 LABOUR FORCE IN AN AIDS AND NO-AIDS SCENARIO								
	1 Highly with AIDS	2 Highly no AIDS	3 Skilled with AIDS	4 Skilled no AIDS	5 Semi & with AIDS	6 Unskilled no AIDS	7 Weighted total with AIDS	8 % difference compared to no-AIDS
2000	2,074,168	2,097,928	3,788,658	3,849,153	11,506,362	11,767,110	17,433,588	-1.6
2001	2,128,591	2,162,204	3,825,218	3,910,797	11,749,814	12,126,135	17,797,313	-2.2
2002	2,182,074	2,228,396	3,859,059	3,976,996	11,954,146	12,480,647	18,127,131	-3.0
2003	2,236,712	2,298,858	3,892,986	4,051,212	12,121,566	12,835,745	18,430,872	-3.9
2004	2,298,042	2,379,208	3,935,103	4,141,758	12,239,118	13,178,368	18,709,092	-5.0
2005	2,363,127	2,466,329	3,978,194	4,240,955	12,319,603	13,518,091	18,963,523	-6.2
2006	2,431,209	2,559,053	4,019,316	4,344,820	12,367,142	13,853,083	19,192,964	-7.5
2007	2,499,390	2,653,904	4,053,264	4,446,679	12,391,904	14,185,945	19,397,491	-8.9
2008	2,571,530	2,754,126	4,087,465	4,552,384	12,402,051	14,516,853	19,594,459	-10.2
2009	2,650,577	2,862,134	4,125,581	4,664,243	12,396,076	14,837,195	19,787,090	-11.5
2010	2,736,277	2,977,240	4,167,731	4,781,276	12,373,991	15,141,414	19,973,804	-12.8
2011	2,827,235	3,097,726	4,212,106	4,900,840	12,340,512	15,430,427	20,155,152	-14.0
2012	2,921,752	3,221,665	4,257,213	5,020,869	12,307,125	15,713,640	20,338,954	-15.1
2013	3,018,388	3,347,484	4,301,252	5,139,218	12,276,051	15,992,473	20,524,060	-16.2
2014	3,115,985	3,473,962	4,343,401	5,254,915	12,249,849	16,269,587	20,711,151	-17.2
2015	3,214,624	3,601,201	4,384,128	5,368,471	12,221,538	16,538,634	20,893,995	-18.1
Source: ASSA 600, version: November 1999 and 1996 Population census, WEFA								

Labour supply will also be affected by the anticipated decline in labour productivity due to absenteeism especially once the patient is suffering from full-blown AIDS. We assume that full-blown AIDS spans the last two years of the HIV+ term.

Absenteeism drags down productivity

The proportion of a working year that is lost for a full-blown AIDS patient can range between 0-2 years, according to JT Cuddington (*Modelling the Macroeconomic Effects of AIDS, with an Application to Tanzania*; The World Bank Economic Review, vol.7, no.2). The reason for a proportion higher than 1 is that, in Cuddington's words, 'the loss may be not only in the AIDS victim's labour but also in the labour of others. For example, if a person who gets AIDS stops working immediately and that person's spouse must also stop working to provide full-time care, then the value could be 2'. However, these assumptions are drawn from experience in sub-Saharan Africa excluding South Africa in the early 1990s, where the medical care system may have been less sophisticated than is currently the case in South Africa. It thus seems reasonable to adopt a value lower than 1, such as 0.33, for our purposes. In other words, for every person with full-blown AIDS, four months of person-year equivalent labour supply will be lost. This set of assumptions generates the impact on labour supply (again weighted by skill) shown in Figure 11. The combined effect of the decline in labour supply due to AIDS deaths weighted by skills groups and to productivity losses is fed through to the production function in the WEFA macro model in order to forecast potential output.

Figure 11 LOSS OF LABOUR SUPPLY RESULTING FROM IMPACT OF AIDS ON LABOUR PRODUCTIVITY

	Full blown AIDS highly skilled	Full blown AIDS skilled	Full blown AIDS semi & unskilled	Weighted decline in labour units	AIDS scenario % difference compared to no-AIDS*
2000	13,554	35,941	165,218	57,454	-0.3
2001	17,648	47,058	218,064	75,542	-0.4
2002	22,192	59,509	277,030	95,727	-0.5
2003	26,946	72,652	337,980	116,723	-0.6
2004	31,558	85,495	395,818	136,845	-0.7
2005	35,669	97,007	445,668	154,433	-0.8
2006	38,998	106,352	484,044	168,250	-0.8
2007	41,421	113,169	509,528	177,779	-0.8
2008	43,002	117,604	522,721	183,245	-0.8
2009	43,886	120,048	525,758	185,343	-0.8
2010	44,228	120,949	521,468	184,950	-0.8
2011	44,182	120,760	512,806	182,968	-0.8
2012	43,889	119,890	502,165	180,154	-0.8
2013	43,468	118,688	491,279	177,086	-0.7
2014	43,037	117,480	481,248	174,196	-0.7
2015	42,605	116,273	471,217	171,306	-0.7

* % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences

Source: WEFA

REMUNERATION COST INCREASES

It is expected that employers will need to adjust their contribution to pension, life and medical benefits upwards on account of the AIDS epidemic. In addition there may be indirect cost increases to account for, such as recruitment, additional sickness and compassionate leave, as well as costs of ensuring occupational health and safety standards, loss of turnover and profits due to the impact of AIDS on clients. We calculate the overall change in costs to the employer stemming from higher benefit contributions and other indirect costs according to the economy-wide relative importance of wages as a production input for 45 sectors in the South African economy.

Companies face higher direct and indirect costs ...

As a starting point, we propose to consider work done by the Metropolitan Employee Benefits unit on the cost of AIDS to companies. Metropolitan noted that 'the cost of an average set of benefits is expected to double for many schemes by 2005 and triple by 2010'. Where employers have full responsibility for the provision of benefits, Metropolitan projects that this could add around 15% to the remuneration costs of an average manufacturing company by 2005 and about 30% by 2010. Indirect costs, Metropolitan estimates, could add a further 10% and 15% respectively. We assume that employers are responsible for carrying two-thirds of the wage cost increases while, employees carry one third.

1. Higher wage cost passed on to consumer via PPI

It is conceivable that employers will not be able to pass on the full wage cost increase to customers in the form of higher prices. If we take Metropolitan's assumption for 2005 as a starting point and assume that the proportion of wage cost increases that can be passed on is 50% across all economic activities in South Africa (not just manufacturing), then the initial wage cost increase is 12.5% for that year. A doubling of the 2005 benefits bill, as suggested by Metropolitan, would result in a 22.5% wage bill increase by 2010. We propose to apply linear intrapolation between 2000 and 2005 and between 2005 and 2010 and we keep the increase beyond 2010 constant.

... which will feed through to higher prices ...

Moreover, we exclude unskilled labour from the wage cost calculations as it is less likely that this skill category is covered by these benefits and few indirect costs will be incurred. We estimate the cost impact across sectors with an input-output model and then weigh them according to aggregate sectoral intermediate sales to arrive at an approximation for the change in PPI. This latter PPI forecast will feed into the macroeconomic model.

The results of our cost simulation and the estimates effect on PPI are shown in Figure 12.

Figure 12 DIRECT IMPACT OF AIDS ON WAGE COSTS (%)					
	Average Increase in wage bill** (1999 prices)	Initial Increase in wage bill***	Employer passing on to customer†	Direct Impact on the economy- wide firm costs	Direct & indirect impact on PPI*
2000		7.1	2.4	0.3	0.7
2001		10.7	3.6	0.5	1.1
2002		14.3	4.8	0.7	1.4
2003		17.9	6.0	0.8	1.8
2004		21.4	7.1	1.0	2.1
2005	25.0	25.0	8.3	1.2	2.5
2006		29.0	9.7	1.4	2.9
2007		33.0	11.0	1.6	3.3
2008		37.0	12.3	1.8	3.7
2009		41.0	13.7	1.9	4.1
2010	45.0	45.0	15.0	2.1	4.5
2011		45.0	15.0	2.1	4.5
2012		45.0	15.0	2.1	4.5
2013		45.0	15.0	2.1	4.5
2014		45.0	15.0	2.1	4.5
2015		45.0	15.0	2.1	4.5

* % difference in index levels between Aids and no-Aids scenario, and not YoY growth rate differences

** Metropolitan projection

*** Skilled and highly skilled only due to AIDs

† 50% of two thirds of the increase in the wage bill of skilled and highly skilled labour

Source: WEFA

2. Higher wage cost financed from operating surplus

Since we assume that companies will only be able to pass on 50% of the wage cost increases to its customers, the remaining 50% can be assumed to be absorbed by the firm in the form of lower operating surpluses. The impact on gross operating surpluses is weighted by cost exposure across sectors, as in the previous section, and feeds directly into our macroeconomic framework as a reduction of overall gross operating surplus. The results are shown in Figure 13.

... or be absorbed by operating surpluses

Figure 13 DIRECT IMPACT OF AIDS ON OPERATING SURPLUS (%)				
	Average increase in wage bill (1999 prices)**	Initial increase in wage bill***	Employer absorbing internally†	Direct impact on economy-wide gross operating surplus *
2000		7.1	2.4	-1.5
2001		10.7	3.6	-2.3
2002		14.3	4.8	-3.1
2003		17.9	6.0	-3.8
2004		21.4	7.1	-4.6
2005	25.0	25.0	8.3	-5.4
2006		29.0	9.7	-6.2
2007		33.0	11.0	-7.1
2008		37.0	12.3	-7.9
2009		41.0	13.7	-8.8
2010	45.0	45.0	15.0	-9.7
2011		45.0	15.0	-9.7
2012		45.0	15.0	-9.7
2013		45.0	15.0	-9.7
2014		45.0	15.0	-9.7
2015		45.0	15.0	-9.7

* Real % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences

** Metropolitan projection

*** Skilled and highly skilled only due to AIDS

† 50% of two thirds of the increase in the wage bill of skilled and highly skilled labour

Source: WEFA

DEMAND CHANGES AMONG HOUSEHOLDS

The AIDS epidemic affects household demand through three distinct channels:

1. lower wage income especially among the skilled and highly skilled who absorb some of the higher healthcare and other benefit schemes;
2. lower overall population numbers which affect the distribution of household income and thus demand;
3. the higher need for healthcare, which diverts fund away from other expenditure categories.

We model each of these effects separately and then aggregate the results.

1. AIDS costs absorbed by employee via lower wage income

We argued above that two thirds of the higher wage bill due to costs related to HIV/AIDS will be borne by the employer who either passes it on through higher prices or absorbs it from the operating surplus. The remaining third of the higher costs may well be borne by the employee (skilled and highly skilled) and translate into lower labour income for these skills groups across sectors. Column 1 in Figure 14 shows the drop in wage income for the skilled and highly skilled, who benefit from health and pension schemes, which could be expected to be as much as 15% by 2010. If translated into a change in wage income for the economy as a whole, the effect is obviously less dramatic. Nevertheless, wage income is still expected to be almost 6% lower than in the no-AIDS scenario by 2010.

Wage income is expected to fall ...

We are trying to assess in addition, what effect the lower wage income for the higher skills groups will have on economy-wide demand patterns. For that purpose, we use a WEFA model based on income distribution patterns from the 1995 October Household Survey (OHS). We first analyse the impact of the lower wage income for the skilled and the highly skilled on household income. The households that are dependent on skilled or highly skilled income earners may be the most adversely affected. We then feed the lower wage income profile by household income classes through the income distribution model to assess the change in demand composition across the various expenditure categories. When we compare the effect of lower wage income to a no-AIDS scenario, we observe that the drop in wage income does affect all expenditure categories. However, demand for services, durables and savings suffer the most under these conditions. We incorporate this first order effect of lower wage incomes in the macro-model.

Figure 14 CHANGE IN DEMAND ASSOCIATED WITH THE LOWER LABOUR INCOME IN THE AIDS SCENARIO (%)

	Ch in wage inc of skilled and highly skilled labour*	Ch in economy- wide wage income*	Ch in demand for residential buildings*	Ch in demand for durables*	Ch in demand for semi- durables	Ch in demand for non-durables*	Ch in demand for services*	Ch in savings*
2000	-2.4	-1.5	-0.9	-1.3	-1.2	-0.6	-1.1	-1.4
2001	-3.6	-2.2	-1.3	-2.0	-1.8	-1.0	-1.8	-2.1
2002	-4.8	-2.9	-1.8	-2.8	-2.4	-1.3	-2.8	-3.1
2003	-6.0	-3.7	-2.2	-3.5	-3.0	-1.6	-3.4	-3.9
2004	-7.1	-4.4	-2.6	-4.2	-3.5	-1.9	-4.2	-4.8
2005	-8.3	-5.1	-3.1	-5.0	-4.2	-2.3	-5.1	-5.7
2006	-9.7	-6.0	-3.7	-5.8	-4.9	-2.7	-6.0	-6.7
2007	-11.0	-6.8	-4.3	-6.7	-5.7	-3.1	-6.8	-7.7
2008	-12.3	-7.6	-4.8	-7.6	-6.5	-3.5	-7.7	-8.7
2009	-13.7	-8.4	-5.3	-8.9	-8.1	-4.1	-8.9	-10.4
2010	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6
2011	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6
2012	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6
2013	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6
2014	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6
2015	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6

* Real % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences

Source: WEFA

2. Lower population resulting in changing household demand

The wage income effect on household demand cannot be seen in isolation, however. The population developments noted in the first part of the report will have some implications for consumption patterns as well. One can probably assume that the epidemic does not initially affect the distribution of income among earners in the context of a labour surplus economy, as each time an income earner dies he/she is replaced by another. However, the epidemic will affect income distribution within households, as it will result in a decrease in the number of individuals per household while total economy-wide income earned remains constant. The effect of this is an initial increase in per capita income of households. Note, this does not translate into higher disposable incomes, as will be explained later.

... but lower population numbers might initially raise household incomes

In order to determine the potential effect of the falling population on household demand, we employ again the WEFA income distribution model. We isolate the population impact of AIDS on income distribution by separately running an AIDS and no-AIDS scenario and compare the resulting income distributions of the two scenarios. All other economic variables are kept constant, ie, it is only population growth that differs. A comparison of consumption patterns then reveals that as income per household moves up under the AIDS scenario, one can expect a shift away from non- and semi-durables towards durables and services as the latter constitute a higher proportion of high-income household expenditure. For the

same reason one could also expect a lower demand for residential buildings, which by 2009, could be almost 2.5% lower than in the no-AIDS scenario.

