The principle of 'event-driven benefits' underpins the AfA programme. This unique concept links defined biological and pathological events to specific treatment programmes. The occurrence of such an event in the patient's illness will make available the benefits to fund the approved treatment protocol. The AfA programme therefore depends on co-operation from the responsible medical practitioner to notify the programme once an event has occurred, otherwise the benefit cannot be made available. Pre-authorisation is only required for hospitalisation and certain very costly investigations and therapies, and this has been kept to a minimum to limit the administrative burden on providers of care.

The issue of confidentiality has been addressed by creating a restricted access administrative unit with a dedicated computer and communication system. Provided patients, doctors, pharmacists and hospitals deal directly with the unit, HIV-positive beneficiaries cannot be identified by the employer, the medical scheme or the administrator. Secure toll-free fax and phone lines are available for medical practitioners, and a dedicated nurseline is available for use by members enrolled on the programme to assist with queries and enhance compliance with prescribed treatment. This has been identified as a major factor in the effectiveness of antiretroviral therapy.

AfA has no interests in the buying, distribution or selling of medicines. It will, however, work closely with the pharmaceutical industry in order to reduce the cost of expensive antiretroviral therapy and other drugs used in the treatment of opportunistic infections. Encouraging developments have already occurred in this regard. These will benefit persons who are not members of medical schemes as well. Co-operation with academic institutions and professional organisations, as well as other interest groups, is being explored. The programme also offers opportunity for research and the development of an Afrocentric approach to the treatment of HIV/AIDS in South Africa.

While accepting certain financial realities, the AfA programme represents a significant advance in the provision of care and availability of benefits to the majority of previously disadvantaged medical scheme members and their dependants who are living with HIV infection and AIDS.

1. Palella FJJ, Delaney KM, Moorman AC, *et al.* Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. HIV Outpatient Study Investigators. *N Engl J Med* 1998; 338: 853-860.
2. Report of the NIH Panel to Define Principles of Therapy of HIV Infection. *MMWR* 1998; 47: (RR-5): 1-41.

CONFRONTING AIDS — A PLEA FOR A NATIONAL DRIED MILK FORMULA

D L Woods

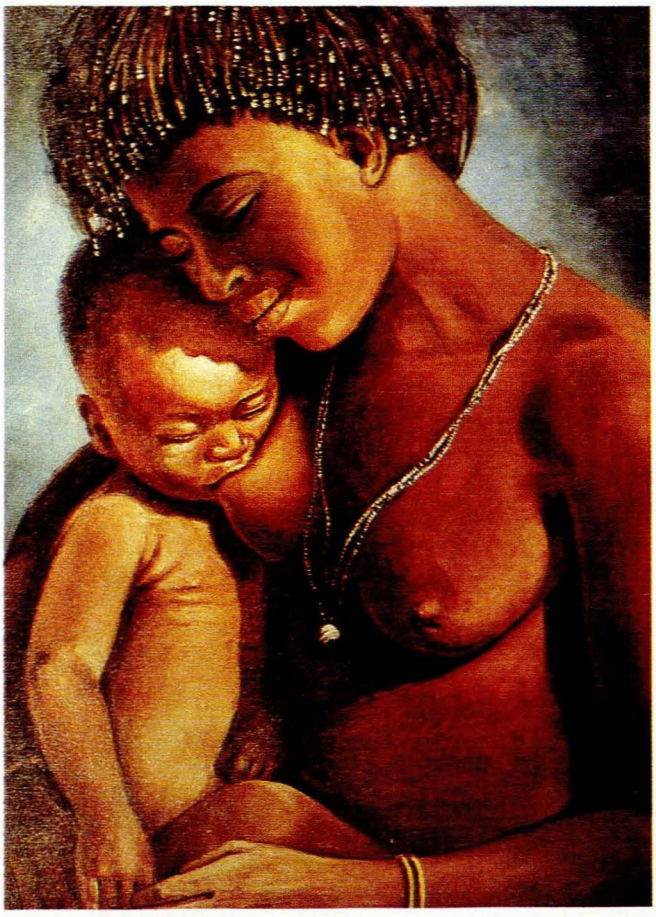
The threat of AIDS is rapidly spreading across South Africa, and few are at greater risk of infection than babies born to HIV-positive women. The risk of vertical transmission of HIV from mother to infant is approximately 35% in South African populations where breast-feeding is commonly practised. It has been estimated that up to half of perinatal transmission may occur via breast-milk. As a result, many HIV-infected mothers are advised not to breast-feed their infants. While this practice is widely accepted in affluent countries, it must be viewed with caution in poor communities where undernutrition and gastro-enteritis remain common causes of infant mortality.

