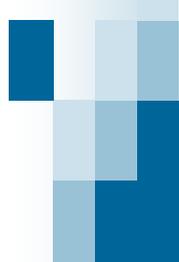




UNIVERSITY of the
WESTERN CAPE



SoPH BULLETIN

The UWC School of Public Health Newsletter June 2013

THE MAUERBERGER FOUNDATION AND UWC LAUNCH THE

Jakes Gerwel Award in Public Health

The Award Professor Jakes Chancellor of UWC leader who went President Vice Chancellor he passionately for development of School of Public established school. He clearly UWC to focus on practice that led to improvements in was based on solid last few years the these aspirations.



honors the late Gerwel, former Vice as a visionary on to serve in Mandela's. As UWC advocated and supported South Africa's first Health to be outside a medical saw the need for public health measurable peoples' health and science. Over the School has achieved

The Award, to be made annually, honors and recognizes Jakes Gerwel's central role in promoting public health practice and is open to all graduates of the School who have demonstrated through their work, the ability to have an impact on some aspect of population health. Evidence of impact could be derived from epidemiological or other studies and need to specify the population who benefited from a specific set of interventions, policies or measures and the measurable impact on people's health. UWC Faculty, student and graduates are invited to nominate people for a prestigious award that will both bring attention to the work of Prof Gerwel while at the same time highlighting the importance and leadership role of the School. The award shall be open to all former graduates of the School of Public Health within and beyond South Africa.

1

GETTING THE DIAGNOSIS RIGHT: CAPACITY CONSTRAINTS VERSUS UNCONTROLLED MEDICINES REGISTRATION IN SOUTH AFRICA AND PUBLIC ACCESS TO ESSENTIAL AND AFFORDABLE DRUGS

Henry M. J. Leng¹, David Sanders¹ and Allyson M. Pollock²

¹ School of Public Health, University of the Western Cape

² Centre for Primary Care and Public Health, Queen Mary, University of London

Abstract

Objective

To determine if the backlog in registration applications at the Medicines Control Council impedes access to affordable medicines.

Methods

Annual trends in registration applications and licences issued were followed to determine if significant changes in their numbers could be linked to the implementation of new policies. The number of registered generic, innovator and biologic medicines were compared to determine which class contributed most to the backlog. The market for a group of tracer medicines was segmented by volume and/or value per brand to determine the number of leading brands versus the total number available. Price and market share for several brands of tracer medicines were compared to determine the extent to which price influence access.

Findings

The backlog is the result of the implementation of pro-generics policies without strengthening the MCC. Only 54% of registered medicines are marketed and a maximum of only five brands account for 80% or more of the market for a particular medicine. Price appears not to be an important determinant of market share of generics since the lowest priced generic does not have the highest market share.

Conclusion

The backlog in registration applications at the MCC is not a barrier to access to affordable medicines. If the primary purpose for the establishment of a better resourced new regulatory authority in South Africa is to speed up the registration process, then it would serve the interests of the pharmaceutical industry more than that of the public.

2

ASSESSING EQUITY IN THE DISTRIBUTION OF PHARMACY SERVICES IN PREPARATION FOR THE NATIONAL HEALTH INSURANCE AT PROVINCIAL AND DISTRICT LEVEL: ROLE OF CORPORATES, INDEPENDENT COMMUNITY PHARMACIES AND PUBLIC CLINICS

Ward KL^{1,2}, Leng HMJ², Sanders, D² and Pollock,*

¹School of Pharmacy, University of the Western Cape

²School of Public Health, University of the Western Cape

³Centre for Primary Care and Public Health, Queen Mary, University of London

**Corresponding author: Tel: 27(21) 959-3440 E-mail: kward@uwc.ac.za*

Abstract

Background

In 1994, regulatory reform to the community pharmacy (CP) sector in South Africa's post-apartheid era was implemented to address the unequal distribution of pharmaceutical services, which historically favoured urban metropolises. The proposal for a National Health Insurance (NHI) system identifies CPs as additional access points for medicines in combination with public clinics. This paper reviews the impact of regulatory reform since 1994 on the distribution of CPs and public clinics in SA's 9 provinces and 10 selected districts.

