the poverty line because they fall ill, use health services, and pay out of pocket. Many have to sell assets or go into debt to meet the payments. The paradox is that the lack of access to health services impoverishes some people because they are unable to work, whereas using health services impoverishes others because they cannot afford the payments. This situation makes the links between health, sustainable development, and economic growth starkly clear.

A prerequisite, therefore, of sustainable development must be to help countries move closer to universal health coverage. Health financing reforms are crucial and countries as diverse as Gabon, Rwanda, Thailand, and Mexico offer useful lessons. These reforms must be accompanied by measures to ensure that the health services people need are available and of good quality; that the health workers needed to deliver them are well trained, motivated, and close to people; and that the drugs and equipment they need are available and distributed appropriately.

More broadly, universal coverage requires multi-sectoral collaboration. Engagement with ministries and institutions dealing with fiscal and monetary policy and education, among others, is essential to ensure sufficient funding for health, raised in ways that minimise financial barriers, and to allow the appropriate types of health workers to be trained. Collaboration with ministries of labour and social security to ensure that social protection becomes universal and not limited to the formal sector is a requirement of the UN’s Social Protection Floor Initiative. Strong political leadership and commitment is important to make such collaboration work.

The Rio+20 conference recognised that universal health coverage has the potential to increase economic growth, improve educational opportunities, reduce impoverishment and inequalities, and foster social cohesion. Debates about post-Millennium Development Goal targets are now beginning with country and thematic consultations, a UN Task Team, and a post-2015 high-level panel established by the UN Secretary General. Formal UN discussions will begin in 2013. Universal health coverage and its contribution to sustainable development must be recognised and incorporated into post-2015 development goals and targets, to support all countries to move rapidly towards it and to maintain the gains that many have already made.

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One key aspect of this effort is the transfer of tasks previously thought to be the domain of doctors to others. At least two published randomised controlled trials have suggested that nurses can effectively continue prescription of ART after its initiation by doctors. In The Lancet, Lara Fairall and colleagues present a cluster-randomised trial done in the Free State province of South Africa that tested task shifting...
of ART prescribing from doctors to primary care nurses (the Streamlining Tasks and Roles to Expand Treatment and Care for HIV [STRETCH] programme). All 31 clinics participating in a Free State ART programme at the time the study was initiated were included. Care in clinics assigned to the STRETCH intervention—made up of educational and organisational components—differed from that in control clinics in several ways.

The investigators enrolled two cohorts of patients to establish the effects of the intervention when patients became eligible for ART (cohort 1), and for those already on long-term treatment (cohort 2). 9252 ART-naive adults in cohort 1 were followed up for 12 months or longer. The recommended CD4 count threshold for ART initiation in South Africa at the time was less than 200 cells per μL. The primary outcome was time from enrolment to death and was designed to assess the superiority of the intervention. The aim was to establish whether nurse-led initiation of ART could improve the high mortality rate associated with the standard of care at the time—29% of patients enrolled in the province’s programme between 2004 and 2007 were dead within a year.8 Cohort 2 included 6231 adults who had been receiving ART for 6 months or longer. The primary outcome was the proportion of participants with a viral load of less than 400 copies per mL after 12 months. The second cohort allowed researchers to test the hypothesis that nurse-led ART prescription would be equivalent (<6% difference) to that achieved by doctors. The enrolment of many participants in both cohorts conferred sufficient power to test the hypotheses robustly.

The good news is that, despite several unanticipated difficulties encountered during the study, viral suppression after 1 year in cohort 2 did not differ between groups (risk difference 1·1%, 95% CI –2·4 to 4·6), showing that nurse-led continuation of already established ART prescribing is equivalent to that led by doctors. However, the mortality outcome was disappointing. The anticipated improvement in the intervention group in cohort 1 did not occur—997 (20%) of 4943 participants analysed in intervention clinics died versus 747 (19%) of 3862 in control clinics (hazard ratio [HR] 0·94, 95% CI 0·76–1·15). Nevertheless, the mortality rates in both groups represent a substantial improvement on previous estimates.

A preplanned subanalysis of cohort 1 showed that patients in intervention clinics with CD4 counts of 201–350 cells per μL had a lower risk of death than did those in control clinics (adjusted HR 0·70, 95% CI 0·52–0·95; p for interaction=0·020). Although this finding is not unequivocal and should be interpreted with caution, it might show that ART was initiated earlier in intervention than in control clinics. It is now widely accepted that initiation of ART is indicated at a CD4 threshold of 350 cells per μL;9,10 the CIPRA-HT 001 trial11 prompted WHO to raise the recommended threshold for ART initiation in low-income and middle-income countries to this value.4 Evidence gathered from elsewhere in South Africa consistently supports this new threshold.12 Whether an even higher ART initiation threshold is warranted is contested;13–16 this notion is the subject of a clinical endpoint in an in-progress trial (START; NCT00867048). If South Africa and other countries of low and middle income can expand ART services rapidly and consistently enough to treat people with HIV or AIDS earlier than they do now, we should expect to see mortality decline. However, the scarcity of trained personnel to prescribe ART could be a barrier to broadening of service delivery. Nurses are more plentiful than are doctors, and STRETCH suggests that they can effectively prescribe ART when adequately trained and supported.

Whether these findings from South Africa could translate to other countries of low and middle income in sub-Saharan Africa and elsewhere will be debated. Although task-shifting management of ART to nurses could work in the fairly good-quality health service infrastructure in South Africa, it might not elsewhere. However, STRETCH has established that,
Victimisation of children with disabilities

Researchers have long acknowledged the seemingly increased rates of abuse and maltreatment in individuals with disabilities.1-3 However, only recently have data from methodologically rigorous meta-analyses and systematic reviews provided empirical proof of consistently raised rates of maltreatment specifically in adults4,5 and children6 with disabilities, and high rates of lifetime victimisation.2 Lisa Jones and colleagues’ meta-analysis of violence against children with disabilities8 in The Lancet contributes greatly to the scientific knowledge about this group. The authors report pooled estimates of the prevalence of violence against children with disabilities of 26.7% (95% CI 13·8–42·1), with estimates for physical violence and sexual violence of 20·4% (13·4–28·5) and 13·7% (9·2–18·9), respectively.

The investigators present a comprehensive cross-section of reports from the literature and provide information about both the quality and characteristics of the included studies. This information allows readers to form a more complete picture of the present state of the science in this specialty. Of note, the investigators report that many studies included in their meta-analysis did not provide adequate information about the demographics of the sample of children with disabilities, the control group without disabilities, or both. Inadequate demographic information can hamper the synthesis and generalisation of the results and might restrict the applicability of results in clinical settings. Thus, future studies need to contain an adequate description of study participants; this is especially important because of the heterogeneity of the disability community and the need to acknowledge and control for potential confounders in analysis and interpretation. Other methodological issues noted by Jones and colleagues, such as the almost universal failure to include confidence intervals in studies in which prevalence was assessed, should not be perpetuated in future studies.