Figure 15 CHANGE IN DEMAND ASSOCIATED WITH THE LOWER POPULATION IN THE AIDS SCENARIO

(%)	Residential*	Durables*	Semi-durables*	Non-durables*	Services*	Savings*
2000	-0.2	0.0	-0.1	-0.3	0.0	0.0
2001	-0.2	0.0	-0.1	-0.4	0.0	0.1
2002	-0.3	0.2	-0.1	-0.5	0.4	0.4
2003	-0.5	0.2	-0.1	-0.7	0.4	0.6
2004	-0.7	0.3	-0.2	-1.1	0.7	0.9
2005	-1.0	0.4	-0.4	-1.5	1.0	1.2
2006	-1.3	0.5	-0.5	-1.9	1.3	1.6
2007	-1.6	0.6	-0.6	-2.4	1.6	1.9
2008	-2.0	0.8	-0.7	-3.0	1.8	2.3
2009	-2.2	0.8	-0.8	-3.3	2.1	2.6
2010	-2.4	0.9	-0.9	-3.6	2.3	2.8
2011	-2.6	1.0	-1.0	-3.9	2.5	3.1
2012	-2.8	1.1	-1.0	-4.2	2.7	3.4
2013	-3.0	1.2	-1.1	-4.5	3.0	3.6
2014	-3.2	1.3	-1.2	-4.8	3.2	3.9
2015	-3.4	1.4	-1.3	-5.1	3.4	4.2

* Real % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences

Source: WEFA

3. Increased demand for health services

The demand picture would be incomplete without taking into account a higher demand for health care. Presumably, part of the higher wage costs, which are either passed on by the employers eventually resulting in a higher PPI, or they are absorbed by the employers as lower operating surplus or by employees as lower labour income, are used to contract in a range of health and other services. We assume that at least 25% of the higher cost to the private sector (employer and employees) will be spent on health-related services. As a result, we find that demand for health services could be over 11% higher by 2010 than in a no-AIDS scenario.

Demand will shift to health services

Figure 16 CHANGE IN DEMAND FOR HEALTH AND RELATED SERVICES ASSOCIATED WITH HIGHER WAGE COSTS

%ch in demand for health related services*	
2000	1.8
2001	2.7
2002	3.6
2003	4.5
2004	5.4
2005	6.3
2006	7.3
2007	8.3
2008	9.4
2009	10.4
2010	11.4
2011	11.4
2012	11.4
2013	11.4
2014	11.4
2015	11.4

* Real % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences

Source: WEFA

We add this higher demand for health services to the change in demand from services resulting from the previous assumptions (lower wage income and lower population). The net effect of all three demand-assumptions is shown below and will be used in the macroeconomic model. We find that the net impact on household demand of the three effects described above is negative. All expenditure categories are expected to be down with the exception of services, which are boosted by the higher demand for health-related services. Maybe not surprisingly, it is the spending on semi-durables and durables as well as residential buildings that suffer the most. The fall in demand for savings trails behind, probably as a result of the already low household savings rate.

Figure 17 NET CHANGE IN HOUSEHOLD DEMAND						
	%ch in demand for residential*	%ch in demand for durables*	%ch in demand for semi-durables*	%ch in demand for non-durables*	%ch in demand for services*	%ch in demand for savings*
2000	-1.1	-1.3	-1.2	-0.9	0.6	-1.3
2001	-1.6	-2.0	-1.9	-1.3	1.0	-2.0
2002	-2.1	-2.6	-2.5	-1.8	1.2	-2.7
2003	-2.7	-3.3	-3.2	-2.4	1.5	-3.3
2004	-3.3	-3.9	-3.8	-3.0	1.9	-3.9
2005	-4.1	-4.6	-4.6	-3.8	2.3	-4.5
2006	-5.0	-5.3	-5.4	-4.6	2.7	-5.1
2007	-5.9	-6.1	-6.3	-5.6	3.1	-5.7
2008	-6.8	-6.8	-7.2	-6.5	3.5	-6.4
2009	-7.5	-8.0	-8.9	-7.3	3.6	-7.9
2010	-8.1	-8.3	-8.9	-7.8	4.4	-7.8
2011	-8.3	-8.2	-9.0	-8.1	4.6	-7.5
2012	-8.5	-8.1	-9.1	-8.4	4.8	-7.3
2013	-8.7	-8.0	-9.1	-8.7	5.0	-7.0
2014	-8.9	-7.9	-9.2	-9.0	5.3	-6.7
2015	-9.1	-7.8	-9.3	-9.3	5.5	-6.5

* % difference in constant price levels of AIDS and no-AIDS scenarios; not YoY growth rate differentials

Source: WEFA

HIGHER GOVERNMENT EXPENDITURE

The medical costs for treatment of AIDS discussed in the previous sections relate to the highly skilled and skilled labour force. Medical costs of other AIDS patients are assumed to be carried by the public sector. Given the number of patients with full-blown AIDS for the economically active (by skill class) and non-economically active population we can proceed by calculating the costs to the public sector. Conservative official estimates being muted are that the public sector currently spends between R3,000 and R4,500 per AIDS patient per year. This would result in annual increases in health spending in excess of R4bn by 2008.

While we use this number in our analysis, it is important to note that there are no reliable estimates available. Additionally, it is also naïve to assume, as we do, that the pattern of AIDS-related government expenditure will not change over the next 15 years. However, in the absence of reliable data and projections we have little choice but to assume a constant cost profile. As mentioned before, the significance of this analysis lies in identifying the potential ripple effects of certain assumptions.

The results are shown in Figure 18.

Medical costs are expected to push up the deficit

Figure 18

DIRECT IMPACT OF AIDS ON GOVERNMENT CURRENT EXPENDITURE

	Full blown AIDS total population (1)	Full blown AIDS highly skilled & skilled (2)	Full blown AIDS for which govt responsible (1-2)	Government health expenditure at R3,750 per patient per year (Rm)
2000	447,550	49,494	398,056	1,493
2001	569,686	64,706	504,980	1,894
2002	702,310	81,702	620,608	2,327
2003	837,075	99,598	737,477	2,766
2004	963,768	117,053	846,715	3,175
2005	1,072,597	132,676	939,921	3,525
2006	1,156,543	145,350	1,011,193	3,792
2007	1,212,802	154,589	1,058,212	3,968
2008	1,242,806	160,605	1,082,201	4,058
2009	1,251,038	163,934	1,087,104	4,077
2010	1,243,376	165,177	1,078,199	4,043
2011	1,225,693	164,941	1,060,751	3,978
2012	1,202,978	163,779	1,039,199	3,897
2013	1,179,002	162,156	1,016,846	3,813
2014	1,156,343	160,517	995,825	3,734
2015	1,133,683	158,878	974,805	3,656

Source: WEFA

There are several ways in which this expenditure can be financed.

- Expenditure switching within the health department or by sacrificing other current expenditure.
- Expenditure switching by forfeiting public sector capital expenditure.
- Higher budget deficit.

The first two options are difficult to model at the macro level. Unless a significant channel can be established that handles the long-term macroeconomic effect of lower current expenditure on, say, housing and education to off-set the higher expenditure on health on macro level productivity, the net macro effect is relatively small as it involves compositional changes. Similarly, forfeiting public sector capital expenditure has a long-term productivity effect, but this requires an independent modelling exercise that is based on a wide range of macroeconomic assumptions. At this stage the most practical approach is to ignore macro effects of expenditure switching and to focus on higher budget deficits as our baseline scenario. The higher health spending by the government is thus used as an assumption in the macro-modelling, which will then have economy-wide demand and crowding-out effects.

SUMMARY OF ASSUMPTIONS

The assumptions discussed above can be summarised in Figure 19 and are fed into the WEFA long term macroeconomic model.

Figure 19 SUMMARY OF MACROECONOMIC AIDS ASSUMPTIONS

	%ch in demand for residential* (%)	%ch in demand for durables* (%)	%ch in demand for semi- durables* (%)	%ch in demand for non- durables* (%)	%ch in demand for services* (%)	%ch in savings* (%)	%ch in labour supply* (%)	%ch in PPI* (%)	%ch in GOS* # (%)	Abs ch in govt curr exp (Rm)
2000	-1.1	-1.3	-1.2	-0.9	0.6	-1.3	-1.8	0.7	-1.5	1,493
2001	-1.6	-2.0	-1.9	-1.3	1.0	-2.0	-2.5	1.1	-2.2	1,894
2002	-2.1	-2.6	-2.5	-1.8	1.2	-2.7	-3.4	1.4	-2.9	2,327
2003	-2.7	-3.3	-3.2	-2.4	1.5	-3.3	-4.6	1.8	-3.7	2,766
2004	-3.3	-3.9	-3.8	-3.0	1.9	-3.9	-6.1	2.1	-4.4	3,175
2005	-4.1	-4.6	-4.6	-3.8	2.3	-4.5	-7.7	2.5	-5.1	3,525
2006	-5.0	-5.3	-5.4	-4.6	2.7	-5.1	-9.6	2.9	-6.0	3,792
2007	-5.9	-6.1	-6.3	-5.6	3.1	-5.7	-11.6	3.3	-6.8	3,968
2008	-6.8	-6.8	-7.2	-6.5	3.5	-6.4	-13.7	3.7	-7.6	4,058
2009	-7.5	-8.0	-8.9	-7.3	3.6	-7.9	-15.6	4.1	-8.4	4,077
2010	-8.1	-8.3	-8.9	-7.8	4.4	-7.8	-17.6	4.5	-9.2	4,043
2011	-8.3	-8.2	-9.0	-8.1	4.6	-7.5	-19.5	4.5	-9.2	3,978
2012	-8.5	-8.1	-9.1	-8.4	4.8	-7.3	-21.4	4.5	-9.2	3,897
2013	-8.7	-8.0	-9.1	-8.7	5.0	-7.0	-23.2	4.5	-9.2	3,813
2014	-8.9	-7.9	-9.2	-9.0	5.3	-6.7	-25.0	4.5	-9.2	3,734
2015	-9.1	-7.8	-9.3	-9.3	5.5	-6.5	-26.7	4.5	-9.2	3,656

* Real % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences
Gross operating surplus

Source: WEFA

In summary, compared with a no-AIDS scenario, an AIDS scenario will be characterised by a lower population and labour supply. This will have a negative effect on demand, although unemployment may also decline. The initial effect of lower demand in our assumptions is reflected in the lower expenditure on all categories other than services, which incorporates higher health spending.

THE METHODOLOGY AND THE MODEL USED

The net impact of the often counterbalancing effects of the AIDS epidemic were explored with WEFA's annual macroeconomic modelling framework.

Our first step was to create a no-AIDS reference scenario, which is characterised by higher population and a higher labour force. We used the ASSA model's demographic forecasts for population and labour force (see first sections of the report) and to add estimated AIDS deaths back into the population and labour force numbers and adjust for fertility and mortality changes.

The model itself was designed primarily for the purposes of long-term (up to 20 year) forecasts of the South African economy. A forecast of the level of economic activity as measured by gross domestic product (GDP) is driven by two basic components: the first is the rate of use of existing resources and technologies. This component is the focus of short-run macroeconomic fluctuations. Such projections primarily involve forecasting changes in the level of aggregate demand and the subsequent split between output changes and price changes given the current economic environment. The second component is the rate of expansion of the country's resource and technology base of the economy, which is the focus of long-run economic growth (aggregate supply) analysis.

WEFA's long-term macromodel is a blend of these two approaches. In the first few years of the outlook period, the results are dominated by aggregate demand projections, since both the resource and technology bases are relatively constant. The second part of the long-term forecast, which comprises the period 2002 to 2015, is dominated by supply factors such as population growth, labour force participation and productivity growth. Fiscal policy, monetary policy, regional trade and the projected degree of international economic integration are also incorporated into the long-term forecast.

There are two basic types of long-term scenarios: trend and cycle. The WEFA long-term forecast is a trend forecast. The principal characteristic of a trend scenario is the absence of any business cycle. It is not our belief that business cycles will never occur. Rather, the perspective is that business cycle turning points, far into the future, are virtually impossible to predict accurately. Historically, cycles have often been generated by random events, such as oil shocks, wars and natural disasters.

A trend scenario assumes that the real economy grows at historical averages in relation to population growth and other factors, as indicated previously. A trend forecast does not represent the economy as growing at a 'full employment' path, but rather as growing with a certain amount of slack. In a sense, the trend forecast represents the average growth of the economy over the business cycles. The advantage of a trend forecast is that it reflects supply factors. The reason a trend forecast is used in business planning is that it allows a business to comprehend how the evolution of the economy will affect it without the noise of the business cycle obscuring the fundamentals of growth.

The broad structure of the model may be described as that of a full supply-demand econometric model which is derived from economic theory on the one hand and will have the flexibility to incorporate short-run adjustments and technological constraints on the other. These supply elements consist of a measure of potential output which, in conjunction with the expenditure-determined total output, provides a measure of economy-wide capacity utilisation. The latter then serves as a variable supply constraint in the determination of imports, investment, prices and wages.

The model was estimated with Ordinary Least Squares (except for some equations where Cochrane-Orcutt adjustments were used), using annual data. The period of estimation varied between 1960 to 1998 depending on data availability and other concerns. The model consists of 90 equations, of which 23 are behavioural equations and 67 technical relations and identities. Some 49 variables are treated as assumptions.

The model consists of the following sectors:

1. The demand side

- private consumption expenditure
- investment (fixed and inventory)
- imports, exports and the balance of payments
- government sector

2. The supply side.

3. Employment, potential output and capacity utilisation.

4. Prices and wages.

5. Monetary sector.

RESULTS OF THE MACRO-MODELLING

With the assumptions and the modelling framework in place we can now turn our attention to the results. The results are summarised by means of deviations from the no-AIDS baseline.