Methods

Data on CP licences and registrations were sourced from the National Department of Health (NDOH), Licencing Unit and the South African Pharmacy Council (SAPC), respectively. Data for public clinics at provincial level were obtained National Health Facility audits conducted in 2003 and 2012. Geographical equity was measured using CPs and public clinics per 10,000 residents at provincial and (selected) district levels. These facilities were also pooled

for purposes of analysing the distribution of facilities under the NHI. Key informant interviews were conducted with 8 key leaders in pharmacy.

Results

The key findings for this paper are as follows: i) the quality of existing data on CPs and the availability of data on public clinics is poor; ii) there has been a decline in the number of CPs relative to population since 1994 and enormous differences between provinces and within provinces at district level in numbers and ratios of CPs and public clinics; iii) the increase in numbers of CPs and in public clinics has not kept pace with population growth and need; iv) corporates have seen the main areas of growth but this has not associated with meeting need or equity in distribution and v) the interviews with key pharmacy leaders confirms the empirical data.

Conclusion

The NHI system must have a for strong monitoring and enforcement system to promote equity, incentives to support CP services in rural areas, and firm plans for improving the pharmacy workforce. In the absence of these, the liberalisation of public health funding through the NHI allowing CPs to be reimbursed by government for services rendered could undermine equity with respect to pharmaceutical services.

FRONTLINE HEALTH WORKERS AS BROKERS: PROVIDER EXCEPTIONS, EXPERIENCES AND MITIGATING STRATEGIES TO IMPROVE ACCESS TO MEDICINES IN THE EASTERN CAPE PROVINCE, SOUTH AFRICA

Magadzire BP¹, Budden A², Ward K^{1,3}, Jeffery R⁴, Sanders D¹

¹*School of Public Health, University of Western Cape*

²*Swiss Tropical and Public Health Institute, University of Basel*

³*School of Pharmacy, University of Western Cape*

⁴*School of Social and Political Science, University of Edinburgh*

Corresponding author: Email: bmagadzire@gmail.com

Background:

Health providers are well placed at the interface of medicine distribution and the patient to understand and respond to barriers to medicine access. This study examines perceptions and interventions employed by health providers to deal with barriers to medicine access and recommended future strategies.

Methods:

Thirty-nine key informant interviews were held with health providers at six public-sector CHCs in two districts and sub-district and provincial managers in Eastern Cape.

Results:

Informants indicated that medicine stock outs are precipitated by ineffective logistical management practices at various levels of the supply chain and insufficient capacity to meet increased treatment demand. Also, the organization of vertical disease programmes undermines the needs of patients with co-morbidities and inferior services at peripheral clinics threaten the down-referral programme. On the demand side, the major inhibiting factors to accessing medicines are poverty and unreliable public transport. For patients on long-term care, proximity to other services such as grant distribution points and shopping centres was an important influence on the choice of where to obtain medicines. Providers mitigate these constraints by adopting flexible prescribing and dispensing patterns based on perceived patient need and aligning clinic appointments with social grant collection appointments to limit costs associated with care.

Conclusion:

Suggested possible mechanisms for consideration under the NHI to address the aforementioned challenges include strengthening the supply chain through public-private partnerships, involving ward based PHC outreach teams in medicine distribution coupled with other alternative models, improved coordination between facilities, intersectoral action.

Counting Child Deaths and Making Them Count

Kate Kerber



Audit and feedback is a longstanding strategy undertaken to change health worker behaviour with the aim of improving maternal, newborn and child care and reducing mortality. The systematic and critical examination of the quality of medical care in a multi-disciplinary, no-blame environment is used to identify common health service problems and identify solutions to these problems. Confidential enquiries into maternal deaths, stillbirths, and neonatal deaths have been an essential activity in high-income countries for decades but the use of audit has been limited in low- and middle-income countries.

