FROM THE EDITOR

COMBINATION COUNSELLING

One wonders how much influence the Iraqi war and planned re-building of that country will have on deflecting and redirecting international focus and funding away from the war against HIV/AIDS in sub-Saharan Africa. We have already seen the impact the war has had on the travel plans of scientists from the developed world (the United Kingdom and the United States of America). As Gerald Friedland said at the recent Boston Retrovirus Conference, 'perhaps more progress would be made if HIV were declared a weapon of mass destruction'.

Highlights of the Boston Conference included impressive presentations on antiretroviral therapy in resource-poor settings, covered in more detail in an article in this issue. At last, feasible, punitive obstacles such as adherence issues were shown not to be the bogeymen that we have all been led to believe. Patients in southern Africa are as adherent as anywhere else in the world.

Good but careful attention to counselling to obtain commitment to lifelong treatment is required and ongoing counselling regarding other associated issues is essential. In other words, the message here is for doctors not simply to write scripts but to counsel patients on side-effects and toxicities (short- and long-term), because once patients understand these issues they are more than willing to commit to lifelong therapy.

We are constantly told that directly observed therapy (DOTS) for tuberculosis treatment has not been a huge success in the developing world. But, once again, we believe that not enough attention is given to counselling around the tuberculosis treatment issue. It simply is no good just to give patients the drugs and leave them to their own devices. So the new catchword is not combination treatment so much as combination counselling. That combination is: time, effort, and culturally appropriate counselling.

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