The HIV & AIDS and STI National Strategic Plan 2007 - 2011

'The plan is an important framework document, which should provide the necessary directionality for addressing the paediatric HIV epidemic in South Africa'.[1] This is the conclusion of Michaels and Eley in their paper considering the paediatric perspectives of the South African National Strategic Plan (NSP)[2] for HIV and AIDS. But however ambitious, comprehensive and committed a plan might be, the devil is in the detail, and any review of that plan must highlight that detail or lack thereof. Article 3 of the UN Convention on the Rights of the Child states that *'In all actions concerning children … the best interests of the child shall be a primary consideration'*.[3] Such language can be used to claim the moral high ground and criticise the efforts of others. Yet, constructive critique of the NSP is necessary to identify the gaps that might hinder its implementation and the prioritisation required to achieve the most important goals.

Michaels and Eley correctly comment on the wide range of child-specific elements included in the NSP and applaud the detail included therein. But is this too generous? The NSP projects that if successfully implemented, it will result in a 50% decrease in HIV incidence (adult and children) and bring appropriate care to more than 80% of HIV-infected individuals and families by 2011. Yet the evidence base for interventions, behavioural or otherwise, that can reduce primary infection in adolescents and adults remains disappointing and the all-out efforts of health workers to date have only achieved about 15% coverage rates for highly active antiretroviral therapy (HAART) in adults and children. The annual targets for several of the NSP interventions are arbitrary and without clear meaning. The quality of baseline data on very many of the indicators is poor and cannot easily be used for annual comparisons. For example, there are no good national estimates of the number of children with neurodevelopmental delay, and hence to aim for a 90% increase in those being diagnosed is problematic. The interventions cited for reducing mother-to-child transmission to 5% cannot alone achieve this desired target. For example, AZT and single-dose NVP in trial settings achieved a vertical transmission rate of 6.5%.[4] The NSP and this review overlook or do not comment on the fact that, even with optimal coverage of 95%, simple dual therapy prophylaxis cannot reach this target.

In looking to the past, the 2007 - 2011 NSP acknowledges that previous programmes tended to be vertical, with deficits in the capacity needed for implementation; that the lack of a monitoring and evaluation framework with clear targets and responsibilities was a major weakness. These are critical acknowledgements that might bode well for future programming. However, substance must now be given to statements on the failure to integrate health services and provide meaningful maternal, child and family care, lest the problems of the past are perpetuated. Absent from the NSP is any sense of how capacity to achieve the interventions will be achieved. Psychosocial and educational support for exposed/affected children needs to be delivered by trained persons. Yet, vast numbers of nurses, teachers and social workers are simply not available for training and deployment.[5,6] Past experiences of identifying vulnerable children and providing social security are not encouraging, and stating that 'mechanisms to link … [OVCs and child-headed households] to grants and social benefits will be developed' raises concern about feasibility and attainment within a reasonable timeline.

The 2007 - 2011 NSP is unquestionably 'an improvement' on the 2001 - 2006 version. However, given the magnitude of the HIV/AIDS epidemic in South Africa and the devastation that it has wrought so far, is it enough? The answer is probably yes, and especially for children, but only if a number of additional steps are rapidly pursued. Prioritisation is needed to identify the programmatic activities with an established evidence base that can reduce maternal and child mortality (including mother-to-child transmission), if implemented effectively and rapidly. This starts with identifying HIV-infected pregnant women with CD4 counts <200 and starting them on lifelong HAART early in pregnancy. While representing only 15 - 20% of all HIV-infected pregnant women they account for more than 50% of non-obstetric maternal deaths and about 50% of all mother-to-child transmissions; their children, irrespective of HIV status, are 3 - 4 times more likely to die than children of mothers with higher CD4 counts.[7] Second, detailed district implementation plans to deliver effective prevention of mother-to-child transmission (PMTCT) services must be developed as a matter of urgency. PMTCT protocols largely define the interaction and care offered by the individual health care professional to their client. District health systems, depending on their management style and functionality, either enable or disable health workers to implement those protocols. Third, models for implementing prevention, treatment and care activities that integrate rather than compartmentalise are needed. Such models need to be flexible and responsive to local settings rather than being entirely rigid and prescriptive. Implementation research that evaluates different models rather than just describing problems is critically needed. Fourth, while true for all health services, strategies for retaining and motivating staff in urban and rural facilities will have very immediate and direct implications for the prevention and care of HIV-infected children. Data management systems that routinely and quickly feed back information about their performance to clinics and hospitals have the potential to inform local problem solving and change of practices. Fifth, high-quality counselling and support to help mothers feed their infants in a way that is most likely to avoid HIV infection, and also death from diarrhoea, pneumonia and malnutrition, is crucial.

Lastly, child survival and not just the prevention of HIV transmission needs to be the paradigm that governs decisions for the children of southern Africa.[8] The majority of children born to HIV-infected mothers never become infected, even if mothers receive no prophylaxis and mix-breastfeed for 2 years or more. Yet, these children are exposed and vulnerable; the fact that their survival depends on the survival and well-being of their mothers must be shouted from the mountain tops, so that health workers cannot fail to understand and act. Paediatricians need to be advocates for maternal health and obstetricians and midwives need to appreciate their unique opportunity to reverse the upward trends in child mortality. Child survival will be the measure of our collective efforts and whether the title of 'success' or 'failure' will be afforded. The

NSP 2007 - 2011 is 'not a plan for the health sector alone. It … seeks to be relevant to all agencies working on HIV/AIDS in South Africa, within and working outside the government'.[2] We do need to be advocates and co-workers for its achievement. Such advocacy requires objective and constructive criticism from the pitch and not just from the sidelines.

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