In South Africa, three national mortality audit programmes exist: the Confidential Enquiry into Maternal Deaths, the Perinatal Problem Identification Programme (PPIP), and the Child Problem Identification Programme (Child PIP). In May I had the honour of speaking at the National Child PIP 2012 workshop in Johannesburg on the status of child survival progress in the country and globally. I was able to present on UWC's work with the global Child Health Epidemiology Reference Group which aims to improve the cause of death data for South Africa's newborns and children.

The workshop brought together Child PIP users from across the country and each province had an opportunity to present overview data charting progress since they began auditing deaths. It has been ten years since the first Child PIP mortality data was collected and now 141 health facilities across the country (nearly 50% of public hospitals) are conducting regular mortality audit reviews and submitting data to the national team for collation and analysis.

Child PIP is a reliable, valid and highly valued source of mortality information. One expert has called it "the best tool of its kind in the world." The creators of these user-driven, facility-initiated mortality audit tools and systems continue to refine and improve the tools based on feedback and the changing context. This information can and has been used to advocate for change at ward, facility, district, provincial and national levels. Though not designed to be population-representative, the audit data has also been used to document changes in the epidemiological profile of mothers, babies and children over time.

The popularity of the national audit programmes has now been recognized at the highest levels: the new national Maternal, Newborn Child and Women's Health and Nutrition strategy mandates maternal, perinatal and child mortality audit to take place in health facilities with delivery and paediatric services.

The meeting participants reflected and celebrated a decade of Child PIP data collection, development and dedication. It is easy to feel helpless in the face of stories of preventable deaths, but helplessness is not necessary. The act of auditing these deaths and taking deliberate steps to do better is one way to honour these children and make every death count.

For more information, please see www.ppip.co.za and www.childpip.org.za

Linkage to Care following Home-based HIV Counseling and Testing

Reshma Naik



Background

Timely linkage to care and treatment by HIV-positive individuals can lead to significant decreases in morbidity and mortality as well as increases in life expectancy and quality of life.^{1, 2} Further, there are significant prevention benefits as early initiation on antiretroviral treatment (ART) can significantly reduce HIV transmission to uninfected partners.^{3, 4} Modeling exercises also suggest that universal HIV testing coupled with immediate treatment could decrease HIV incidence and virtually eliminate the HIV/AIDS pandemic. To achieve this, the rate of linkage to care must be 100%.⁵

This underscores the importance of understanding and addressing barriers to linkage. Little is known about such barriers, particularly for newer community-based models of testing such as home-based HIV counseling and testing (HBHCT). Current evidence suggests that HBHCT is acceptable and effective in raising HIV awareness.^{6, 7} Thus the mandate for scale up is strong, and the next step is to ensure that appropriate measures are put in place to maximize the benefits of timely linkage.



Study Methods

This study employed a mixed methods approach to: 1) determine rates of linkage from HBHCT to the first point of contact with the health system – defined as obtaining a CD4 count; and 2) identify predisposing and other factors that may hinder or facilitate timely linkage. The study was conducted in the Umzimkhulu municipality, a poor rural area in Kwazulu-Natal, South Africa. It comprised a predominantly female sample of 492 HIV-positive HBHCT clients.