Figure 20 THE IMPACT OF AIDS ON GDP AND COMPONENTS OF CONSUMPTION EXPENDITURE

	Real GDP*	Growth	Real household disposable inc*	Growth	Real % consumption expenditure*	Growth
	(%)	(% point diff)**	(%)	(% point diff)**	(%)	(% point diff)**
2000	0.7		-1.0		-0.6	
2001	-1.0	-0.3	-1.3	-0.4	-0.8	-0.3
2002	-1.2	-0.2	-1.7	-0.5	-1.2	-0.4
2003	-1.4	-0.2	-2.1	-0.4	-1.5	-0.3
2004	-1.6	-0.2	-2.4	-0.4	-1.9	-0.4
2005	-1.9	-0.3	-2.8	-0.4	-2.4	-0.5
2006-2010	-3.1	-0.4	-4.4	-0.6	-4.7	-0.8
2011-2015	-4.7	-0.3	-5.8	-0.2	-8.4	-0.8

* Real % difference between AIDS and no-AIDS scenarios, not YoY growth rate differences
 ** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

Given the assumptions that we have outlined above, AIDS is expected to have a negative impact on GDP. In 2006-2010, constant price GDP in the AIDS scenario will be an annual average 3.1% lower than in the no-AIDS baseline; in 2011-15, it is expected to be 4.7% lower on an annual average basis. In constant 1995 terms, GDP would be R12.5bn below its no-AIDS level by 2005 and R41bn by 2015. GDP growth rates are expected to be 0.4 percentage points lower in 2006-10 and 0.3 percentage points in 2011-15. This is mainly the result of the lower household income assumption, which translates into lower disposable incomes and lower consumption expenditure, as can be seen in the remaining columns of Figure 20. In constant 1995 rand terms, this would also mean that real disposable income would be R20bn lower by 2005 and R40bn lower by 2015 than in the no-AIDS scenario. The higher anticipated demand for health services is insufficient to pull consumption growth back into the positive category – but at least it helps to dampen the negative effect. It is important to note that, on average over the period, the decline in consumption expenditure is less than the decline in disposable income, so that household savings will be declining in the AIDS scenario.

GDP and growth will be lower due to lower consumption ...

Capacity utilisation is helped by the lower labour supply and labour productivity. This reduces the gap between potential and actual output and induces firms to invest more in capital. As a result, total fixed investment in constant rand terms and its YoY real growth relative to the no-AIDS baseline is only marginally affected, as the drop in demand for residential buildings that we assume following the income and expenditure analysis is counterbalanced by the switching of some firms to more capital intensive production methods. In fact, as can be seen in Figure 21, column 5, GDFI can even be expected to increase as a percentage of GDP.

... while investment holds up fairly well

Figure 21 THE IMPACT OF AIDS ON SELECTED INVESTMENT DEMAND COMPONENTS OF GDP

	Real fixed inv: residential* (%)	Growth (% point diff)**	GDF* (%)	Growth (% point diff)**	GDF/GDP (% point diff)**	Capacity utilisation (% point diff)**	Inventories (diff in levels) (Rm)
2000	-1.1		-1.3		-0.2	-0.1	-2,245
2001	-1.5	-0.4	-1.4	-0.1	-0.1	-0.2	-130
2002	-2.2	-0.7	-1.3	0.1	-0.1	-0.1	-698
2003	-2.6	-0.4	-1.1	0.2	0.0	-0.1	-935
2004	-3.3	-0.7	-1.0	0.2	0.0	0.0	-852
2005	-4.1	-0.8	-0.9	0.1	0.1	0.1	-1,116
2006-2010	-6.6	-0.9	-1.2	-0.1	0.3	0.0	-4,014
2011-2015	-8.7	-0.2	-1.1	0.0	0.7	0.0	-4,676

* Real % difference between AIDS and no-AIDS scenario, not YoY growth rate differences
 ** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

The decline in the demand for labour, is expected to be faster than the slowdown in GDP. However, with the supply of labour falling even more, the unemployment rate is set to decline marginally in the AIDS scenario.

Government current expenditure in constant rand prices as well as in terms of YoY growth is expected to drop less than GDP because of the additional expenditure on health and related services which is set to rise with more AIDS patients. However, government current revenue will decline with economic activity. Consequently, AIDS will create pressure on the budget deficit on two fronts: higher health expenditure and lower revenues which is not counterbalanced sufficiently by expenditure declines linked to lower economic activity. We have here assumed a flexible budget deficit. If we were to assume stringent fiscal discipline in line with the medium-term budget framework, government expenditure would have to decline more or less in line with government revenue, which will cause GDP to decline even more than is forecast in our baseline case. This, in turn, would cause government revenue to decline further, dragging down GDP with it – a process that can be referred to as the pro-cyclical effects of fiscal discipline. The flexible budget deficit, which we assume in our baseline case, prevents this downward spiral, at the expense of a higher public sector borrowing requirement (about 1% higher as a percentage of GDP than the no-AIDS scenario) and lower government savings (see Figure 22).

The fiscal deficit deteriorates not only due to higher expenditure but also lower revenue

Figure 22 THE IMPACT OF AIDS ON GOVERNMENT FINANCES

	Government consump expen* (%)	Growth (% point diff)**	Government revenue* (%)	Growth (% point diff)**	Public sector deficit/GDP (% point diff)**
2000	-1.3		-0.7		-0.2
2001	-1.2	0.1	-0.8	-0.2	-0.3
2002	-1.2	0.1	-0.9	-0.3	-0.3
2003	-1.1	0.1	-1.2	-0.2	-0.4
2004	-1.0	0.1	-1.4	-0.2	-0.5
2005	-1.0	0.1	-1.6	-0.2	-0.6
2006-2010	-1.1	-0.1	-2.6	-0.4	-0.8
2011-2015	-2.0	-0.2	-4.1	-0.2	-0.9

* Real % difference between AIDS and no-AIDS scenario, not YoY growth rate differences
 ** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

As described above, the AIDS epidemic will result in lower disposable incomes that are not matched fully by lower consumption expenditure. This will have a negative effect on household savings, as presented in the table below. Public sector savings will also be adversely affected by the higher public sector borrowing requirement. Furthermore, corporate savings will suffer as some of the higher wage bill faced by employers will be financed out of the operating surplus and savings. Total domestic savings as a percentage of GDP is thus forecast to be on average about 2 percentage points lower than in a no-AIDS scenario. This means that South Africa's savings rate is unlikely to top the 20% of GDP level required to accelerate trend growth. This highlights an important potential problem area for the South African economy: as domestic savings are already low and presenting a real capital constraint to the economy, any further deterioration in the formation of savings will lower the country's investment potential.

*Domestic savings
will suffer across the
board ...*

In our analysis, some of the decline in savings (in constant rand terms) will be matched by lower real investment. The switching of companies away from labour towards more capital-intensive means of production will be more than compensated by a reduction in demand for residential buildings, leaving overall investment lower. Nevertheless, the remainder of the fall in savings will have to be made up by foreign savings – most likely in the form of foreign loans and a widening current account deficit. If foreign funding is unavailable, however, to plug the savings-investment gap, the higher investment demand will translate into heightened upward pressure on interest rates, further slowing the economy.

*... and will need to
be made up by
foreign savings -*

Figure 23 THE IMPACT OF AIDS ON COMPONENTS OF DOMESTIC SAVINGS

	Private* (%)	Public* (%)	Corporate* (%)	Total domestic savings* (% point diff)**	GDS/GDP (%)	Total savings = Investment (%)
2000	-7.4	-5.8	-27.8	-10.4	-1.4	-3.7
2001	-16.1	-9.2	-17.7	-10.4	-1.5	-1.4
2002	-33.3	-11.1	-3.7	-7.7	-1.1	-1.7
2003	-31.7	-13.7	-4.6	-9.9	-1.3	-1.7
2004	-32.4	-16.5	-2.7	-11.1	-1.5	-1.5
2005	-30.6	-19.1	-1.7	-12.2	-1.7	-1.5
2006-2010	-32.9	-23.2	-2.9	-14.8	-2.1	-2.3
2011-2015	-23.6	-22.7	-7.1	-15.0	-2.2	-1.9

* Real % difference between AIDS and no-AIDS scenario, not YoY growth rate differences
 ** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

Following on from the need for foreign savings in the form of foreign currency loans, resultant higher net factor payments will lead to a widening current account deficit. This is despite an expected improvement in the trade balance. With lower domestic activity, producers are diverted to international markets, while imports will decline on account of lower domestic demand. On average over our forecast horizon, the current-account deficit as percentage of GDP would be about 2 percentage points higher than in a no-AIDS case. This would push the overall current-account deficit closer to 3% of GDP – a less comfortable deficit level than the present 1-1.5%.

*... which will lead to
a higher current-
account deficit*

Figure 24 THE IMPACT OF AIDS ON SELECTED TRADE AND THE CURRENT ACCOUNT

	Exports* (%)	Growth (% point diff)**	Imports* (%)	Growth (% point diff)**	Current account/ GDP (% point diff)**
2000	0.1		-0.4		-1.4
2001	0.2	0.1	0.0	0.4	-1.0
2002	0.2	0.1	-0.1	-0.2	-1.2
2003	0.3	0.1	0.1	0.2	-1.4
2004	0.4	0.1	0.1	0.0	-1.7
2005	0.4	0.1	0.0	-0.1	-1.7
2006-2010	0.6	0.1	-1.1	-0.3	-2.4
2011-2015	0.8	0.0	-3.1	-0.5	-2.4

* Real % difference between AIDS and no-AIDS scenario, not YoY growth rate differences

** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

The upward pressures on the PPI are largely responsible for an anticipated increase in the overall CPI inflation rate by an annual average 0.4 percentage points in 2006-2010 compared to the no-AIDS baseline. The overall effect on the CPI has been muted by the slowdown in domestic demand. Nevertheless, given the policy focus on inflation targeting, the higher CPI will translate into some upward pressure on interest rates. We would expect the prime lending rate to be less than 0.5 percentage points higher per year. But this slightly higher interest rate outlook is also one of the reasons why investment is slowing.

A higher CPI will put some pressure on interest rates and the exchange rate

The higher CPI profile will also have some negative repercussions for the nominal exchange rate. If we assume the real effective exchange rate constant throughout the period of observation, we would expect the nominal trade weighted rand exchange rate to depreciate pretty much in line with inflation differentials.

Figure 25 THE IMPACT OF AIDS ON SELECTED FINANCIAL VARIABLES AND EMPLOYMENT

	CPI* (%)	Inflation rate (% point diff)**	Prime Interest rate (% point diff)**	Trade weighted nominal exchange rate* (%)	Employment* (%)	Unemployment rate (% point diff)**
2000	0.4		-0.2	-0.4	-1.1	-0.2
2001	0.7	0.7	0.0	-0.7	-1.5	-0.3
2002	1.3	0.2	0.0	-1.3	-2.1	-0.3
2003	1.4	0.4	0.0	-1.4	-2.8	-0.4
2004	1.9	0.3	0.1	-1.8	-3.7	-0.5
2005	2.2	0.4	0.2	-2.1	-4.7	-0.6
2006-2010	3.2	0.4	0.3	-3.0	-8.3	-0.9
2011-2015	4.3	-0.1	0.6	-3.9	-14.1	-1.2

* Real % difference between AIDS and no-AIDS scenario, not YoY growth rate differences

** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

SECTORAL RISK EXPOSURE

Given the absence of any requirement of disclosure, very little actual information is available dealing with company or sectoral infection profiles and response strategies. From our analysis, however, we can identify two key areas of risk to sectors due to AIDS:

1. An exposure of sectors to infection risk
2. An exposure of sectors to higher skills groups and thus higher costs associated with AIDS

We propose to combine the two issues into a sector risk ranking. First, we calculated sectoral infection rates and ranked these. Secondly, we compiled the percentage of the total wage bill of highly skilled and skilled workers, and ranked those. We applied a weighting of the ranks of 60% for the exposure to infections and 40% for the exposure to remuneration for the higher skilled. The final ranking gives us a sectoral rating that reflects the relative risk exposure to the AIDS epidemic.

We compiled a sectoral risk ranking

SECTORAL INFECTION RATES

From our demographic modelling, we were able to overlay our forecasts of population and age groups as well as skill levels on sectoral data from the population census to arrive at infection rates and AIDS death variables for selected sectors in the South African economy. It is important to bear in mind that the calculation of sectoral infection and death rates is a very mechanical process and should be viewed as a framework for assessing relative rather than absolute sectoral risk exposure to the AIDS epidemic.

Infection risk is one factor

No special assumptions have been made to adjust the risk profile of any population group, skill group or sector. For example, mineworkers have not been assigned a higher HIV+ infection rate because they may or may not be more exposed to the 'PRO' group as noted in Figure 3. Similarly, no special assumptions have been made in respect of transport or health workers.

Figure 26 HIV+ PER 100 WORKERS				
	2000	2005	2010	2015
Agriculture, forestry and fishing	17.3	23.2	23.2	21.8
Mining	24.1	29.3	26.4	24.4
Consumer manufacturing	17.3	23.0	22.9	21.3
Forestry products	15.2	20.2	19.8	18.6
Chemicals	16.6	21.6	20.7	19.3
Metals	15.0	19.9	19.3	17.8
Machinery	15.9	21.2	20.8	19.5
Construction	18.2	23.9	23.4	22.1
Retail	16.2	21.3	20.7	19.3
Catering and accommodation	17.9	23.0	22.2	20.8
Transport and storage	18.5	23.5	22.0	20.2
Communication	12.1	16.5	16.3	15.3
Finance and insurance	8.9	12.4	12.5	11.7
Business services	11.9	15.6	15.1	14.3
Health	14.9	20.0	19.0	16.6
General government	17.2	24.5	26.0	26.1

Source: WEFA

Figure 27

AIDS DEATHS PER 100 WORKERS

	2000	2005	2010	2015
Agriculture, forestry and fishing	0.6	1.7	2.4	2.2
Mining	0.8	2.5	3.0	2.7
Consumer manufacturing	0.6	1.8	2.5	2.4
Forestry products	0.5	1.6	2.1	2.0
Chemicals	0.6	1.8	2.4	2.2
Metals	0.5	1.6	2.1	2.0
Machinery	0.5	1.6	2.1	1.9
Construction	0.5	1.7	2.2	2.1
Retail	0.6	1.8	2.3	2.1
Catering and accommodation	0.6	2.0	2.5	2.3
Transport and storage	0.4	1.3	1.7	1.7
Communication	0.3	0.9	1.2	1.2
Finance and insurance	0.4	1.1	1.5	1.4
Business services	0.6	1.9	2.5	2.2
Health	0.4	1.3	1.7	1.6
General government	0.4	1.0	1.4	1.4

Source: WEFA

Figure 28

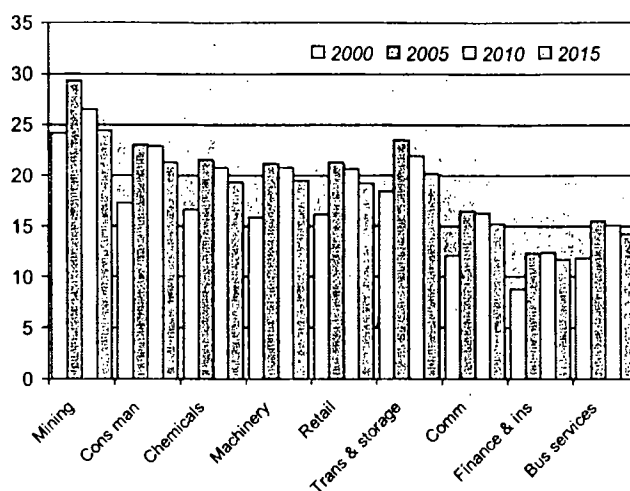
AIDS DEATHS PER 100 NORMAL DEATHS

	2000	2005	2010	2015
Agriculture, forestry and fishing	103.9	342.4	489.0	503.9
Mining	174.7	560.3	741.2	759.2
Consumer manufacturing	164.9	545.2	804.3	867.2
Forestry products	125.5	415.5	596.0	636.6
Chemicals	130.6	432.9	605.9	632.5
Metals	123.5	417.6	612.2	658.4
Machinery	116.6	389.2	542.3	563.6
Construction	142.7	470.5	662.7	694.6
Retail	188.9	605.6	836.2	876.4
Catering and accommodation	128.5	424.4	584.8	601.9
Transport and storage	117.4	403.5	598.8	652.6
Communication	93.8	322.8	484.0	528.4
Finance and insurance	99.4	324.4	454.3	479.6
Business services	162.8	557.5	784.6	788.8
Health	96.1	323.5	457.5	471.9
General government	74.3	191.0	239.1	229.1

Source: WEFA

Figure 29

HIV+ PER 100 WORKERS FOR SELECTED SECTORS AND YEARS



Source: WEFA

The figures above highlight the risk exposure of the mining sector, where infections peak at above 29% and deaths at 3 out of 100 workers. The reason is that mine workers are mainly black, male and generally fall into those age groups that are relatively more at risk. The possibility that mine workers are more in contact with high risk groups such as PRO is not accounted for at this stage. As a result, the actual infection rates in the mining sector are likely to be even higher.

