population level and will also allow estimates of both acquired and transmitted resistance.

Without an effective HIV vaccine, and the stringent treatment outcomes needed for a treatment as prevention-only intervention to be successful, contextualised and targeted combination intervention that includes pre-exposure prophylaxis, circumcision and behavioural change will be needed to bend the epidemic curve. This requires political commitment.

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HCV and HIV: shared challenges, shared solutions

Hepatitis C virus (HCV) and HIV are both major causes of death in many parts of the world. They share common routes of transmission, and so are expected to co-infect the same individuals. When they do, they can exacerbate the clinical effects of one another. In particular, liver fibrosis associated with HCV progresses more rapidly in individuals with HIV, even if they receive effective HIV treatment. When treatment for HCV was primarily with interferon, HCV treatment in HIV-positive patients was much more challenging, with poorer cure rates and greater toxic effects than in those who were not infected with HIV.

In their Article, Lucy Platt and colleagues present the first attempt to quantify the global prevalence of HIV-HCV co-infection, estimating 2·3 million HIV-positive individuals to have been infected with HCV. Eastern Europe and central Asia contribute more to this total than any other region owing to a higher concentration of people who inject drugs (PWID), a highly efficient mode of transmission for both viruses.

These insights are very helpful, but there are several points to note. Firstly, the confidence intervals of the estimates are wide. This in part reflects the paucity of high quality data from population studies (note the large grey areas on figure 2) and the strategy adopted by the authors to exclude some data (to reduce biases from low specificity serological assays).

Secondly, the estimates focus on the presence of antibodies to HCV. Studies from high burden HIV populations suggest that perhaps only half of patients with HCV antibodies have detectable virus and would thus be in need of HCV treatment. Such studies are too few to extrapolate widely, but as we turn from description to action, accurate estimates of those needing treatment become more important.
Finally, although these estimates of prevalence are very helpful in drawing attention to geographical areas and risk groups with high prevalence, further data and analysis are now needed to establish the extent of morbidity and mortality that can be attributed to HIV–HCV and how that might differ between populations.

The estimates from Platt and colleagues help to place HIV–HCV co-infection in the context of the wider challenge of HCV. The co-infected population is a small proportion of those infected with HCV worldwide, probably less than 5% (estimates of HCV prevalence vary), although potentially a greater proportion of individuals with HCV-attributable morbidity and mortality. However, targeting the HIV–HCV co-infected population could be an initial way to begin the scale-up of wider scale-up of HCV treatment.

The scale-up of HIV treatment (and in some places, programmes offering services for PWID) means that many HIV–HCV co-infected individuals in need of HCV treatment will be known to health programmes. Furthermore, many patients will be receiving ART and will have shown their ability to adhere to treatment.

Programmes have many other calls on their resources, but it should be their ambition to diagnose and eliminate HCV from their HIV cohorts. The instruments, with perhaps the exception of appropriate molecular diagnostics, are there to do it if prices for treatment can reach affordable levels. As well as being highly effective with cure rates of more than 90%, new interferon-free treatments are almost as effective in patients with HIV and relatively easy to give with ART. Major international agencies have shown willing to support programmes in co-infection and, in addition to using the infrastructure of HIV programmes to treat HIV–HCV co-infected individuals, the global community needs to leverage and emulate the wider success of the AIDS response to ensure greater access to HCV treatment for all.

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Forgotten but not gone: HIV-associated cryptococcal meningitis

The introduction of effective antiretroviral therapy (ART) in the late 1990s led to a marked decline in the incidence of HIV-associated cryptococcal meningitis in high-income countries. The perception among many in the HIV research community was that cryptococcal meningitis had ceased to be a public health concern, and for almost 15 years after the landmark study by van der Horst and colleagues, no large clinical endpoint trials of cryptococcal meningitis treatments were reported.

But, as Joshua Rhein and colleagues highlight in The Lancet Infectious Diseases, cryptococcal meningitis has far from disappeared in Africa. The high ongoing burden of HIV, coupled with overstretched health-care...