

Although this situation reflects in part a broader mistrust of official pronouncements, and has been fuelled by media campaigning, it is founded on the misinformed perception that there is ongoing scientific uncertainty. There is now unequivocal evidence that MMR is not a risk factor for autism—this statement is not spin or medical conspiracy, but reflects an unprecedented volume of medical study on a worldwide basis. By any rational standards of risk/benefit calculation, it is an illogical and potentially dangerous mistake for parents to be prepared to take their children in a car on the motorway or in an aeroplane on holiday, but not to protect them with the MMR vaccine. An unprotected child is not only at personal danger, but represents a potential hazard to others, including unborn children. Unless vaccine uptake improves rapidly, major measles epidemics are likely in the UK this winter.²

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- 3 Wakefield AJ, Murch SH, Anthony A, et al. Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children. *Lancet* 1998; **351**: 637–41.
- 4 Horvath K, Perman JA. Autistic disorder and gastrointestinal disease. *Curr Opin Pediatr* 2002; **14**: 583–87.
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Antiretroviral therapy: challenges and options in South Africa

Sir—As highlighted in your Aug 16 Editorial,¹ the momentous decision of the South African government to make antiretroviral therapy available in the public sector is a defining moment in the country's response to the challenges posed by the HIV-1/AIDS epidemic.

The Ministry of Health has now been tasked with drawing up a plan on how to introduce antiretroviral treatment into the public-health system. However, if the ministry adopts the standard medical treatment

models of AIDS care, the plan will not have the desired effect on HIV-1/AIDS in South Africa. Increasing morbidity and high HIV-1 incidence demand an approach that addresses both treatment and prevention in an integrated manner.

Substantial resources and effort have been put into the prevention of HIV-1 infection in South Africa. However, HIV-1 incidence remains unacceptably high and the burden of sexually transmitted infections has not abated.² Stigma and discrimination are some of the key reasons for the failure of prevention programmes, since they form a major barrier to accessing HIV-1 prevention, care, and support services. Despite the widespread availability of HIV-1 voluntary counselling and testing (VCT) services, less than 10% of HIV-1-infected people are estimated to be aware of their HIV-1 status, and less than 1% know their CD4 count. People living with HIV-1 and AIDS are afraid to speak openly about their HIV-1 status. Fear, in turn, perpetuates secrecy and denial of personal risk as well as the presence and scale of the HIV-1 epidemic. Not only does denial affect prevention, it also presents a major challenge to the provision of antiretroviral therapy.

Transforming AIDS into a treatable disease has the potential to change community perceptions of people living with AIDS. The individual patient paradigm that currently exists is inadequate as a modality for treating AIDS. Instead, a public-health model that integrates prevention and AIDS care is required.

South Africa is reaching the plateau of its HIV-1 epidemic curve—ie, prevalence is static because incidence is currently similar to mortality. The introduction of antiretroviral therapy without concomitant improvements in prevention is likely to lead to an upward turn in the epidemic curve since new infections will continue to increase while deaths decrease. Treatment must therefore be accompanied by improved prevention so that AIDS deaths and new HIV-1 infections both decrease.

VCT is central to both prevention and treatment. The availability of antiretroviral drugs could be a catalyst to encourage the widespread uptake of VCT as a mechanism to counter stigma and discrimination. Linking community outreach for VCT with programmes providing AIDS treatment and antiretroviral drugs for the prevention of mother-to-child transmission is one practical manifestation of the proposed

approach. Further, linking promotion of condoms and identification and treatment of sexually transmitted diseases to AIDS treatment and VCT programmes could reduce the number of high-risk discordant sexual acts by involving both HIV-1 negative and HIV-1 positive individuals in HIV-1 prevention.

The increasing availability of antiretroviral therapy through resources from, among others, the Global Fund against AIDS, Tuberculosis and Malaria is a major step forward in the global effort against AIDS. The provision of antiretroviral therapy will save lives and relieve the widespread suffering due to AIDS—it can also serve as an impetus for overcoming stigma and improving prevention through a public-health model for integration of AIDS treatment and prevention.

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Depression as risk factor for mortality after coronary artery bypass surgery

Sir—James Blumenthal and colleagues (Aug 23, p 604)¹ report that depression is an independent predictor of death after coronary artery bypass graft. However, where are the data from the patients' autopsies?

10% of non-depressed patients died during the follow-up, compared with 19% of depressed patients. But what is the cause of this significant excess mortality? I looked in vain for any autopsy results or clinical data to answer this question.

Blumenthal and colleagues hint that “cardiac events” may be responsible, and in the discussion they refer to variables that affect depression which could also affect coronary perfusion. The Kaplan-Meier survival curves indicate that variation in operator performance was not relevant in the