The mining sector is followed closely by the general government sector, where infections peak at over 26%. Agriculture, manufacturing, machinery, construction, retail, catering and accommodation and transport and storage are all expected to record infection rate peaks above 20%. However, even sectors such as finance and insurance or business services, which draw on a high proportion of skilled and highly skilled employees, are still expected to face infection rates in excess of 10%. The ranking of sectors by infection rate is given below.

Figure 30

HIV+ PER 100 WORKERS

	2000	Rank
Finance and insurance	8.9	1
Business services	11.9	2
Communication	12.1	3
Health	14.9	4
Metals	15.0	5
Forestry products	15.2	6
Machinery	15.9	7
Retail	16.2	8
Chemicals	16.6	9
General government	17.2	10
Consumer manufacturing	17.3	11
Agriculture, forestry and fishing	17.3	12
Catering and accommodation	17.9	13
Construction	18.2	14
Transport and storage	18.5	15
Mining	24.1	16

Source: WEFA

SECTORAL REMUNERATION COSTS

If we look at the composition of sectoral wage bills, we find, not surprisingly, that service industries, such as finance and business services, are the most skills-intensive, while mining and manufacturing feature at the opposite end of the spectrum.

Potential wage costs are another consideration

Figure 31 % OF SKILLED & HIGHLY SKILLED OF WAGE BILL		
	1997	Rank
Agriculture, forestry and fishing	15.2	1
Mining	34.5	2
Construction	36.5	3
Consumer manufacturing	42.9	4
Metals	50.7	5
Machinery	56.2	6
Chemicals	65.7	7
Forestry products	65.8	8
Transport and storage	78.1	9
Retail	81.7	10
Communication	85.9	11
Catering and accommodation	88.8	12
General government	91.1	13
Health	97.2	14
Business services	98.2	15
Finance and insurance	98.8	16

Source: WEFA; OHS 1995, Population Census 1996

COMPOSITE SECTOR RISK RANKING

If we combine the two rankings with a 60:40 weighting, we find that the transport and storage industry, as well as the catering and accommodation sector, are most exposed to the AIDS risk. Not only are these sectors' infection rates high, they are also more reliant on a skilled workforce than mining or agriculture, say, whose infection rates are also very high. Finance and insurance and business services, which face the lowest infection risk, feature in the middle field in the composite ranking, as their high dependence on skills is likely to lead to higher remuneration costs in the form of rising benefit and retraining payments. While this ranking should provide a useful reference framework for relative sector risk exposure, it is important to emphasise that no sector can afford to be complacent in light of the AIDS epidemic. The effect will be felt across all sectors – just to varying degrees.

Transport, catering and accommodation are most exposed to AIDS risk

The AIDS epidemic is expected to lead to a stagnation in population growth within the next 10 years. Infection rates are expected to peak at almost 17% for the population as a whole and at a massive 26% for the economically active population. That means South Africa's workforce is disproportionately affected by the epidemic. With an official unemployment rate in excess of 30%, South Africa faces a labour surplus situation, which should mean that every person dying from AIDS-related illnesses should be replaced without much problem, leaving the production process and total income intact. However, the reality is not quite as straightforward. Most of the unemployed are unskilled or only semi-skilled. While most of the infections and deaths occur in this segment of the workforce, skilled and highly skilled groups are expected to be notably affected as well, with infection rates peaking at well above 20% and 10% respectively. The epidemic will thus exacerbate the existing skills shortage within the economy.

The AIDS epidemic will exacerbate South Africa's skills shortage

The cost of the epidemic will be borne by companies, households and government:

- The costs to companies will be significant, as higher health and other insurance benefits as well as higher training and replacement costs will add to the remuneration bill. Some of these higher costs will be passed on to consumers in the form of higher PPI inflation. But given the limited pricing power of companies, some of the higher costs will be absorbed by operating profits and come out of company savings.
- Household incomes will also be affected by higher health and insurance costs which are likely to result in lower take-home pay. This is in addition to the effect of a lower number of people in employment. The net effect is negative for disposable income, consumption demand and savings.
- Government will have to finance the health costs not covered by the private medical insurances. Unless current expenditure is switched from other categories to health spending or capital spending is cut, the higher health spending will add to the fiscal deficit, the public sector borrowing requirement and exacerbate government dissavings.

The net effect of the AIDS epidemic will be negative for growth. In our analysis, where we employed very conservative assumptions about costs to companies and government as well as the drop in household income, we found that the average annual trend rate of GDP growth over the next 15 years is likely to be 0.3-0.4 percentage points below the rate in a no-AIDS scenario.

The net effect will be negative for growth

There are some vicious cycles at work when analysing the economic effects of the AIDS epidemic: The most important is related to the savings constraint. The costs of the disease will almost certainly drain household, corporate and government savings. This will exacerbate the country's savings-investment constraint. Even if companies decided to invest further in technology and reduce their dependence on labour, the reduction in their operating profits as well as savings will leave them with much less room to manoeuvre.

One possibility is to draw in foreign savings to plug the savings-investment gap. However, a heightened perception of country risk associated with the AIDS epidemic is unlikely to encourage the inflow of foreign capital. The majority of capital inflows would thus have to be in the form of foreign loans. These would not only push up the country's foreign debt exposure, but also lead to a notable widening in the current-account deficit due to associated higher outflows of net factor payments. In the absence of foreign savings, the domestic savings-investment imbalance would force interest rates notably higher, further slowing economic growth and reining back investment demand.

The savings constraint will worsen ...

Another possibility is for the government to stick to its tight fiscal deficit targets and reduce expenditure in line with the lower revenue generated due to lower economic activity.

However, this in itself would set off a vicious spiral, as lower expenditure would exacerbate the fall in domestic demand and GDP, leading to even lower revenue generation, forcing the government to spend even less, etc.

The savings-investment imbalance could thus exacerbate the outlook for the South African economy under the AIDS scenario.

Even in our baseline case, the likely worsening of the country's growth, inflation and interest rate outlook will adversely affect the country's investment profile and hamper equity and bond market performance. Investors will start to look more carefully at sectoral exposure to the AIDS risk. As a result, we will probably face mounting claims for a disclosure of company infection profiles and coping strategies. While this area is clearly very sensitive, any improvement in information provision would advance the quality of analysis of the epidemic and thus help policy formulation and implementation.

... dampening the outlook for the markets

In the absence of reliable data and information, we propose to look at risk exposure of sectors in terms of two factors – firstly, their reliance on a workforce that has a high infection risk and, secondly, their reliance on skilled workers, the replacement of whom in case of illness and death is much higher than of the unskilled. If we aggregate those two factors, we find that transport and storage and catering and accommodation are the most exposed to the AIDS risk, while machinery, communication and metals fare relatively better. An important finding is, however, that service industries, such as finance and business services, rank in the middle field, as their reliance on skilled personnel makes them more vulnerable to a rising remuneration bill. Overall, no company can ignore the potential impact of the AIDS epidemic. Company management does have choices that will influence the future impact of the epidemic – as does government.

Sector risk assessments will become important

So far, no clear strategies have been forthcoming from either; but they are urgently needed in order to mitigate the destructive effect of the epidemic on all parts of the economy and society.

- The government needs to formulate a clear AIDS strategy that will allow domestic institutions and international development agencies to channel funds into the fight of the epidemic in South Africa. An explicit strategy would also ideally provide the public with more up-to-date and complete data on the spreading of the epidemic and allow better prognosis and response strategy from the private sector. Information creates a better understanding of the epidemic. In the absence of it, foreign investors, in particular, will remain deterred by the uncertainty surrounding the effects of the disease on the economy.
- The government should also move faster to dismantle structural obstacles to foreign investment in order to avoid a worsening of the savings-investment constraints.
- The government also has choices regarding the provision of AIDS drugs, especially to pregnant mothers in order to reduce the risk of mother-to-child transmission.
- At public as well as private sector level, the focus needs to be on education, increased access to condoms and the treatment of sexually transmitted diseases.

But most importantly, a clear AIDS strategy from the government is needed

Given the abundance of policy choices and the limited availability of data, modelling the effect of AIDS on the macroeconomy remains a moving target. However, we believe that, given the limitations of data availability, we have modelled a realistic scenario. Furthermore, we have established a framework of analysis that allows us to incorporate changes to the demographic outlook, government policy, household expenditure patterns as well as company responses in the future.

INTRODUCTION

This perspective does not set out to offer a complete analysis of equity investment over the period analysed for the economic impact of HIV/AIDS in the accompanying report. Rather, it hopes to remind readers of where the various equity sectors lie in terms of size and earnings momentum and, most importantly, to sensitize readers to the external and internal impacts which HIV/AIDS can be expected to bring about on the profit and valuation drivers.

To this end, we have taken the outputs from the AIDS analysis regarding sectoral impacts, and used these as inputs to make subjective calls on the internal and external impacts. This required adjustment for the sectors' operating positioning and their relative market positioning: this not only takes into account the high or low infection strata of the SA market itself, but also to what extent a company might have exposure to low-HIV foreign markets.

The top-down nature of both the HIV/AIDS analysis and this equity perspective hopefully flag sectors and companies which require further micro-analysis.

SA MACRO ENVIRONMENT

Equities appear on the surface to offer a good value proposition now, with SA in an economic upswing. Real GDP growth, which bottomed at 0.6% in 1998, is now accelerating through 1.2% in 1999 to 3.3% for 2000. Consumption is in the vanguard, with real retail sales growth set to rise to 5% in 2000 from 1% in 1999, and the broader real PCE growth to rise to 3.5% (from 0.7%). The upswing will see a strong increase in growth of imports (to +6% from -7%), but the economy is sufficiently robust to afford this, with the current account deficit rising to R11bn (1.2% of GDP) in 2000, but then stabilising at around 1% of GDP thanks to improving terms of trade. The vigorous growth in the economy is unlikely to translate into inflationary pressure as capacity utilisation and industry pricing pressure are low – we anticipate core inflation at around 6% next year. In spite of this, interest rates are unlikely to come down from current levels as formal, tight inflation targets have been introduced.

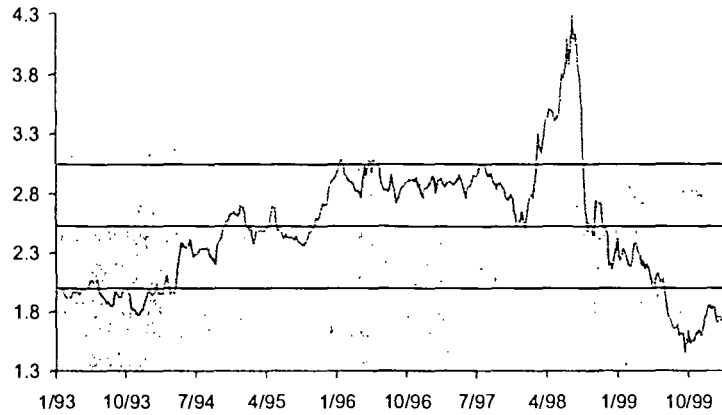
This is the one- to two-year view, however, and the broad investment negative for SA of the HIV/AIDS pandemic leads to a far less bullish investment view over a 5-15 year timeframe. We believe that AIDS will almost neutralise the birth-rate-driven population increase of 2% which would otherwise prevail in SA, and have a corresponding dampening effect on the economy – especially on the sectors exposed to domestic consumption. Many SA businesses also trade in the adjoining sub-Saharan region of Africa and this region carries some two thirds of the world's HIV infected people. The recent past has seen high margin add-ons to SA companies in the retail, beverage and food sectors and this sweetener to earnings faces clear pressure from HIV.

SA EQUITY MARKET LEVELS

In the SA framework (ie, relative to the SA interest market), the JSE looks 'cheap' again after its recent pullback, with the FINDI index at a yield relative of 1.64x, and with stronger near-term economic and corporate earnings backdrops.

Figure 33

YIELD RELATIVE – 3 MONTH NCD TO JSE FINDI



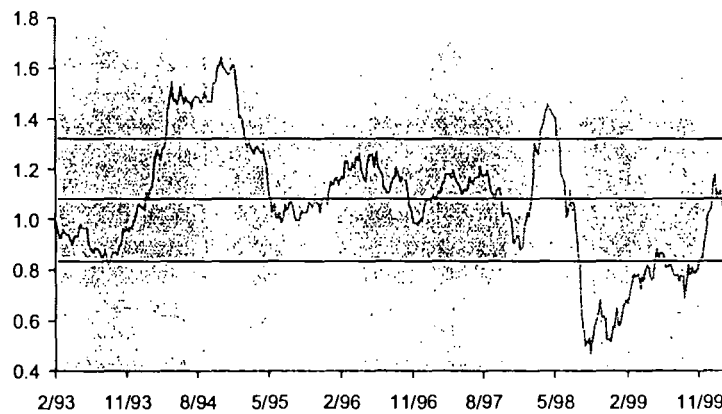
Mean = 2.43. Std Dev = 0.53

Source: I-Net

From a US perspective, however, we note a totally different picture relative to US treasuries, Figure 34.