Key Findings

Linkage to care

- 62.1% of HBHCT clients linked to care within 3 months, which is a rate comparable to what is found in facility-based settings⁸
- The median CD4 count for those who linked to care was 340.5 cells/mm³, indicating that over half were immediately eligible for treatment

Factors influencing linkage

Client experiences following HBHCT are complex and barriers to linkage occur at all levels: individual, relationships, community, and health system (Figure 1). Delayed care seeking is more likely when clients respond poorly to the diagnosis; have difficulty with disclosure and limited social support; lack time, opportunity, and financial resources; and have internalized negative experiences with the health system. For example:

- Clients who did not believe their results had a 52% lower incidence of linkage
- Clients who reported that finding time to seek health is a problem had a 60% lower incidence of linkage
- Clients who believed that drugs/supplies are generally available at the local clinic had a 78% greater incidence of linkage



The qualitative analysis offered deeper insight about the interrelatedness of these findings and the mechanisms through which they may affect the linkage to care. In particular, the qualitative findings highlight the influential role of interpersonal relationships, psychosocial factors, and the subtle impact of stigma. Importantly, youth may be particularly vulnerable to each of these barriers and subsequent delays in care seeking.

Clients aged 16-24 years had a 50% lower incidence of linkage to care compared to their older counterparts.

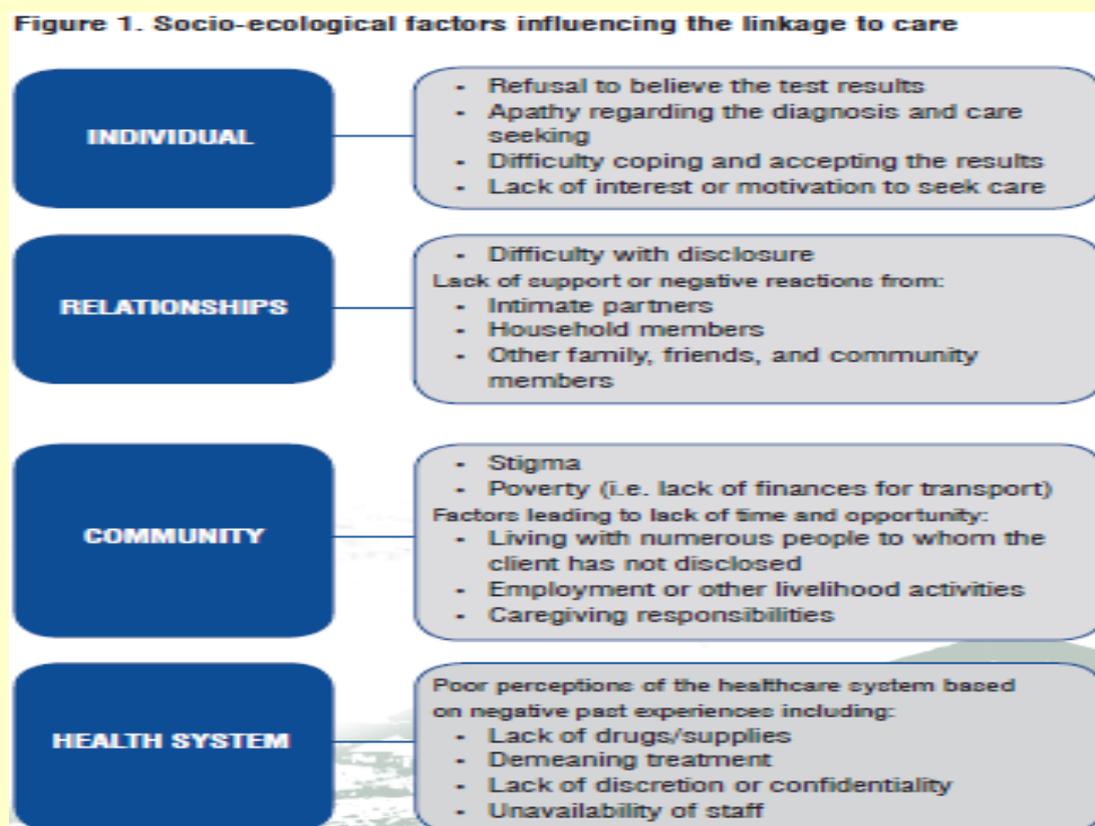
Client Voices

- What made me not to believe [my results]...is that...my husband passed away in 2004...and I have never had sex with any man...does it mean that I got it from my husband because this thing hides in one's blood? Does it mean that he was infected before he died? No sister, I don't believe it...where did I get it because I'm a widow and I don't go around taking other women's men. - Female, 47 years, had not linked to care at the last point of contact (231 days)

