SA Journal of Child Health

HIV priorities in children – what do the experts say?

It was not hard to decide on the 'hot topic' for this second issue of *SAJCH*, particularly as the HIV/AIDS conference had just ended in Durban. In spite of the amount of money and effort that is going into reducing the number of new cases, the epidemic seems to progress unabated. The operative word in that last sentence, 'seems', is based on surrogate measures of infection such as rising infant mortality rates, non-accidental deaths in young adults, and teenage pregnancy rates – in addition to actual recently reported incidences.[1]

We often see so many long articles written by different experts that we thought it would be great to put a group of practitioners under pressure. We asked them to tell us what they think the priorities in HIV management are – by answering two questions (in about a paragraph)! Yes, this is a tough call, but we thought it would be interesting to see the responses. The e-mail sent to participants simply read: 'You are invited to participate as one of the experts and you may also suggest other participants. In view of the huge problem of HIV and the deliberations at the recent conference we thought it would be interesting to ask a few leaders in the field (both clinicians and researchers) to answer the following two questions.' In your opinion:

1. What is the single most important priority in dealing with the HIV/AIDS epidemic?

2. If you could, what would be the single most practical and cost-effective intervention you would choose?

Professor Haroon Saloojeeh, University of the Witwatersrand, Johannesburg

1. Optimising the delivery of PMTCT.
2. Universal (opt-out) HIV testing of pregnant women, followed by delivery of nevirapine (and ideally AZT too).

Professor Nigel C Rollins, Centre for Maternal and Child Health, KwaZulu-Natal

1. From a child health perspective I would say that we need to address the implementation of known PMTCT interventions. As many have stated, we have more than enough knowledge about drugs, etc. that work, but the health system does not support them. Second to that though, and something of a wish list, would be reducing the incidence of HIV, especially among young women. Both of these would have a major impact on child transmission and survival rates.
2. As for a single most important priority – tough call – I would struggle between choosing provision of AZT alongside single-dose NVP as prophylaxis for all HIV-infected pregnant women, and targeting of pregnant HIV-infected women with low CD4 counts and starting them on lifelong HAART.

Professor Brian Eley, Red Cross Children's Hospital, Cape Town

1. As a paediatrician, the most important priority would be to reverse unnecessary suffering caused by the paediatric HIV epidemic.
2. HIV infection is an extremely complex disease. Consequently, single interventions may not achieve much. Several well-constructed interventions are required to address the paediatric epidemic effectively. Two interventions deserve priority. Firstly, comprehensive implementation of PMTCT programmes based on dual AZT/nevirapine prophylaxis or HAART. To date, we have made very little progress with this objective throughout sub-Saharan Africa, including South Africa. Secondly, optimal care of the very young HIV-exposed and infected child (< 2 years old). This is probably the most neglected area of the paediatric epidemic. Natural history studies from Africa have shown that more than 50% of infected children die before their second birthday. Unless we begin to manage these young children correctly we will never achieve Millennium Development Goal (MDG) 4, which aims to reduce the under-5 mortality rate by two-thirds, between 1990 and 2015. Attention should be directed towards improving the pre-HAART care of these children, and ensuring appropriate access to HAART.

Dr Mmakabelo A Krug, Mafikeng

1. We need more access, staff and facilities for ART for adults and children and poverty relief; others have already mentioned this. As rural doctors we have spent most of our energy and time to promote health and reduce morbidity and mortality from the time of conception up to the age of about 6 years. But what about children and young people between 6 and 20 years, when they should prepare themselves to become competent and health-promoting parents? This includes reproductive health, but it needs more than that. A young person, who wants to live and protect his/her life and the lives of others, needs self-esteem, social competencies and a positive vision for the future. I think the foundation for this is linked to spiritual experiences and to experiences of being loved, accepted and needed in a community/group/family.
2. To intensify and improve all steps of an effective and comprehensive PMTCT programme, to do operational research (including social anthropology) into PMTCT, and to understand and correct the many implementation problems and poor coverage of the programme. A good PMTCT programme must include universal testing for pregnant women early in pregnancy, fast-track to ART if the CD4 count is less than 350, nevirapine *with AZT* for those with a CD4 above 350, focused safe infant feeding counselling and active regular feeding support for the mothers for 1 year, and to concentrate on *survival* of moms and infants.