Figure 34

YIELD RELATIVE – US 10YR BONDS TO JSE FINDI



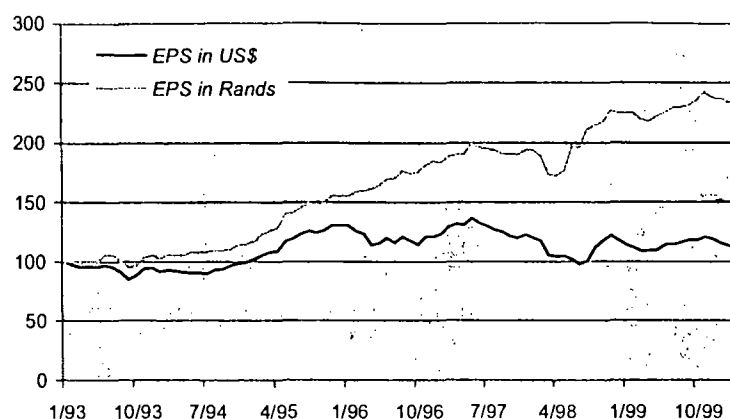
Mean = 1.07. Std Dev = 0.25

Source: I-Net

Here we see a yield relative of 1.0x – but equities should cost more because of the growth. Establishing the growth (in US\$ terms), which our equities have actually delivered (the black line in Figure 35), shows a very modest increase – up only 12% in the eight years plotted.

Figure 35

EARNINGS GROWTH



Source: I-Net

Figure 35 clearly shows the dull dollar growth, with the R/\$ cracks in 1996, and 1997/98 lowering the end growth and adding volatility – both reasons not to overpay for the JSE's equity performance. The negative impact on the economy from AIDS reinforces the cautious stance.

SECTOR DYNAMICS UNDER THE AIDS SCENARIO

SA's equity market has a high commodity weighting, with a third of the market capitalisation being resource-based companies. In the nature of commodity businesses (ie, price takers) many of the relevant share prices have been at historically high levels in 1999/2000, anticipating strong demand for these resources from the (consensus forecast) global economic upswing. The market is now trying to establish the duration rather than the fact of the world growth upcycle, before these stocks revisit their highs. Labour use in these businesses is intensive, but predominantly un- and semi-skilled. The capital intensity of mineshafts, refining plants, and process plants is obviously not itself vulnerable to AIDS, and the high availability of unskilled labour in the region also shields these businesses. From a demand perspective, these export-driven businesses have a further shield from the domestic economic impact of AIDS in the form of demand from HIV-remote economies.

The larger proportion of the SA equity market is the FINDI (or Financial and Industrial) universe, however. Internal performance is more important for these companies which are less exposed to external price determination, so our key investment screens are volume growth, pricing power (ie, segment leadership), and cost control. Achieved together, these three would certainly flag out-performance. Our categorisation of the FINDI sub-sectors according to their longer term potential is shown below. We have also shown the expected impact of (or vulnerability to) HIV/AIDS in terms of internal company risk and external customer or market risk. High impact indicates a negative view on the investment case for that sector.

Figure 36 KEY INVESTMENT SCREENS					
Sun-sector	Volume growth	Pricing power	Cost control	HIV/A impact - Internal	Relative HIV/AIDS impact - customers
Banks	Medium	High	High	Medium	High
Insurance	Medium	Medium	High	Medium	Medium
Fin. Services	Low (med nearterm)	Low	Low	Medium	Low
Food/Pckg.	Low	Low	Medium	Medium	High
Beverage	Low	High	High	Medium	Medium
Hotel&Leisure	High	Low	Medium	High	Medium
Retail	Medium	Low	Medium	High	High
Tobacco	High	High	High	Medium	Low
Transport	Medium	Medium	High	High	Medium
Services	High	Medium	Medium	Medium	Medium
Info Tech	High	High	Medium	Low	Low
Telecom	High	High	High	Low	High
Source: ING Barings					

The bottom-up earnings growth, which we forecast by FINDI sector for the next two years, is set out in Figure 37, together with expected longer term growth. The magnitude of sectoral AIDS impact, which we believe should be brought into investment thinking is shown in the last column.

Figure 37 SECTORAL PERFORMANCE FORECASTS AND AIDS RISK SCREEN				
Sector	Market cap (Rm)	%CAGR in EPS (now - 2 yrs out)	% CAGR In EPS (long term)	HIV/AIDS impact on long term rating
Banks	183,971	23.7	18	High
Insurance	116,034	22.7	19	Medium
Fin services	36,400	26.1	17	Medium
Ind resources	44,180	18.3	12	Low
Food/pckg	38,435	16.2	13	High
Bev/hotel leisure	50,363	9.5	13	High
Retail	44,519	20.7	13	High
Divers ind	148,811	15.4	16	Medium
Info tech	95,925	38.6	30	Low
Telecom	42,073	32.0	25	Medium
Mining resources	346,876	19.7	14	Low
Source: ING Barings				

Stuart Thompson

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C-SA

MEMORANDUM

To: Rob Cogorno
From: Sandy Thurman
Michael Iskowitz
Date: December 11, 1999
Re: **AIDS Funding for South Africa**

We have gotten clearance for the Codel to announce the FY2000 US funding for AIDS in South Africa. Here is the relevant information.

South Africa AIDS Funding:

- **FY1999 = \$2 million**
- **FY2000 = \$9.3 million as a result of the LIFE Initiative**
("more than \$9 million" is what they would like you to say given that it could still change by \$1-200,000 either way)

As you know, the LIFE Initiative provides for a \$100 million increase in global AIDS funding (mostly to Africa but some to India) in FY2000 as follows:

- \$65 million USAID (FY1999 = \$125 million; FY2000 = \$190 million)
- \$35 million CDC (FY1999 = \$0; FY2000 = \$35 million)

The LIFE Initiative is targeted to four essential activities:

- prevention (including prevention of mother-to-child transmission);
- basic care and treatment;
- support for children orphaned by AIDS; and
- capacity and infrastructure development.

While this is a vitaly important first step, UNAIDS projects that it will cost \$1 billion for to stem the rising tide of HIV infection, and another \$1 billion will just begin to provide basic care and treatment for those already sick, in Africa alone. Currently, all donors and host governments are spending less than \$350 million in Africa on prevention, and spending on care is virtually non-existent.

It would be great if the Codel was willing to say that the US response needs to be "sustained and strengthened" to begin to keep pace with a pandemic that is out of control.

Between James McIntyre (doc at Baragwanath) and Ken Yamashita (health officer at USAID), they should be able to talk about what the money will do and how much remains to be done.

C-SA

HIV/AIDS/STD STRATEGIC PLAN FOR SOUTH AFRICA 2000-2005



AIDS HELPLINE
1-800-012-322

JANUARY 2000

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ATIC	AIDS Training and Information Centre
BHF	Board of Health Funders
CBOs	Community-based Organisations
CGE	Commission on Gender Equality
CMA	Civil Military Alliance
DENOSA	Democratic Nursing Organisation of South Africa
DOE	Department of Education
DOF	Department of Finance
DOH	Department of Health
DOJ	Department of Justice
DOL	Department of Labour
DOME	Department of Minerals and Energy
DOT	Department of Transport
DOTS	Direct Observed Therapy Short Course
DOW	Department of Welfare
EDL	Essential Drug List
GCIS	Government Communication and Information Systems
IDC	Interdepartmental Committee on AIDS
IMC	Inter-Ministerial Committee on AIDS
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
IEC	Information, Education, and Communication
IMC	Inter-Ministerial Committee on AIDS
MOH	Ministry of Health
MEC	Member of Executive Committee
MRC	Medical Research Council
MTCT	Mother-to child transmission
MTEF	Medium Term Expenditure Framework

NAC	National AIDS Council
NACOSA	National AIDS Co-ordinating Committee of South Africa
NGOs	Non-Government Organisations
NPPHCN	National Progressive Primary Health Care Network
PEP	Post-exposure prophylaxis
PWA	People living with HIV infection or AIDS
PHRC	Provincial Health Restructuring Committee
SAIMR	South African Institute of Medical Research
SALC	South African law Commission
SAMA	South African Medical Association
SAPS	South Africa Police Service
SADC	Southern Africa Development Community
SANDF	South African National Defence Force
STDs	Sexually Transmitted Diseases
SM	Syndromic Management
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VTC	Voluntary HIV Testing and Counselling
WHO	World Health Organisation

1. INTRODUCTION

During the last two decades, the HIV pandemic has entered our consciousness as an incomprehensible calamity. HIV/AIDS has already taken a terrible human toll, laying claim to millions of lives, inflicting pain and grief, causing fear and uncertainty and threatening economic devastation.

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), the number of people living with HIV by the end of 1998 was estimated to be 33.4 million, a 100% increase compared to 1997. In Sub-Saharan Africa, more than a quarter of young adults are infected with HIV.

Assuming that no cure is found, it is estimated that more than 40 million people globally will be living with HIV by 2000. The impact of the epidemic on the economy is already being felt in most countries. Life expectancy has been significantly reduced as many people in the 15-49 year age group are now dying of AIDS.

Many countries both in Africa and Asia have taken urgent steps to curb the epidemic with varying degrees of success. In South Africa, despite our efforts, the HIV infection rate has increased significantly over the past 5 years. This increase in the infection rate calls for a renewed commitment from all South Africans.

1.1 PURPOSE OF THE STRATEGIC PLAN

This document is broad national strategic plan designed to guide the country's response as a whole to the epidemic. It is not a plan for the health sector specifically, but a statement of intent for the country as a whole, both within and outside government. It is recognised that no single sector, ministry, department or organisation is by itself responsible for the addressing the HIV epidemic. It is envisaged that all government departments, organisations and stakeholders will use this document as the basis to develop their own strategic and operational plans so that all our initiatives as a country as a whole can be harmonised to maximise efficiency and effectiveness.

1.2 DEVELOPMENT OF THE STRATEGIC PLAN

The development of this strategic plan was initiated by the Minister of Health, Dr. Manto Tsabalala-Msimang in July 1999 in response to President, Mr Thabo Mbeki's, challenge to all sectors of society to become actively involved in initiatives designed to address the HIV/AIDS epidemic.

It began with a meeting in July 1999 to review the current HIV/AIDS prevention, treatment, and care efforts in South Africa. The meeting was attended by representatives of faith-based organisations, people living with HIV infection and AIDS, human rights organisations, academic institutions, the civil military alliance, the Salvation Army, the media, organised labour, organised sports, organised business, insurance companies, women's organisations, youth organisations, international donor organisations, medical and health professionals, medical and health consulting organisations, political parties, and relevant government departments.

After priority areas for future efforts were discussed and agreed upon, a committee was charged with developing a five-year HIV/AIDS and STD Strategic Plan. Task teams were established to review current goals and objectives for the designated priority areas. The priority areas are prevention; treatment, care and support; legal and human rights; and monitoring, research and evaluation.

In addition, the Minister of Health held bilateral meetings with several important sectors including traditional leaders, faith-based organisations and business to obtain their views and to discuss ways to facilitate their active participation.

In September 1999, the Minister of Health and the nine provincial MECs for Health reconfirmed the previous priority areas. This was followed in October 1999 by a two-day National AIDS Meeting where Provincial AIDS Co-ordinators, the National DOH HIV/AIDS/STD Directorate, representatives of the AIDS Training and Information Centres (ATICs) and representatives of several other organisations discussed progress in the five-year HIV/AIDS/STD strategic plan.

In October and November 1999 the task teams met to further develop their goals and objectives. Task Teams were expected to review the *National AIDS Plan for South Africa, 1994*, the Department of Health *White Paper for the Transformation of the Health System*, the *1997 Annual*

HIV/AIDS/STD review, and reports from the September meeting of the Provincial MECs for Health, and the National AIDS meeting.

In November 1999 a draft document was presented to the Inter-Ministerial Committee on AIDS, and additional comments were solicited from all government Ministers. The final document was completed in January 2000.

2. BACKGROUND

2.1 SITUATION ANALYSIS

The South African picture of the epidemic

Recent estimates suggest that of all people living with HIV in the world, 6 out of every 10 men, 8 out of every 10 women, and 9 out of every 10 children are in Sub-Saharan Africa. These figures provide sufficient evidence to make HIV/AIDS both a regional and a national priority.

Data from the DOH's annual National HIV Seroprevalence Surveys of Women attending Antenatal Clinics for the past 9 years provides a good estimate of HIV prevalence and trends over time in South Africa (See figure 1).

Figure 1: National HIV survey of women attending antenatal clinics of the public health services in South Africa, 1990 - 1998

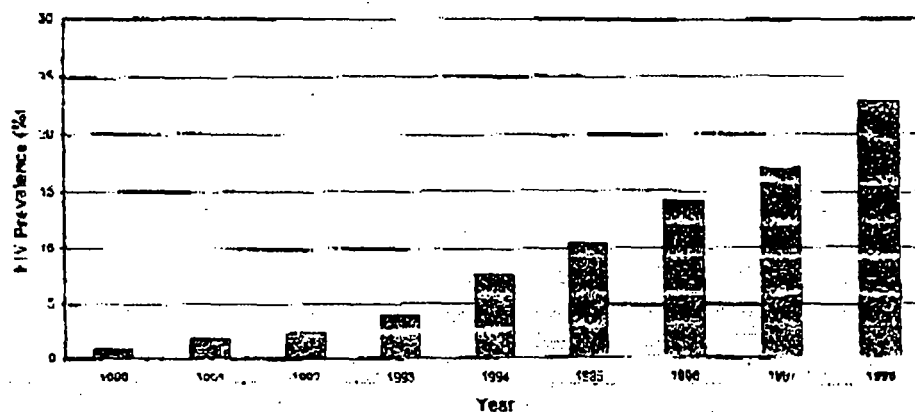
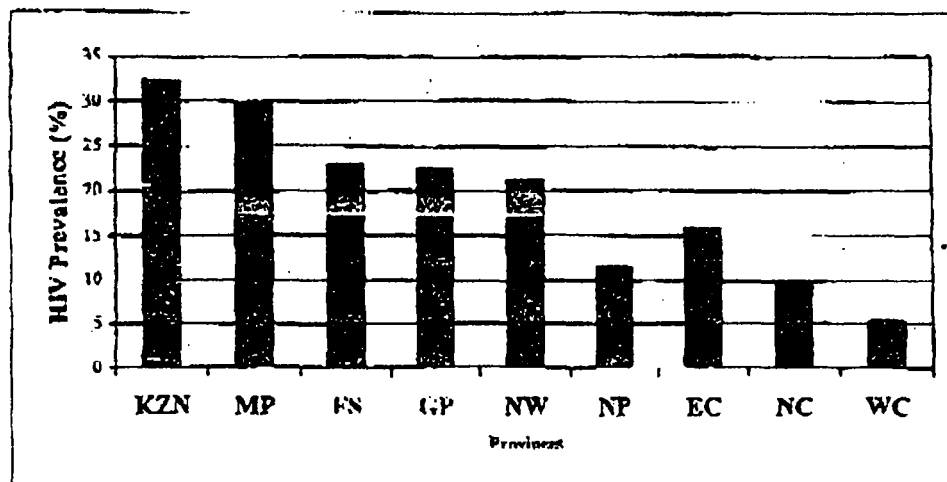


Figure 2 presents HIV prevalence in women attending antenatal clinics by province in 1998.