- I will indeed go [to the clinic] but I'm still waiting for my husband and we will go together... I won't say anything on the phone. Things like this you can't just say it anyhow...I will wait for him. I'm not saying I will not go but when the time is right and I feel it's time for me to move on with my life...my stand is we need to go together. For now I won't do anything, I'm waiting for him... - Female, 32 years, had not linked to care at last point of contact (542 days)

- ...I've been staying with my grandmother the whole day...my mother gets off only on Saturdays, she works from Monday to Saturday. On Saturday she knocks off at 3pm and clinics don't operate on Sundays. That's the thing that has been making me not be able to go to the clinic. - Female, 20 years, had not linked to care at last point of contact (146 days)

- I haven't done anything with [the referral letter]...because staff at the local clinic don't have confidentiality...I've heard them talking about other people...I have to use money to go to the clinic that I like but then I don't have money yet. - Female, 22 years, had not linked at last point of contact (192 days)



Recommendations

To promote a supportive infrastructure for HBHCT and linkage:

- Add HBHCT and facilitation of linkage to CHW scope of work
- Engage communities to reduce stigma and normalize HIV/AIDS

To address psychosocial barriers to linkage:

- Encourage couples counseling and testing to facilitate partner support
- Conduct short-term intensive community-based support groups

- Implement a brief disclosure intervention
- Offer a repeat test when needed to quickly avert disbelief of results
- Offer tailored counseling to address common concerns

To overcome access barriers to linkage:

- Offer community-based point-of-care CD4 counts
- Pilot and evaluate community-based nurse-initiated treatment

To address the unique needs and concerns of youth:

- Partner with the school health team and youth-focused organizations

References

1. Nakagawa F, Lodwick RK, Smith CJ, Smith R, Cambiano V, Lundgren JD, et al. Projected life expectancy of people with HIV according to timing of diagnosis. *AIDS*. 2012; 26(3): 335-43.
2. Beard J, Feeley F, Rosen S. Economic and quality of life outcomes of antiretroviral therapy for HIV/AIDS in developing countries: a systematic literature review. *AIDS Care*. 2009; 21(11): 1343-56.
3. Donnell D, Baeten JM, Kiarie J, Thomas KK, Stevens W, Cohen CR, et al. Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis. *Lancet*. 2010; 375(9731): 2092-8.
4. Cohen MS, Chen YQ, McCauley M, Gamble T, Hosseinipour MC, Kumarasamy N, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med*. 2011; 365(6): 493-505.
5. Granich RM, Gilks CF, Dye C, De Cock KM, Williams BG. Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model. *Lancet*. 2009; 373(9657): 48-57.
6. Naik R, Tabana H, Doherty T, Zembe W, Jackson D. Client characteristics and acceptability of a home-based HIV counselling and testing intervention in rural South Africa. *BMC Public Health*. 2012; 12(1): 824.
7. Sabapathy K, Van den Bergh R, Fidler S, Hayes R, Ford N. Uptake of HomeBased Voluntary HIV Testing in Sub-Saharan Africa: A Systematic Review and Meta-Analysis. *PLoS Med*. 2012; 9(12): e1001351.
8. Rosen S, Fox MP. Retention in HIV care between testing and treatment in sub-Saharan Africa: a systematic review. *PLoS Med*. 2011; 8(7): e1001056.

For more information about this study, please contact Dr. Reshma Naik at reshnaik@gmail.com.