Dr Tammy Meyers, University of the Witwatersrand, Johannesburg

1. Getting people to know their status, i.e. getting as many people as possible tested – men, women, the youth and of course infants and young children.
2. Making HIV testing part of routine care, using an opt-out approach for counselling and testing. Simultaneously, community awareness must be raised by mass media

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campaigns that provide clear, consistent messages to educate people about HIV transmission and prevention as well as the positive outcomes of treatment.

Summary

The sample of clinicians participating is obviously not representative. But continuing with the survey seemed pointless and we decided to abort the process. The trend of the answers was not surprising; after all this is a journal of child health and our target is the child health practitioner. There is a clear non-ambiguous thread going through most of the answers, i.e. universal opt-out HIV testing, optimising PMTCT and ensuring appropriate access to HAART. Sounds simple enough, so what is the problem? Maybe that should have been the topic of the survey! An interesting look at some issues that may be contributing to blockages to achieving effective disease prevention and treatment was the unexpected additional note from one of the participants (please see below). Yes, addressing the blockages to the delivery of universally accepted strategies – that is the real challenge of this epidemic!

I would like to thank all participants and those who recommended others. Clinicians and researchers are busy people. We understand the pressure on your time and we are grateful for your contribution. Please suggest future subjects and contributors for this 'hot topics' section of the journal. Volunteers to put this section together are also invited.

Nonhlanhla P Khumalo
Editor

Reference

1. Rehle T, Shisana O, Pillay V, Zuma K, Puren A, Parker W. National HIV incidence measures – new insights into the South African epidemic. *S Afr Med J* 2007; 97(3):194-199.

LETTER

The mother tongue as educational medium

To the Editor: Thank you for your recent editorial 'Who determines culture? (*SAMJ* 2007; 97: 385) Indeed, *language* carries thinking and the concepts of how we understand life, the community and ourselves. The HIV epidemic needs strong primary prevention programmes for children and adolescents and improved PMTCT programmes. Both need powerful communication. For this I suggest a *pro-African language approach.*

I grew up in Finland. The country gained independence in 1916 and changed quickly from a developing country into a leading industrial democracy. How? Through changing the medium of education from a colonial language (Swedish) to the mother tongue. Consistent use of Finnish by political and educational leaders, both in private and public life, made this move credible. Is this relevant with regard to South Africa? Finnish is structurally as distant from the colonisers' languages (Swedish and Russian) as African languages are distant from English. It is estimated that less than half of all children are highly gifted in languages. Only these children will survive an educational system with a structurally different language as their medium of education. The other children will drop out, and their talents will never be seen or developed. I think this is happening in South Africa, and that this is a violation of children's rights to development and education (as signed by South Africa in 1996). The educational crisis may also be fuelling the HIV epidemic.

By having one's mother tongue as the medium of education as an option for parents to choose (as suggested in our constitution, but actually not implemented), we would unlock the development of talents of half of our children who are presently becoming dropouts.

The other benefit of using one's mother tongue is building a stronger identity and personality. I suspect that the early and dominating use of English leads to split personalities in many children and young adults in Africa. Split personalities cannot stand firm in life's decisions. Many young Africans despise their own roots. Upper-class children (in private schools) despise the language of their parents and grandparents. This results in further loss of social cohesion, which makes the society vulnerable to crime and epidemics. Self-contempt and contempt for one's own roots make young people vulnerable to sexual exploitation and domination by materialism.

Finland could dispel the misunderstanding that mother tongue-based education leads to poor English skills. Of course English should be taught as a subject. But parents should not be forced to adopt a colonial language as the only vehicle to obtain development and education for all children, irrespective of whether the latter have the extraordinary and rare language skills to master education in a structurally distant language.

Language gives meaning to life and communicates meaning between people and between generations. It is the basis for respect (for self and others). I do not think we can do without stronger focus on African languages if we want to build hope for the future and a strong will to protect our own life and the lives of others.

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