These data show that there are geographic disparities in the distribution of the HIV/AIDS epidemic in South Africa.

Figure 2: HIV prevalence in pregnant women attending public antenatal clinics by Province, South Africa, 1998



KEY: KZN = KwaZulu-Natal Province; MP = Mpumalanga Province; FS = Free State Province; GP = Gauteng Province; NW = North West Province; NP = Northern Province; EC = Eastern Cape Province; NC = Northern Cape Province; WC = Western Cape Province

Additional information from the survey reveal that:

- The HIV epidemic in South Africa is one of the fastest growing epidemics in the world;
- Young women aged 20-30 have the highest prevalence rates; and
- Young women under age 20 had the highest percentage increase compared to other age groups in 1998 compared to 1997.

These and other data clearly indicate that the HIV epidemic is severely affecting the young, black, and economically poor populations of South Africa.

Currently there are approximately 3.5 million South Africans living with HIV. It is estimated that in 1998 over 1,600 people were infected with HIV each day – translating to more than 550,000 people infected each year. It is estimated that by the year 2003, there will be 6 million South

¹ See Annexure 1 for map

Africans infected with HIV and almost 1 million children under the age of 15 whose mothers will have died of AIDS.

AIDS is currently not a notifiable disease in South Africa and voluntary reporting seriously underestimates the number of people with AIDS. It is estimated that there were approximately 165,000 people living with AIDS and 120,000 AIDS deaths in 1998. Projections indicate that by 2002 a quarter of a million South Africans will die of AIDS each year, and that this figure will rise to more than a million by 2008. Average life expectancy is expected to fall from approximately 60 years to 40 years between 1998 and 2008.

Major causes and determinants of the epidemic in South Africa

The immediate determinants of the epidemic include behavioural factors such as unprotected sexual intercourse and multiple sexual partners, and biological factors such as the high prevalence of sexually transmitted diseases.

The underlying causes include socio-economic factors such as poverty, migrant labour, commercial sex workers, the low status of women, illiteracy, the lack of formal education, stigma and discrimination. The national HIV/AIDS & STD Strategic Plan must address all these immediate determinants and underlying causes.

Tuberculosis and HIV/AIDS

Closely linked to the HIV/AIDS epidemic, is a Tuberculosis (TB) epidemic which is fuelled by HIV infection and which is also the most frequent cause of death in people living with HIV. In South Africa, approximately 40-50% of TB patients are infected with HIV. In some hospitals in South Africa, the HIV prevalence in TB patients has been recorded as over 70%.

Sexually Transmitted Diseases

There is compelling evidence of the importance of STDs as a major determinant of HIV transmission. There are approximately 11 million STD episodes treated annually in South Africa, with approximately 5 million of these managed by private general practitioners. Even without the HIV epidemic, STDs pose an important public health problem.

sensitive or user friendly.

Following this review of both the strengths and weaknesses in addressing the HIV/AIDS epidemic, the following recommendations were made:

- 1. Increase resources and build capacity at provincial and district levels to manage, organise, and implement the HIV/AIDS/STD Programme. Provincial authorities should designate co-ordinators responsible for STD/HIV/AIDS in every Province and District;
- 2. Secure political leadership from the Deputy President and to increase political commitment and public leadership;
- 3. Strengthen interdepartmental and inter-sectoral response to the epidemic;
- 4. Develop concerted effort by all stakeholders to protect human rights, counter discrimination and reduce stigmatisation;
- 5. Support and strengthen PWA initiatives and increase full involvement of PWAs in program design, implementation, and evaluation;
- 6. Increase collaboration between the HIV/AIDS/STD and TB programmes.

Subsequent to the 1997 Review, some of the recommendations have been addressed by the following actions:

- 1. Appointing HIV/AIDS Coordinators in each province and supporting regular training and meetings to facilitate programme implementation;
- 2. Establishing an Inter-Ministerial Committee on AIDS. This Committee consists of Ministers and Deputy Ministers and meets on a monthly basis to discuss HIV/AIDS and provide political direction and policy guidance to the HIV/AIDS & STD Directorate;
- 3. Launching the Partnership against AIDS by the President in 1998 that seeks to broaden and formalise the participation by all sectors in the response to the epidemic;
- 4. Developing an HIV/AIDS policy by the Department of Education for learners and educators. This makes HIV/AIDS education a component in the curricula of all secondary schools;
- 5. Developing other national policies including, the Syndromic Management of STDs and post-exposure prophylaxis (PEP) following occupational exposure to HIV;
- 6. Establishing the South African AIDS Vaccine initiative in 1998. This initiative seeks to develop an effective, affordable preventive vaccine for universal use in South Africa and SADC countries by 2005;
- 7. Establishing the National AIDS Council (NAC), a multi sectoral body that will oversee the national response to the epidemic and the implementation of the Strategic Plan. The NAC

facilitates collaboration between government and all other sectors;

- ✧ Establishing a national Interdepartmental HIV/AIDS Committee that has worked to develop HIV/AIDS workplace policies and minimum HIV/AIDS programmes for all government departments;
- ✧ Developing a Strategic Framework for a South African AIDS Youth Programme; and
- ✧ Improving collaboration between HIV/AIDS/STD and TB programmes in the area of policy formulation and advocacy.

This Strategic Plan aims to address those recommendations that have not been adequately addressed since 1997, and provides a strategic framework for the country's response to the HIV/AIDS and STD epidemic.

Initiatives in the Southern African Development Community (SADC) countries

South Africa is the current chair of and host of the Health Desk of SADC, which has 14 member states: Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

A regional response to HIV/AIDS and STDs is essential in curbing the spread, and to this end a SADC HIV/AIDS/STD task force has been formed and has prepared an HIV/AIDS/STD plan for 1999 - 2003. The three broad goals of the programme are to achieve:

1. A better co-ordinated and harmonised response to HIV/AIDS/STD among Member States.
2. A multi-sectoral response to HIV/AIDS/STD.
3. Improved quality and coverage of the response to HIV/AIDS/STD both at national and regional level.

These initiatives will be important in ensuring that South Africa and its regional partners have a more co-ordinated response to the HIV/AIDS epidemic. SADC thus forms an important link in the mechanisms and structures available to the country.

3. STRUCTURES IN SOUTH AFRICA TO ADDRESS HIV/AIDS

The expanded national response will be managed by different structures at all levels. It is envisaged that each government ministry will have a focal person and team whose responsibility will be to plan, budget, implement and monitor HIV/AIDS interventions. It is also recommended that all other sectors including parastatals, NGOs, the private sector, faith-based organisations, youth, and women will also have dedicated HIV/AIDS focal persons. (See the diagram on the following two pages).

The following presents a brief overview of important structures at national and provincial levels and their specific role and functions relating to HIV/AIDS.

① CABINET

The Cabinet is the highest political authority in the country. The Cabinet meets weekly, but HIV/AIDS issues are not regularly discussed at this level, as all Cabinet members plus all Deputy Ministers and members of the Department of Health meet monthly in the Inter-Ministerial Committee on AIDS (see 11.3).

② NATIONAL AIDS COUNCIL

The National AIDS Council is the highest body that advises government on all matters relating to HIV/AIDS. Its major functions are to: (a) advise government on HIV/AIDS/STI policy, (b) advocate for the effective involvement of sectors and organisations in implementing programmes and strategies, (c) monitor the implementation of the Strategic Plan in all sectors of society, (d) create and strengthen partnerships for an expanded national response among all sectors, (e) mobilise resources for the implementation of the AIDS programmes, and (f) recommend appropriate research.

This body is chaired by the Deputy President, and consists of 15 government representatives (see list below) and 16 civil society representatives (see list below).

Government

Ministers of Health; Education; Welfare and Population Development; Agriculture; Arts, Culture, Science and Technology; Transport; Labour; Finance; Provincial and Local Government; Defence; Minerals and Energy; Correctional Services; the Deputy CEO of the Government

Communication and Information Systems; the Chairperson of the Portfolio Committee on Health; and the Chairperson of the Select Committee on Social Services.

Sectors to be represented

One representative each from Business; People living with HIV/AIDS; Non-government organisations; Faith-based organisations; Trade Unions; Women; Youth; Traditional healers; Traditional leaders; Legal and Human Rights; Disabled People; Celebrities; Sport; Media; Hospitality Industry; and Local government.

Technical Task Teams

The NAC will be assisted in its deliberations and decisions by technical task teams to be established by the Ministry of Health, and comprising experts in the following five areas: a) Prevention; b) Care and Support; c) IFCC and Social Mobilisation; d) Research, Monitoring, Surveillance and Evaluation; and e) Legal Issues and Human Rights.

③ INTER-MINISTERIAL COMMITTEE ON AIDS (IMC)

In 1997, the South African Cabinet formed the IMC. The IMC consists of all Ministers and Deputy Ministers and is chaired by the Deputy President. This committee meets on a monthly basis to review the country's response to the HIV/AIDS epidemic. Issues of strategic importance are discussed and political guidance is given to the HIV/AIDS and STD Directorate and the IDC.

④ INTERDEPARTMENTAL COMMITTEE ON AIDS (IDC)

This committee consists of representatives from all government Departments who co-ordinate HIV/AIDS activities. The IDC meets monthly to review government programs and to fulfil requests from the IMC. Goals of the IDC include facilitating the development of HIV/AIDS workplace policies in all Government Departments, ensuring that all Government Departments allocate financial resources to HIV/AIDS; and developing minimum HIV/AIDS programs for all Government Departments.

⑤ MINMEC

The MinMEC consists of all Provincial Health MECs and the national Minister of Health. The MinMEC meets every six weeks, and is the body that approves national policies and guidelines. HIV/AIDS is a standing item where reports on national and provincial programmes are discussed.

⑥ **PROVINCIAL HEALTH RESTRUCTURING COMMITTEE (PHRC)**

This committee consists of all Provincial Heads of Health and meets on a monthly basis to discuss the strategic issues of national and provincial importance. HIV/AIDS is a standing agenda item where reports from the IMC, National HIV/AIDS/STD Directorate and Provincial HIV/AIDS Co-ordinators are discussed. Once the PHRC has discussed and approved documentation, it is referred to the MinMEC for the political approval.

⑦ **DIRECTOR-GENERALS FORUM**

This forum consists of Director Generals from all the National Government Departments and meets regularly. HIV/AIDS is a standing agenda item where reports from the IMC are discussed.

⑧ **HIV/AIDS AND STD DIRECTORATE, DEPARTMENT OF HEALTH**

HIV/AIDS issues are brought to the attention of the above national bodies by the Department of Health's Directorate of HIV/AIDS and STDs. This Directorate prepares briefing documents for these national forums, and attends meetings to provide further information to aid decision-making in these national committees and bodies.

4. **GUIDING PRINCIPLES**

The following principles for HIV/AIDS and STD prevention, treatment and care efforts for South Africa have been previously adopted in the *National AIDS Plan for South Africa, 1994 - 1995*, and the Department of Health *White Paper for the Transformation of the Health System in South Africa, 1997*, and are reaffirmed.

- 1. People with HIV and AIDS shall be involved in all prevention, intervention and care strategies;
- 2. People with HIV and AIDS, their partners, families and friends shall not suffer from any form of discrimination;
- 3. The vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent infection;
- 4. Confidentiality and informed consent with regard to HIV testing and test results shall be protected;
- 5. Education, counselling and health care shall be sensitive to the culture, language and social

circumstances of all people at all times;

- X The government has a crucial responsibility with regard to the provision of education, care and welfare of all people of South Africa;
- X Full community participation in prevention and care shall be developed and fostered;
- X All intervention and care strategies shall be subject to critical evaluation and assessment;
- X Both government and civil society shall be involved in the fight against HIV/AIDS;
- X A holistic approach to education and care shall be developed and sustained;
- X Capacity building will be emphasised to accelerate HIV/AIDS prevention and control measures; and
- X STD prevention and control are central elements in the response to HIV/AIDS.

5. HIV/AIDS AND STD STRATEGIC PLAN FOR SOUTH AFRICA: 2000 – 2005

The primary goals for the South African HIV/AIDS and STD Strategic Plan are to:

- Reduce the number of new HIV infections (especially among youth); and,
- Reduce the impact of HIV/AIDS on individuals, families and communities.

The primary priority areas are prevention; treatment, care and support; human rights; and monitoring, research and evaluation.

The following general strategies will be used to address the HIV/AIDS epidemic in South Africa:

- Provide HIV/AIDS/STD education to increase public awareness, using an effective communications strategy that will facilitate behavioural change and openness;
- Increase access to voluntary HIV testing and counselling to promote behavioural change and appropriate referral to services;
- Improve STD management, and promote increased condom use to reduce STD and HIV incidence and prevalence; and
- Improve the treatment of HIV positive persons and persons with AIDS to promote better quality of life and limit the need for hospital care.

Youth are not a priority area but are a priority population group especially for prevention efforts.

Youth are both a crosscutting population group that will be addressed in all priority areas and a special group that warrant particular attention.

