

South Africa's AIDS plan

A strategic plan has been developed to tackle the nation's HIV crisis — at last.

After years of prevarication, the government of South Africa has finally adopted a sound and comprehensive strategy for managing the country's AIDS epidemic. The 160-page plan, which was endorsed by the South African National AIDS Council on 30 April, lays out proposals to cut infection rates, improve diagnosis of the disease, and treat the estimated 5.5 million South Africans already infected with HIV.

The plan has been welcomed by physicians, AIDS researchers and activists in South Africa, who have long been frustrated by the reluctance of President Thabo Mbeki's government to confront the world's worst national AIDS problem head-on.

It sets two main objectives: by the end of 2011, the rate of infection should be halved; and antiretroviral treatment should be readily accessible to 80% of the people who require it. The estimated cost of all this is US\$6 billion over the next five years, with drug costs accounting for 40% of the total. The plan expresses the hope that the private sector and foreign donors will provide half of the cash, with the South African government paying the rest.

According to a report released in November by the Actuarial Society of South Africa (ASSA), 1.8 million people have died of AIDS in South Africa so far. Current estimates of the number of people requiring antiretroviral treatment range between 800,000 and 1 million. But only about 300,000 are receiving it, with two-thirds of them being treated by the Department of Health and the rest by private healthcare schemes and non-governmental organizations. Many more of those already infected with HIV will need drug treatment within five years.

The absence of an effective AIDS strategy for South Africa until now has particularly affected the availability of treatment for children born with the disease. Only one-tenth of the estimated 200,000 children who might benefit from antiretroviral treatment are receiving it, according to the International Treatment Preparedness Coalition. That is partly because the treatment of children carries extra bureaucracy. Just to be tested for HIV (a prerequisite for access to antiretroviral treatment), they require identity numbers, which

in many cases they don't have, as well as consent from a biological parent — a problem because many are cared for by other members of the extended family. There is no other medical condition where such criteria have to be met before starting treatment.

Slowing the infection rate may be even more challenging than administering therapy. The rate is already falling in urban areas: ASSA estimates that 530,000 people were infected in South Africa last year, down from the peak annual infection of 650,000 in 1998. But in rural areas such as the Umkhanyakude area of KwaZulu-Natal province, for example (see page 26), infection rates remain high and public understanding of AIDS is threadbare.

Additionally, a lack of trained doctors and nurses is likely to act as a serious constraint on the full implementation of the strategic plan. Many have grown frustrated over the government's AIDS policies, sometimes to the point of leaving the country, or at least the public sector.

Although admirably broad in its scope, the plan falls short of addressing some of the technical and bureaucratic obstacles that stand in the way of AIDS prevention and treatment. Another problem is Mbeki's failure, so far, to publicly acknowledge the AIDS crisis.

Indeed, reluctance on the part of some of South Africa's leaders to face up to the extent of the problem remains an issue. But deputy president Phumzile Mlambo-Ngcuka, whom many see as a possible successor to Mbeki when his term expires in 2009, has rewritten the government's AIDS agenda by helping to draw up the strategic plan. The health minister Manto Tshabalala-Msimang, who embarrassed South Africa with her remarks at the World AIDS Congress in Toronto last August (see *Nature* 444: 663; 2006), is currently on sick leave. If Mbeki is serious about confronting AIDS, he should appoint someone with the necessary aptitude and enthusiasm, such as deputy health minister Nozizwe Madlala-Routledge, to succeed her. ■

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Share your lab notes

The use of electronic laboratory notebooks should be supported by all concerned.

Too often when errors or cases of fraud occur in science, the lab data required to reconstruct what happened have gone astray. And too often, the co-authors failed to exert due scrutiny on their colleagues' activities in order to prevent such misfortunes. The damage to personal and institutional reputations can be severe and, in rare high-profile cases, public trust can be eroded.

It is therefore in everyone's interest to pre-empt such cases as far as possible. Electronic laboratory notebooks offer a partial solution — and have other advantages too. This is despite the fact that maximizing their benefits will require a change in culture that many researchers will no doubt initially resist.

Electronic notebooks, like their paper cousins, record the daily thoughts and experiments of bench scientists. Ideally, they contain data that flow automatically from lab instruments and can be read by all lab members. Pages are date- and time-stamped, and all changes tracked and signed. Earlier versions can be reconstructed.

There are numerous e-notebook products available, but none dominates in all sectors. The pharmaceutical industry, which is well