My Postdoctoral Fellowship at the School of Public Health

Joshua Aransiola

I started my postdoctoral programme with Centre for HIV and AIDS Research, School of Public Health in November 2011 under the supervision of Prof. Christina Zarowsky. My research has focused on *“Irregular migration, human trafficking and HIV/AIDS in South Africa: Baseline situation analysis”*.

In the course of my stay I met with different local and international NGOs, community leaders and government agencies during the course of this study in Cape Town, Johannesburg and Musina in South Africa. The period has been very eventful, productive and highly beneficial to me and a spur to my academic career. I submitted four articles to different Journals of which one has been accepted and two have been revised with the hope that they will finally be accepted. I also have two more papers at the final stages of completion.

I am indebted to my supervisor Prof. Zarowsky for her excellent mentorship during this period; she played a large role in my research achievements. I have gained a lot from her and have acquired better skills on how to conduct ethnographic fieldwork, writing articles for different journals and audiences and seminar presentations among others. She is a good mentor from whom I will take many lessons, especially on how to mentor. This will positively impact on my future career and mentoring of other scholars.

The School of Public Health, University of the Western Cape is a very interesting place to be especially for sound and robust career development. I have gained a lot from many activities of the School. The weekly Journal club became a very important event for me; it

provided opportunity for learning new things and cross fertilization of ideas on productive scholarship. The research domain and postgraduate seminars are wonderful programmes I will miss. I have learnt a lot in the school's programme and hope to replicate them in my department at my home university in Nigeria.

My interaction with the administrative staff in the School of Public Health has also been very remarkable. I cannot forget people like Tamlin Peterson, Shun Govender, Emma Chademana, Corinne and the rest of the team who contributed wonderfully to facilitate my success since I joined the School.

My appreciation goes also to Prof. Uta Lehmann, former Director of SOPH and Prof Helen Schneider, the current Director as well as the academic staff in the School for providing an enabling environment and useful contributions towards the success of my research. I hope to consolidate my postdoctoral experiences and build collaboration with the School in my future career. I will miss you all.



New WHO Guidance on Childhood Obesity and Under-nutrition in Low Middle Income Countries (LMICs)

WHO issues guidance on emerging double threat of childhood obesity and undernutrition in low- and middle-income countries

5 June 2013

Many low- and middle-income countries are neglecting overweight and obesity as major health threats, with policies in place to tackle undernutrition, but lack policies to halt the growing burden of diseases due to the rise of overweight, and obesity, according to new information released by WHO today.

More than 75% of overweight children live in developing countries with the prevalence in Africa almost doubling in the last 20 years. Obese children are more likely to be obese as adults, with an increased risk of diabetes and other diseases.

WHO's Essential Nutrition Actions

To help countries close these policy gaps, WHO has issued a consolidated package of 24 Essential Nutrition Actions, which outline the most effective ways countries can improve their peoples' nutritional status by preventing both undernutrition and overweight. There are many factors during pregnancy and infancy that can affect an older child's and an adult's weight.

Interventions include:

- improve nutrition of pregnant and breastfeeding women;
- encourage early initiation of breastfeeding, exclusive breastfeeding for the first 6 months, then continued breastfeeding up to 2 years;
- promote appropriate solid foods for young children; and
- provide micronutrient supplements and fortified foods, when needed.

“To avoid a massive explosion of nutrition problems in the next generation, policymakers urgently need to give more attention to improving the nutritional status of pregnant women and adolescent girls who will become mothers of the next generation.”

“Increasingly, we find overweight children living in countries where undernutrition is also still an issue,” says Dr Francesco Branca, Director of WHO's Department of Nutrition for Health and Development. “While it is vital to maintain efforts to reduce undernutrition,

the world needs to do much more to prevent and care for the growing numbers of people that are overweight or obese and living in low- and middle-income countries.”

Causes of overweight and undernutrition

These conditions – undernutrition, obesity and overweight – are forms of malnutrition with their causes and consequences closely linked to inadequacies in the food system. A food system that does not deliver a sufficient amount of quality food can lead both to poor growth and to excess weight gain. A child who has grown poorly in his first years of life may turn into a short but overweight adolescent and then later in life, develop chronic disease as an adult.