The following are goals, objectives, selected strategies, indicators and lead agencies for the four priority areas. Time frames and specific targets will be further developed in yearly operational plans. The goals and objectives presented here primarily focus on government and sectors are encouraged to develop strategic plans that will complement what is presented here.

areas:

ROLE OF STDs

Selected Strategies	Indicators	Responsible Agencies
- Medical Schemes regulations to oblige treatment of STDs - Issuing dispensing licences to nurses for STD medication to the private - Primary management within the	- Medical Schemes Act revised - Proportion of private physicians who correctly treat STDs	DOH, SAMA, DENOSA
- Involving SM to be included in health workers - HCWs	Proportion of HCWs who correctly treat STDs	DOH, DENOSA
- Distribute training manuals in building workshops with THs - sector regarding traditional - Systems between traditional and - sources	Number of training sessions with traditional healers	DOH, Traditional Healer Organisations

departments

GOAL 3: REDUCE MOTHER-TO-CHILD HIV TRANSMISSION (MTCT)

Objective	Selected Strategies	Indicators	Lead Agencies
Improve access to HIV testing and counselling in ANC clinics	a) Develop counselling guidelines b) Train counsellors	Number of ANC clinics with appropriate pre- and post-testing services available	DOH, Women's Sector, NGOs
Improve family planning services to known HIV positive women	a) Train reproductive health providers on HIV/AIDS counselling b) Improve access to termination of pregnancy (TOP) services	Number of health facilities that provide HIV/AIDS information and counselling to pregnant women	DOH, Women's Sector, NGOs, NPPHCN

GOAL 4: ADDRESS ISSUES RELATING TO BLOOD TRANSFUSION AND HIV

Objective	Selected Strategies	Indicators	Lead Agencies
Maintain a safe blood transfusion service	a) Monitor existing guidelines on blood transfusion b) Develop national guidelines on HIV and blood transfusion c) Improve the recruitment of low-risk blood donors	HIV transmission rates through transfused blood and blood products	DOH, SA Blood Transfusion Service

GOAL 5: PROVIDE APPROPRIATE POST-EXPOSURE SERVICES

Objective	Selected Strategies	Indicators	Lead Agencies
Provide services for needlestick injuries and occupational exposure	a) Monitor and review existing guidelines on occupational exposure b) Ensure the supply of drugs to treat occupational exposure	Guidelines on Occupational Exposure implemented in health facilities	DOH, DOL
Investigate options to reduce HIV/STD transmission and pregnancy resulting from sexual assault	a) Review research on use of ARV to prevent HIV transmission following sexual assault b) Assess services for women and men following sexual assault c) Consider public health application of	Research and policy options to reduce HIV transmission following sexual assault	DOH, Research Institutions

Objective	Selected Strategies	Indicators	Lead Agencies
	implementation of methods to reduce HIV transmission following sexual assault		

GOAL 6: VOLUNTARY TESTING AND COUNSELLING

Objective	Selected Strategies	Indicators	Lead Agencies
Increase access to youth friendly reproductive health services – including STD management, VTC and rapid HIV testing facilities	a) Review existing reproductive health care service guidelines to be explicit about youth friendliness b) Develop criteria for "youth friendly" services	Number of "youth friendly" reproductive health services	DOH, DOL, Youth Sector
Increase the number of HIV testing and counselling sites	a) Assess the need for health and non-health related testing sites b) Introduce counselling service in all new testing sites c) Identify HCWs for training in HIV testing d) Introduce rapid testing methods and counselling e) Appoint a counselling co-ordinator in each province	Number of testing and counselling sites	DOH
Increase the number of persons seeking voluntary testing and counselling services	a) Promote VTC services b) Ensure the availability of VTC services	Number of people seeking VTC	DOH, All Sector
Increase the proportion of workplaces that have on-site counselling and testing services	a) Integration of HIV counselling into occupational training curriculum b) Modify and integrate HIV counselling into curriculum for workplace social service personnel	Proportion of workplaces that have on-site testing and counselling services	DOL, Business and Labour Sector

Objective	Selected Strategies	Indicators	Lead Agencies
Increase the provision of counselling services to affected and infected children	a) Identify all welfare organisations and NGOs providing specialised services to children b) Train personnel in counselling children c) Establish national children service network d) Modify counsellor training manual to train social worker and all child care workers in counselling children	• Number of social workers & child care workers trained in counselling • Availability of a social workers counsellor training manual	DOW, DOH, DOE, Youth Sector

5.2 PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT

The focus areas for Treatment, Care and Support are:

- Care in facilities
- Care in the community (home-based care)
- Orphans

GOAL 1: PROVIDE TREATMENT, CARE AND SUPPORT SERVICES IN HEALTH FACILITIES

Objective	Selected Strategies	Indicators	Lead Agencies
Improve treatment, care and support for people living with and affected by HIV/AIDS	a) Develop guidelines for the treatment and care of HIV/AIDS patients in health facilities and the community b) Liaise with medical and nursing colleges to include guidelines in curricula c) Ensure uninterrupted supply of drugs for the treatment of opportunistic infections and other related conditions d) Conduct skills audit to ensure adherence to guidelines e) Build capacity of health professionals to provide comprehensive HIV/AIDS/STD/TB treatment, care and support f) Establish strong referral networks from the health facility to the community g) Promote collaboration between HIV/AIDS/STD and TB programmes on the areas of advocacy, policy development, training, supervisory support visits and operational research	• Number of facilities that have implemented guidelines • Number of facilities with access to essential drugs	DOH, Training Institutions, PWAs

Objective	Selected Strategies	Indicators	Lead Agencies
Improve prevention and treatment of TB and other opportunistic infections	a) Finalise and distribute guidelines b) Ensure that necessary drugs are included in the revised Essential Drugs List (EDL) c) Develop supervisory checklist and standardised reporting forms for management of opportunistic infections in people living with HIV d) Train District HIV/AIDS/STD and TB Co-ordinators on guidelines, recording, and reporting e) Expand TB/HIV pilot districts to all provinces to provide VTC and comprehensive prevention, care and support f) Conduct annual assessment on the impact of HIV/AIDS/STDs and TB on health services	Proportion of TB clients successfully treated at first attempt	DOH, SAMA
Establish poverty alleviation projects to address the root causes of HIV/AIDS/STDs and TB	a) Collaborate with existing poverty alleviation strategies in other sectors to incorporate HIV/AIDS issues b) Incorporate HIV/AIDS/STDs and TB as indicators of poverty c) Involve relevant government departments and the private sector in poverty alleviation projects d) Provide skills training and develop income-generating activities in high transmission areas that are at risk for HIV	Successful poverty alleviation projects	Agricultural sector, Government departments, NGOs, Business

GOAL 2: PROVIDE ADEQUATE TREATMENT, CARE AND SUPPORT SERVICES IN COMMUNITIES

Objective	Selected Strategies	Indicators	Lead Agencies
Develop and implement models of home and community-based care in all provinces	a) Develop home-based care guidelines b) Promote the establishment of intersectoral task teams at community level to drive home- and community-based care c) Ensure the availability of resources to communities to provide home-based care	Models of home-based care implemented in all provinces	DOH, NGOs
Increase knowledge of communities regarding HIV/AIDS care and support	a) Address stigma in the community b) Develop IEC materials c) Advocate for more media exposure on care and support d) Develop media packages targeted at infected and affected communities e) Provide information to PWAs on their legal and human rights	Percentage of selected community members with appropriate HIV/AIDS care and support	DOH, NGOs, Government Departments, Media

GOAL 3: DEVELOP AND EXPAND THE PROVISION OF CARE TO CHILDREN AND ORPHANS

Objective	Selected Strategies	Indicators	Lead Agencies
Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS	a) Promote advocacy of all AIDS-related issues that affect children b) Develop a manual for the counselling of children c) Mobilise financial and material resources for orphans and child-headed households d) Investigate the legal protection of child-headed households e) Provide social welfare, legal and human rights support	Programmes to support the needs of children affected by HIV/AIDS in all provinces	DOH, DOW, DOJ, NGOs, Business

5.3 PRIORITY AREA 3: RESEARCH, MONITORING AND EVALUATION

Research priorities for the next five years are:

- Social, cultural and behavioural factors
- Diagnostics for HIV/AIDS/STDs/TB
- Epidemiological research
- Vaccine development
- Biomedical research
- Drug development
- Programme monitoring and evaluation
- Traditional medicines, and
- Policy implementation

GOAL 1: ENSURE VACCINE DEVELOPMENT

Objective	Selected Strategies	Indicators	Responsible Agency
Support efforts to develop a Clade C HIV vaccine	a) Collaborate with international efforts b) Support the South African AIDS Vaccine Initiative c) Develop ethical standards	Candidate Clade C HIV vaccine in Phase I trials	DOH, MRC
Conduct biologic and behavioural research to support the development of an AIDS Vaccine	a) Collaborate with international AIDS Vaccine efforts b) Develop South African ethical guidelines	Biologic and behavioural research to support the development of a Clade C HIV vaccine	DOH, MRC
Investigate traditional medicines to prevent or treat HIV related infections	a) Work with traditional healers b) Research on traditional medicines	Research on traditional medicines and HIV related infections	DOH, MRC

GOAL 2: INVESTIGATE RETROVIRAL USE IN TREATMENT AND CARE

Objective	Selected Strategies	Indicators	Lead Agencies
Review and revise policy on anti-retroviral use and reducing mother-to-child HIV transmission	a) Review and update minimum standards of practice for ANC services b) Establish monitoring and evaluation protocols for all MTCT related programmes and activities c) Identify and implement additional areas of research d) Review current research on the use of anti-retroviral therapy to reduce mother to child HIV transmission e) Review and update national policies to reduce MTCT	Policy guidelines on reducing mother-to-child HIV transmission developed and implemented	DOH, Academic Institutions, Research Institutions, Women's Sector
Conduct research on the cost-effectiveness of other forms of treatment and prophylaxis	a) Review international research b) Facilitate multi-centre collaboration	Research on cost-effectiveness of other forms of treatment and prophylaxis	MRC, DOH
Conduct research on the effectiveness of traditional medicines	a) Conduct clinical trials b) Review international research c) Collaborate with traditional healers	Research findings on traditional medicines in treating HIV/AIDS	Traditional Healers, MRC, DOH

GOAL 3: CONDUCT POLICY RESEARCH

Objective	Selected Strategies	Indicators	Lead Agencies
Conduct HIV/AIDS impact, economic evaluations, and cost effectiveness studies in selected departments and provinces	a) Establish contact with departments, provinces and organisations b) Identify point persons c) Identify required data d) Fund organisation to conduct studies	HIV/AIDS impact studies in selected departments and provinces	DOH, DOF, Government Departments
Conduct research to determine HIV incidence to inform HIV programme evaluation	a) Investigate implementation of the "detuned assay" b) Conduct HIV prevalence surveys in narrow age groups to approximate incidence	HIV incidence studies	MRC, DOH

Develop policy on services to be provided to cross-border target populations in high transmission areas	a) Identify mechanisms to contact cross-border target populations such as commercial sex workers, migrant workers, truckers, immigrants and displaced persons b) Work with SADC to standardise a minimum data set to be carried by patients to facilitate service provision	Policy on cross-border HIV/AIDS services	DOH, Home Affairs, SADC, UNAIDS
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GOAL 4: CONDUCT REGULAR SURVEILLANCE

Objective	Selected Strategies	Indicators	Responsible
Conduct behavioural research and surveillance	a) Review international research b) Facilitate collaboration among health departments and community agencies	- Behavioural research on HIV/AIDS/STD risk behaviours - Behavioural surveillance	DOH, HSRC, MRC
Develop mechanisms for long and short-term training to improve the capacities of provincial and district staff to conduct HIV/AIDS/STD related operations research, surveillance, and research	a) Training for provincial and district staff on research and surveillance b) Collaborate with research and training institutions	Short and long-term training of provincial and district staff to conduct operational research and surveillance	DOH, Academic Institutions
Develop a National STD Surveillance system	a) Review and supplement the MRC recommendations in STD surveillance b) Review current STD surveillance in Gauteng and other provinces c) Develop training programmes for provincial and district staff as appropriate	National STD surveillance system	DOH, SAIMR, MRC

Conduct national HIV infection surveillance in selected populations and groups, including STD and TB clients, hospitalised patients, men, and youth	a) Review and supplement the MRC recommendations on HIV surveillance b) Review current HIV surveillance in other countries c) Develop training programmes for provincial and district staff as appropriate	National HIV surveillance in selected populations	DOH, MRC
Determine AIDS morbidity and mortality	e) Consider AIDS notification h) Consider sentinel AIDS surveillance c) Conduct research on AIDS as a cause of death in death records d) Determine AIDS morbidity in hospitalised clients	Information on AIDS morbidity and mortality	DOH, MRC
Conduct National Surveillance on HIV and STD risk behaviours, especially among youth	a) Review and supplement the MRC recommendations on HIV & STD surveillance b) Review current HIV and STD behavioural surveillance in other SADC countries c) Develop training programmes for provincial and district staff as appropriate d) Consider a youth risk behavioural survey e) Consider sentinel site surveys	National HIV/AIDS/STD behavioural risk surveys	DOH, HSRC, GCIS, MRC, Youth Sector

5.4 PRIORITY AREA 4: HUMAN RIGHTS

The overall aims are to:

1. Create a culture of openness and acceptance around HIV/AIDS & STDs.
2. Develop and sustain a legal environment that protects and promotes the rights of PWAs.
3. Develop appropriate mechanisms to assist PWAs enforce their rights and to monitor human rights abuses related to HIV/AIDS.

