FROM THE EDITOR

This issue of the Journal continues discussions started in the December 2011 issue. Professor Kuhn responds to the concerns raised by Salojee about the national policy promoting breastfeeding in HIV-exposed infants; she discusses the scientific rationale for the policy revisions, and presents a population perspective rooted in overall child morbidity and mortality. For better or worse, infant feeding is likely to remain an important topic for years to come. Both viewpoints need careful consideration, and subsequent discussions in these pages hopefully can be informed by experiences from implementing the new infant feeding policies in different settings around the country.

Another matter is low-dose stavudine in HIV management. In the last Journal, Innes *et al*. presented a rationale for a trial investigating low-dose stavudine's impact on therapeutic and toxicity endpoints. Given increasingly scarce resources for ART in much of sub-Saharan Africa, this proposal has intuitive appeal. We now publish a strong response by Andrieux-Meyer *et al*., who argue that further research into stavudine's use is untenable – with a clear rebuttal from Venter *et al*. There are important nuances – the use of stavudine in adults v. children; follow-up duration of a trial investigating long-term outcomes; and the changing costs of tenofovir and other more expensive medications – that evade oversimplified judgments.

More generally, these two ongoing debates raise important questions about what we know and how well we know it. Although we aim to practice 'evidence-based medicine', the evidence base for many policies and decisions may be surprisingly thin and malleable. The same body of evidence can lead to opposing interpretations, as seen in the debates on infant feeding and low-dose stavudine. The challenge and talent of skilled clinicians and good policymakers is to make sensible decisions in the face of flawed evidence. Fundamental to this is perceiving the likelihood of misjudging – and in turn the ability to acknowledge opposing viewpoints and the importance of continually trying to improve the evidence base on which our decisions are based. These challenges re-emerge constantly, and again in this issue of the Journal. They have been entwined in the theory and practice of medicine for millennia, as recorded in one of Hippocrates' aphorisms on the art of medicine, from around 400 BC: 'Life is short; the art is long; opportunity fleeting; experiment fallible; judgment difficult.'

The Journal presents other exciting pieces, including an important critique on the role of efavirenz in pregnancy from Pillay and Black, where clinical judgment has greatly outpaced policymaking. Johnson presents a model-based analysis of ART initiation across the country, and suggests that the scope of the ART roll-out approaches the targets set by the NSP for 2007 - 2011. This is a major accomplishment that underscores the ability of the public health system to achieve ambitious goals, given adequate capacity and resources. In addition, an opinion piece by Kenyon and colleagues calls into question the widely held belief that poverty alone drives the sexual transmission of HIV across South Africa (a contentious assertion that may give rise to more debate), and Katusiime presents an interesting case study on chronic genital ulcer disease in the context of HIV infection.

Good reading!

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MESSAGE FROM THE EXECUTIVE

The first Southern African HIV Clinicians Society meeting that I attended was in or around 2002, at the Pharmaceutical Society in Glenhove Road. Professor Gary Maartens spoke on isoniazid preventive therapy, and the room was full (it was the last meeting in that too-small venue). The initial function of the Society was to help a group of private doctors to better manage HIV infections.

In the dark years, it seemed unlikely that ART would ever be affordable and available in either the public or private sectors. I was working in a public service clinic, and all we could do was treatment and prevention of opportunistic infections. ART was for a select few with money or taking part in research trials. Then, on 1 April 2004, the first patients accessed therapy from the government programme. For months after that, I went and opened the pharmacy cupboards – just to look at the medicines. The atmosphere at the clinic changed; while people arrived very ill, many got better. Informal support groups formed. I remember celebrating the first 1 000 patients on treatment at our clinic. Today, over 15 000 people receive treatment there.

South Africa now has the largest ART programme in the world, with some 1.5 million on treatment. The DoH, under the leadership of Dr Aaron Motsoaledi, commenced the largest-ever HIV testing campaign last year, and over 15 million South African were tested for HIV. There has been a reduction in mother-to-child transmission to 3.5%.

So do we have it all sorted out, and is there no need for a Southern African HIV Clinicians Society? What are the present challenges? What role will I play as President? I have always seen the function of the Society as pushing the boundaries and leading the way in getting the best possible care to HIV-infected South Africans. We must ensure that our guidelines for all aspects of HIV care and prevention are challenged and aligned with international guidelines. Research in South Africa is of the highest standard. Our researchers have been involved in many of the latest breakthroughs in HIV, including early treatment for infants (CHER), the use of treatment as prevention (HPTN052) and microbiocides (CAPRISA 004). As soon as any research breakthroughs are made, we in the Society need to assist the DoH to implement them. And TB must receive more attention. South Africa's TB incidence is high – second only to Swaziland's – and we rank fourth-highest in the world in multidrug-resistant TB incidence. This huge increase in TB has been driven largely by HIV infection. It seems a great pity to have made such massive progress in HIV treatment, and then lose our people to TB.

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