“To avoid a massive explosion of nutrition problems in the next generation, policymakers urgently need to give more attention to improving the nutritional status of pregnant women and adolescent girls who will become mothers of the next generation,” adds Dr Branca.

Essential Nutrition Actions address many health issues

Many policies to address the other half of the “double burden” of malnutrition – obesity and diet-related diseases such as diabetes, heart disease and stroke – are much further behind, especially in Africa and South-East Asia. And even when policies to address obesity exist at a national level, they are often not implemented at provincial or district level. Only one third of surveyed countries regulate the marketing of foods to children, and only a few have taken measures to reduce salt or trans fats in foods.

Focusing on these essential nutrition actions, countries can reduce infant and child mortality, improve growth and development, and improve productivity. Countries such as Brazil, Ethiopia, and Peru and India’s second most populous state, Maharashtra, have achieved such successes as a result of implementing these actions.

Worldwide, more than 100 million children under five years of age are underweight; 165 million are stunted i.e. have a low height for their age (which is a better indicator of chronic undernutrition). An estimated 35% of all deaths among children under five are associated with undernutrition. At the same time, some 43 million children under five are overweight or obese.

“With the 2015 deadline for the Millennium Development Goals less than 1000 days away, these reports provide countries and development partners with urgently needed analysis of what still needs to be done and consolidated guidance on how to get there,” says Dr Branca.

A Lancet Series on Maternal and Child Nutrition is being published on 6 June. It includes an analysis of the impact of various nutrition interventions on the health of women and children. The Series also gives an estimate of what it would cost to fill some of the gaps identified in the Global Nutrition Policy Review (\$12.6 billion per year including all supplies and staff costs).

http://www.who.int/mediacentre/news/notes/2013/obesity_undernutrition_20130605/en/index.html

KZN winning war against HIV/Aids, TB

By Bhekisisa Mncube

KwaZulu-Natal has recorded a decline in HIV/Aids prevalence as a result of a collective effort by the KZN Provincial Government to deal head-on with the scourge.

“We have seen a reduction in HIV prevalence amongst pregnant women decrease from 39.5% in 2009 to 37.4% in 2011 (Ante-Natal Survey),” KZN MEC for Health Dr Sibongiseni Dhlomo announced on Wednesday.

Alongside this, he said the government efforts in preventing mother to child transmission decreased from 19% in 2007 to 2.1% by July 2012 (MRC Study: 2011).

However in addition to the reduction in HIV prevalence, the MEC noted that they have achieved the following: A decline of the new HIV incidence from an estimated 1.3% in 2009 (nationally) to 1.1% in 2012 in compliance with United Nations Millennium Development Goals (MDG) 6 that calls on government to stop and begin to reverse the HIV and Aids scourge.

“Reduction in reported HIV and Aids related deaths from 67 429 in 2008/9 to 54 337 in 2010/11. HIV prevalence among 15 – 19 year old pregnant women decreased from 22% in 2009 to 16.8% in 2012 HIV prevalence among 20 – 24 year old pregnant women decreased from 37.2% in 2009 to 33.3% in 2012,” he said.

Dhlomo said by the end of March 2013 a total of 7 857 586 people received counselling, 6 832 992 were tested for HIV and of this total, 5 786 365 people were also screened for TB with 887, 688 referred for clinical diagnosis of TB. One million (±) received counselling but did not proceed to testing.

The Medical Research Council confirms that the tide is turning against HIV/Aids; it has found life expectancy to have risen to 60 years in 2011, up from 56.5 years in 2009 as fewer people died of AIDS.