The recent worldwide attempts to promote exclusive breast-feeding of newborn infants, especially in developing countries, have received much support in South Africa, with the implementation of the ten steps to successful breast-feeding and the baby-friendly hospital initiative. The slogan 'breast is best' is often heard, and posters promoting the many advantages of breast-feeding are prominently displayed in antenatal clinics. Will all that has been achieved by these programmes simply be swept away by the AIDS epidemic?

The argument for giving dried milk formulas to newborn infants at risk of HIV infection is convincing. Furthermore, many health care organisations, such as the World Health Organisation, suggest that HIV-infected women who can afford to buy milk formula should be discouraged from breast-feeding. Where does this approach leave the woman who is unable to afford milk formula, or the State, which may not be able to provide free or subsidised formula to these infants? An innovative scheme to bring the cost of milk formula within the reach of most HIV-infected mothers is needed.

A cheap national dried milk formula was introduced into the UK very successfully. A similar scheme could be launched in South Africa. Contracts could be issued on a competitive basis to the private sector for the manufacture of a suitable milk formula which should meet the basic nutritional needs of normal infants. A further reduction in cost could be achieved by packaging the formula in sachets rather than tins. The packaging would carry no commercial name or advertising, but simply give the contents as South African national infant

Associate Professor Dave Woods is head of the Newborn Medicine Unit at Groote Schuur Hospital. His academic interests include the prevention of perinatal HIV infection and the distance training of midwives.



In the shadow of AIDS — is breast still best?

milk formula. Information on the sachets could be used to promote the advantages of cup feeding, the correct method of preparing formula feeds, and the benefits of immunisation. Commercial retailers and spaza shops could distribute the milk. While the scheme would remain under State control, competitive market forces in the private sector would keep the cost of manufacture and sales as low as possible.

The use of clinics and hospitals to sell a national milk formula is more contentious, as this may negate the promotion of breast-feeding in HIV-negative women. It would also need an expensive State infrastructure.

The increased demand for milk could be met by the local agricultural sector, especially subsistence farmers in socio-economically underprivileged areas. Again the private sector could play an important role in transporting milk from the farmer to the milk depot. Peasant farmers could be paid in cash on delivery of the milk to local collection centres. This system would promote rural farming and inject funds directly into the most needy communities.

If a similar scheme were introduced to encourage the growing of millet or sorghum rather than maize, these highly nutritious cereals could be mixed with the cheap milk powder to produce a low-cost supplement for South Africa's many undernourished toddlers and schoolchildren. Again small farmers could benefit from the increased market.

The great danger of these proposals to enhance the availability of cheap breast-milk substitutes is that the incidence of breast-feeding in HIV-negative women may fall, with a resultant increase in infant mortality. However, if antenatal screening for HIV infection were introduced, non-infected women could be identified and receive advice and reassurance that breast-feeding is most advantageous for their infants. At present we do not know what the impact of a cheap milk formula on breast-feeding in the AIDS epidemic will be. This uncertainty should not delay the urgent need for public debate and implementation of a national policy to address the risk of breast-feeding in maternal-to-child-transmission of HIV.

Currently the risk of HIV infection due to breast-feeding while the infant receives antiretroviral agents is unknown. Unless prophylactic treatment is both affordable and effective, access to cheap milk formula will play a major role in controlling the vertical spread of HIV in all communities.