GOAL 1: CREATE AN APPROPRIATE SOCIAL ENVIRONMENT

Objective	Selected Strategies	Indicators	Lead Agencies
Develop a National Inter-Sectoral Campaign on Openness and Acceptance of People Living with HIV/AIDS during 2000-2003	a) Promote open discussion of sexual practices in various sectors of society b) Promote voluntary testing and counselling services c) Target awareness regarding rights and responsibilities of people living with HIV/AIDS in 4 key areas: employment rights, education, health care and socio-economic rights d) Promote supportive environment and social benefits for people living openly with HIV/AIDS/STDs	Awareness and acceptance of HIV/AIDS in all sectors of society	NAC, Government Departments, All Sectors
Create a legal and policy environment which protects the rights of all persons infected and affected by HIV/AIDS by 2005	Create supportive health care legislation and policies by 2001, including: - Passing Health Act entrenching patient rights and complaints procedures; - Enacting national HIV Testing and Informed Consent Policy; - Develop regulations on: condom standards and disposable syringes; - Review and popularisation of the Health Professional's Council's Guidelines on the Management of HIV/AIDS; - Developing Standard Treatment Guidelines by 2000	Number of new legislation or policies that protect and promote rights in the context of HIV/AIDS	DOJ, DOH, SALC

Objective	Selected Strategies	Indicators	Lead Agency
Increase the number of schools that have implemented HIV/AIDS policies	a) Review and enact new Children's Law by 2001, to take into account the needs of children infected and affected by HIV/AIDS	Number of schools with HIV/AIDS policies	DOE, Youth Sector, SALC
Investigate the use of welfare benefits to assist children and families infected and affected by HIV/AIDS	a) Review research into subsidising adoption b) Review disability grant criteria	Research and implementation of welfare benefits to assist children and families infected by HIV/AIDS	DOW
Monitor human rights abuses and to develop enforcement mechanisms to assist PWAs enforce their rights, by 2005	a) Statutory commissions (HRC and CGE) to set up a discrimination database to collect information on the nature and extent of discrimination against people affected by HIV/AIDS b) Improve access to justice for people infected / affected by HIV/AIDS	Number of human rights abuses of people infected and affected by HIV/AIDS and complaints	DOJ, HRC, CGE

GOAL 2: DEVELOP AN APPROPRIATE LEGAL AND POLICY ENVIRONMENT

Objective	Selected Strategies	Indicators	Lead Agency
Review policy to establish a minimum package of care relating to HIV/AIDS	a) Review international and regional practices relating to HIV and medical insurance b) Lobby medical schemes industry to review benefits and coverage for HIV positive clients c) Standardise a minimum package of treatment and care for people living with HIV/AIDS in public and private sector	Minimum package of treatment and care in private and public sector	DOH, BHF
Develop policy and legislation relating to HIV/AIDS and employment	a) Increase the number of workplaces that have implemented HIV/AIDS policies b) Finalise Code of Good Practice on HIV/AIDS in the Workplace, and accompanying regulations, to enforce workplace HIV/AIDS policies, by 2000	Number of workplaces with HIV/AIDS policies	DOL, DOH

Objective	Selected Strategies	Indicators	Lead agencies
	c) Support the development of workplace HIV/AIDS policies during 2000-2003		
Develop policy and legislation relating to HIV/AIDS and sexual assault	a) Develop criminal law mechanisms which protect the rights of victims of sexual violence, by 2001 b) Investigate the provision of PEP to the victims of sexual violence c) Investigate decriminalising commercial sex work	Legal mechanisms to reduce HIV transmission associated with sexual behaviours	DOJ, DOH, SALC

6. YOUTH AS A TARGET GROUP

As indicated earlier in this document, youth is a specific focus area in the fight against HIV/AIDS as people between the ages of 14 – 35 the most vulnerable to HIV infection. In addition, the youth are an important target group to protect against future HIV infection as they represent both the present and future economic powerhouse of the country.

In this section those strategies that relate to youth will be replicated to once again emphasise the need for all sectors of society to focus a significant amount of their resources and energies on this age group.

Objective: Increase access to youth friendly reproductive health services – including STD management, VTC and rapid HIV testing facilities (special focus on youth, women, and migrant workers)

- a) Review existing reproductive health care service guidelines about youth friendliness
- b) Develop criteria for “youth friendly” services
- c) Train HCWs
- d) Involve youth sector

Objective: Implement life skills education in all primary and secondary schools

- a) Involve NGOs and CBOs that are already involved in HIV/AIDS & STDs intervention programmes in primary and secondary schools
- b) Include school attenders in the formulation of interventions
- c) Train teachers and parents
- d) Develop peer education capacity and link to youth centres
- e) Evaluate implementation and effectiveness

Objective: Assist and support sectors to develop HIV/AIDS/STD programmes and policies. Targeted sectors are: Traditional leaders; Youth; Faith-Based Organisations; Gender; Business; People living with HIV/AIDS; Disabled people; Entertainers; NGOs; Media

- a) Capacity building programme for sectors
- b) Link all sectors to resources
- c) Support with technical assistance

d) Develop sector specific information packs

Objective: Improve access to male and female condoms

- a) Expand condoms distribution through non-traditional outlets
- b) Conduct an acceptability survey on female condoms

Objective: Increase condom use amongst 15 – 25 year olds

- a) Increase acceptance, attitudes, perceptions, efficacy and use of condoms, and among the youth
- b) Ensure condom availability and access in both health and non-health facilities
- c) Improve knowledge on safety, use and benefits of condom use and the consequences of not using condoms
- d) Involve youth directly in the development of activities geared towards increasing acceptance of condoms

Objective: Investigate options to reduce HIV/STD transmission and pregnancies resulting from sexual assault

- a) Review research on use of ARV to prevent HIV transmission following sexual assault
- b) Assess services for women and men following sexual assault
- c) Consider public health application of implementation of methods to reduce HIV transmission following sexual assault

Objective: Increase access to youth friendly reproductive health services – including STI management, VTC and rapid HIV testing facilities

- a) Review existing reproductive health care service guidelines to be explicit about youth friendliness
- b) Develop criteria for "youth friendly" services

Objective: Increase the provision of counselling services to affected and infected children

- a) Identify all welfare organisations and NGOs providing specialised services to children
- b) Train personnel in counselling children
- c) Establish national children service network
- d) Modify counsellor training manual to train social worker and all child care workers in counselling children

Objective: Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS

- a) Promote advocacy of all AIDS-related issues that affect children
- b) Develop a manual for the counselling of children
- c) Mobilise financial and material resources for orphans and child-headed households
- d) Investigate the legal protection of child-headed households
- e) Provide social welfare, legal and human rights support

Objective: Conduct behavioural research and surveillance

- a) Review international research
- b) Facilitate collaboration among health departments and community agencies

Objective: Conduct national HIV infection surveillance in selected populations and groups, including STD and TB clients, hospitalised patients, men, and youth

- a) Review and supplement the MRC recommendations on HIV surveillance
- b) Review current HIV surveillance in other countries
- c) Develop training programmes for provincial and district staff as appropriate

Objective: Conduct National Surveillance on HIV and STD risk behaviours, especially among youth

- a) Review and supplement the MRC recommendations on HIV & STD surveillance
- b) Review current HIV and STD behavioural surveillance in other SADC countries
- c) Develop training programmes for provincial and district staff as appropriate
- d) Consider a youth risk behavioural survey
- e) Consider sentinel site surveys

Objective: Increase the number of schools that have implemented HIV/AIDS policies

- a) Review and enact new Children's Law by 2001, to take into account the needs of children infected and affected by HIV/AIDS

Objective: Investigate the use of welfare benefits to assist children and families infected and affected by HIV/AIDS

- a) Review research into subsidising adoption
- b) Review disability grant criteria

Objective: Develop policy and legislation relating to HIV/AIDS and sexual assault

- a) Develop criminal law mechanisms which protect the rights of victims of sexual violence, by 2001
- b) Investigate the provision of PEP to the victims of sexual violence
- c) Investigate decriminalising commercial sex work

7. WAY FORWARD

Implementing the HIV/AIDS & STD Strategic Plan is essential to ensure the achievement of the national goals. Broad principles for implementation include the requirement that activities and practices are appropriate and cost effective for South Africa. Activities should be based on known evidence based practices.

Key critical areas for effective delivery include:

- A. Authority and political will at all levels
- B. Structures:
 - 1 Delivery and Implementation
 - 2 Co-ordination
- C. Resources
 - 1 Financial Resources
 - 2 Human Resources
 - 3 Technical Resources
- D. Capacity
 - 1 HIV AIDS & STD understanding
 - 2 Management
 - 3 Monitoring and evaluation
- E. Communication
 - 1 National ↔ Provincial & Provincial ↔ National
 - 2 Provincial ↔ Provincial
 - 3 Provincial ↔ District ↔ Community
 - 4 Government ↔ Civil society

7.1 EFFECTIVE IMPLEMENTATION OF THE HIV/AIDS AND STD STRATEGIC PLAN

To achieve this, the following issues will be addressed:

- 1. Approval of the HIV/AIDS & STD Strategic Plan by national bodies such as the Inter-Ministerial Committee on AIDS (IMC), NAC and National HIV/AIDS & STDs Directorate, followed by provincial and local structures**

The HIV/AIDS & STD Strategic Plan should be used in developing national, provincial and district operational plans. Yearly operational plans should be based on realistic objectives. These should be developed taking into consideration existing financial and human resources, the capacity thereof, the process of recruitment as well as the political commitment in each of the provinces. The setting of national goals will allow for inter-provincial comparisons and ensure a measure of unity regardless of the relative autonomy of the provinces. The provinces should then take these national goals and objectives and present them to key role players within the province to ensure all buy into what would be a Provincial Strategic AIDS Plan.

- 2. Improve structures for delivery**

This involves reviewing and developing where necessary structures at all levels, from national to community. The concept of appropriate national structures such as the IMC, IDC and NAC should be considered for duplication within provinces, keeping in mind the importance of delivery within communities.

The most important structures to create to guide the implementation of the Strategic Plan are:

- A National AIDS Council, with duplicate bodies in each province
- Interdepartmental Committees on HIV/AIDS in every province. One of the functions of the Interdepartmental Committees within the provinces would be to define each government department's unique and generic responsibility within the HIV/AIDS and STD Strategic Plan.

Equally important is the establishment of appropriate structures at district level to ensure the implementation of the HIV/AIDS and STD Strategic Plan. It is thus recommended that District HIV/AIDS Committees be established. These district structures should include community-based committees that represent major role-players within the relevant

community in the field of HIV/AIDS. These committees should include local government to ensure the integration of HIV/AIDS/STDs and TB issues and development plans. It is vital that this include non-health issues as part of HIV/AIDS/STD planning, such as transport and poverty alleviation.

3. Establish acceptable standards for provinces with respect to resources

Financial Resources: It is important to ensure that adequate funding is available at national and provincial levels within the healthcare environment to ensure delivery. One method is to establish an agreed resource standard for all provinces to directly place financial resources into HIV/AIDS. This is currently (in 1999/2000 prices) set as R10 per person per year or a total of R400 million per year for the whole country.

Related activities include:

- Audit financial resources for HIV/AIDS activities within Provinces over the preceding three years.
- Compare resources between provinces on a per capita and per HIV infected population.
- Agree on standards or conditions by National bodies such as MinMEC, PHRC for allocating dedicated HIV/AIDS funding from National bodies.
- Cost the HIV/AIDS and STD Strategic Plan and Programmes.
- Agree on the continued funding by the National DOH of activities and products (such as condoms) that have a major cross provincial impact.

Funds for HIV/AIDS should be devolved to provinces from the national government only on the condition that certain standards are met. These include:

- Presence of an Inter Departmental Committee on HIV/AIDS;
- Commitment to "ringfence" funds for direct HIV/AIDS activities within provinces;
- Commitment to distribute funds according to the HIV/AIDS & STD Strategic Plan;
- Commitment to spend over 80% of the funds in one financial year;
- Commitment to roll funds over funds into the new financial year without risk of penalty;
- Commitment to prioritise the process of HIV/AIDS spending within the provinces;
- Commitment to ongoing national and provincial communication;
- Regular review of the implementation of HIV/AIDS Plans; and
- Establishing realistic goals and objectives that can be implemented within provinces

and districts.

Human Resources; It is vital to the success of this Strategic Plan that adequate human resources are available to ensure delivery. The constraint on action is arguably capacity rather than funding. The current standard suggested is one dedicated employee per 100,000 population. To evaluate the availability of human resources, it will be necessary to audit the existing human resources at national, provincial, regional and district levels. This audit should inform the process of establishing standards of personnel at district, regional and provincial levels of management.

4. Regularly review the implementation of the strategic Plan

The HIV/AIDS Strategic Plan must be reviewed every 12 months at National and Provincial levels, with quarterly reports to be submitted to provincial and national structures.

The National DOH has overall responsibility for the implementation of the Strategic Plan within the provincial structures. Specific measurable targets and indicators will be developed for each objective and reported in yearly operational plans. The Strategic Plan will be monitored by these objectives and supplemented with additional monitoring including national, provincial and local behavioural surveys. These surveys will measure changes in HIV related risk behaviours including condom use, delay of sexual initiation among youth, HIV incidence, and the number of sexual partners.

Another important point is to establish a mechanism of constant and consistent feedback and reporting by provinces to national structures and vice versa. Information from the regular review should be used to serve as an information tool in communication between provinces of successes, as well as to other stakeholders to provide guidelines on activities to be involved in.

7.2 THE ROLE OF SECTORS

The HIV/AIDS and STD Strategic Plan provides a broad framework for government, NGOs, business, labour, women and all sectors of society. Each sector should develop more specific plans based on their role in society, activities and their specific strengths. These plans should be based on each sector's comparative advantage in implementing the planned activities. Sectors are

encouraged to establish technical AIDS committees, which will be responsible for advocating for, managing and co-ordination, the implementation of HIV/AIDS activities within that sector.

The sectoral AIDS committees will also be responsible for liaison with other sectors and the Directorate: HIV/AIDS and STDs. The recommended role of the sectors will be as follows:

- Identify determinants of the spread of HIV/AIDS/STDs specific to the sector
- Identify strengths and weaknesses with respect to HIV/AIDS/STDs
- Identify obstacles to the response within the sector
- Integrate HIV/AIDS/STD's activities in their yearly plans
- Formulate specific HIV/AIDS sectoral plans and budget for their implementation
- Mobilise resources for the interventions
- Document best practice within the sectors and share information
- Prepare and submit quarterly reports to the NAC

All Ministries, including the MOH, will submit quarterly reports to the NAC on their HIV/AIDS activities.

7.3 MONITORING AND EVALUATION

The effective implementation of the activities outlined in the Strategic Plan will largely depend on the availability of human, financial and institutional resources. The sustainability of the response will depend on an efficient monitoring process in the areas of policy development, institutional strengthening and service delivery.

Monitoring will ensure that activities are being implemented according to the plan and that each implementing agency and all partners contribute to the accomplishment of policy aims. This activity should be seen as mutually beneficial for the implementing agencies to assess their performance and seek corrective measures, and for government to formulate appropriate policy.

Effective monitoring and evaluation tools will be developed and customised for each intervention. These tools will identify strengths and weaknesses in the response programmes and activities and identify areas that need the redirection of resources. The cost effectiveness of selected interventions will be determined through special operational research.

ACKNOWLEDGEMENTS

7.4 CONCLUDING REMARKS

The HIV/AIDS and STD Strategic Plan is a living document and will be subjected 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.

Map of South Africa

Annexure A

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