Dhlomo was delivering the 2013-2014 Health Budget Speech before the KwaZulu-Natal Provincial Legislature in Pietermaritzburg. The total budget for 2013/14 is R28 647 877 000 billion

He said the total number of patients on Highly Active Antiretroviral Therapy increased from 225 389 in 2008 to 705 024 currently, contributing just above a third of the country's 1.9 million patients on ARVs.

Maternal Deaths

He revealed that maternal deaths have also decreased. “We are happy to say that there is an encouraging downward trend in maternal mortality. By the end of March 2013, a total of 317 maternal deaths were reported, a decrease of 46 compared to 2011.”

He ascribed this to the introduction of 38 specialized Obstetric Ambulances used for the transportation of pregnant women – a first for the country.

Neonatal Mortality

He said neonatal mortality has not changed and remains consistent around 14/1 000 live births, however the department is striving to reach the national target of 12/1000 by 2014. “Infant mortality has dropped from 40 in 2009 to 30 in 2011, having already exceeded the target of 36 for 2014. Similarly under-5 mortality has dropped from 56 in 2009 to 42 in 2011,” he said.

He also said the department has completed the 1st round of the campaign to immunize children against Measles and Polio. The target population was 1.2 million children and to date 89% of the target has been achieved.

Condom Distribution

In a final onslaught against the HIV/Aids pandemic the MEC said the department has distributed 84 million male condoms and 1 337 485 female condoms in 2012 alone. “For the current year, we plan to distribute 212 million male and 2.8 million female condoms as part of the prevention strategy,” he said.

He also announced that the province has acquired 38 GeneXpert machines. The GeneXpert machine is a cartridge-based, automated diagnostic test that diagnoses TB much faster (in no more than 2 hours) compared to several days or weeks using old methods. “This has greatly assisted in ensuring that 5 680 diagnosed MDR-TB patients and 832 XDR-TB were put on treatment during the period 2010 to 2012,” he said. –
SAnews.gov.za

<http://www.sanews.gov.za/south-africa/kzn-winning-war-against-hiv-aids-tb>

30 years of HIV: where next?

[The Lancet Editorial, 15 June 2013](#)

Kuala Lumpur will host the 2013 International AIDS Society (IAS) meeting from June 30–July 3. This issue of *The Lancet* will be there too, with its content rich in the diverse diaspora that characterises global efforts to prevent, treat, and ultimately cure the disease that today affects 34 million people worldwide.

The emergence of antiretroviral therapy (ART) in 1996 heralded a new era in HIV treatment that continues to this day. The scale-up of ART in the past few years is testament to the extraordinary international public health response to the epidemic. In 2011, for the first time, more than half of people eligible for ART in low-income and middle-income countries were receiving it (54%): the glass is just over half full. But accessibility to ART is only the start of the so-called treatment cascade, where individuals with HIV and country programmes have to be prepared for the reality of first-line treatment failure and the commitment to switch therapy, and to adhere to it. An Article by Mark Boyd and colleagues offers a welcome new therapeutic option after first-line treatment failure.

HIV prevention efforts remain key, yet a vaccine remains frustratingly elusive, with the failure of the latest trial, HVTN-505, announced in April. However, a new scientific movement is emerging, illustrated by a 2 day symposium attached to IAS 2013 that will discuss new approaches in basic science under an arresting banner: towards an HIV cure. A Review by Rafick Sekaly outlines the molecular barriers that currently stand in the way of this goal, and sets out future strategies for ultimately conquering the virus, including the initiation of ART at higher CD4 cell counts, and gene therapy. But as Sharon Lewin rightly articulates in a Comment, expectations must not run away from reality. Although the ultimate goal must be a world free of HIV for all people, rich or poor, our efforts of the past three decades must be sustained to prevent and treat a disease for which a cure, tantalising though that sounds, almost certainly remains years away.

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)61226-X/fulltext?elsca1=ETOC-LANCET&elsca2=email&elsca3=E24A35F](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61226-X/fulltext?elsca1=ETOC-LANCET&elsca2=email&elsca3=E24A35F)