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. This is the conclusion of Michaels and Eley in their paper considering the paediatric perspectives of the South African National Strategic Plan (NSP) 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’.

Such language can be used to claim the moral high ground … the best interests of the child shall be a primary consideration’. 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%. 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. Past experiences of identifying vulnerable children and providing social security are not encouraging, and stating that ‘mechanisms to link …
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’. 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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