Urinalysis and estimated glomerular filtration calculated with the serum creatinine rate is the most cost-effective way to identify these two entities. Dipstick urinalysis also identifies microalbuminuria effectively, because the test is sensitive enough to detect urinary protein equivalent to microalbuminuria. Prevalences of microalbuminuria and macroalbuminuria were 64% and 7%, respectively, in patients with 1+ proteinuria in a Japanese study. Screening for chronic kidney disease is the best method because such screening also targets high-risk patients with diabetes, hypertension, and family history of chronic kidney disease.

Awareness of chronic kidney disease is generally low among patients in Asia—3.5% and 7.9% in patients in Taiwan and China, respectively. Wen and colleagues emphasise that prevalence is high and awareness especially low among the least educated people. Furthermore, the number of nephrologists is very low in some Asian countries (eg, Cambodia and Laos have none, Burma ten, Indonesia 43, China 4000, and Japan 2976). The first step in reducing the rate of progression of chronic kidney disease and comorbidity is to increase awareness. “Know your GFR and check your urine”, a modified slogan of the World Kidney Day for Asia, must be spread throughout Asia. International collaboration among Asian countries is needed to address the emerging ageing society in the next 10 years, including the increase in kidney diseases. The Asian forum of chronic kidney disease initiatives, implemented in 2007 by Asian nephrologists, has begun important action to suppress chronic kidney disease in the region.

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We declare that we have no conflict of interest.

3. Zhang L, Zang PH, Wang F, et al. Prevalence of factors associated with HIV viral load and transmission, or potential reductions in the potential biases of using data from voluntary counselling and testing to derive estimates for the general population, because people seeking such services might be more likely to be ill and to adhere to prevention recommendations. Additionally, their estimates of transmission risk-reduction after couples seek voluntary counselling and testing are drawn from studies done several years ago, and do not include potential benefits of antiretroviral therapy on HIV viral load and transmission, or potential reductions in acquisition associated with male circumcision (an

Universal HIV testing and counselling in Africa

In today's *Lancet*, Kristin Dunkle and colleagues present a mathematical model of the expected proportion of new heterosexually transmitted HIV infections in urban Zambia and Rwanda that are acquired during marriage or cohabitation. Their model, which uses existing data from voluntary counselling and testing and population-based surveys for HIV, consistently estimates that most new HIV infections occur within marriage or cohabitation. They conclude that HIV-prevention efforts should expand beyond individuals to target couples.

Dunkle and colleagues’ study is a creative secondary analysis of existing data and elucidates some strengths of nationally representative population-based HIV surveys. However, they might not have fully addressed the potential biases of using data from voluntary counselling and testing to derive estimates for the general population, because people seeking such services might be more likely to be ill and to adhere to prevention recommendations. Additionally, their estimates of transmission risk-reduction after couples seek voluntary counselling and testing are drawn from studies done several years ago, and do not include potential benefits of antiretroviral therapy on HIV viral load and transmission, or potential reductions in acquisition associated with male circumcision (an
intervention that is associated with a 60% reduction of HIV acquisition in men). Both factors could potentially avert millions of new HIV infections in HIV-discordant partnerships. These interventions might have particular relevance for prevention within cohabitating HIV-discordant partnerships, which could have higher frequency of exposure and lower use of condoms than non-cohabitating partnerships. Thus the effect that a comprehensive prevention package can have on couples could be even higher than that estimated by Dunkle and colleagues.

More than 20 years into the epidemic, it is striking that nearly 80% of HIV-infected adults in sub-Saharan Africa are unaware of their HIV status and more than 90% are unaware of their partners’ status. Nationally representative data from east Africa suggests that 40–50% of married HIV-infected individuals have an HIV-uninfected spouse, and most do not know their own or their partner’s status and do not understand that HIV discordance can exist within couples. Because most HIV-infected people are not diagnosed, they do not benefit from HIV care and treatment, circumcision of male partners who are not infected, condom use, or other interventions with proven efficacy for reducing HIV transmission risk. Despite this low level of testing, less than 10% of projected prevention programmes and funding are directed towards HIV testing, and testing for couples is not highlighted in planning documents.

Scaling up of testing for couples will need an expansion from current individually focused programmatic efforts to couple-based and population-based approaches. Testing of partners has been effectively incorporated into provider-initiated testing in clinical settings and into care and treatment programmes. Home-based and door-to-door counselling and testing approaches have been associated with high participation rates, a high proportion of married or cohabitating individuals testing as couples, and positive social outcomes for men and women. Dunkle and colleagues’ findings show the potential effect of couples who seek voluntary counselling and testing in east Africa, where peak HIV prevalence is in those older than 30 years of age and most adults are married. In southern Africa, where many partnerships are non-cohabitating, additional strategies will be needed, including standardisation of clear counselling messages on HIV discordance for those testing as individuals.

The printed journal includes an image merely for illustration

In Kenya, where nearly 500,000 untested HIV-uninfected people live with an HIV-infected partner, a multipronged strategy to expand HIV testing, which includes provider-initiated home-based and clinic-based testing with an emphasis on couples, has been adopted to help unmask discordance within couples and to reduce risk interventions for non-cohabitating couples and for those with concordant HIV status. Guidelines and training for couples who seek voluntary counselling and testing have been developed, emphasising that testing should be voluntary, involve mutual disclosure, and include counsellor support to minimise negative social consequences. Such voluntary counselling and testing can alleviate potential disclosure challenges and provide HIV-discordant couples with counselling support to understand discordance and develop plans for risk reduction.

The findings by Dunkle and colleagues are an urgent call to governments and programmes for HIV prevention, care, and treatment throughout the continent to truly scale up HIV testing with an emphasis on couples and a goal of universal coverage. Definition, standardisation, and implementation of a complete package for efficacious couple-based interventions for all types of couples for HIV prevention and care, including antiretroviral therapy and circumcision, will further decrease HIV transmission within the largest population group at risk in sub-Saharan Africa.
Oral substitution treatments for opioid dependence

Illicit opioid dependence, once largely a problem in developed countries, has become an increasingly important public-health concern over the past few decades in countries such as China, India, Indonesia, Iran, Malaysia, Pakistan, and Russia.1 In 2003, its health effects were estimated to account for 0.7% of global disease burden.1,2

Many developing countries have prohibited the use of pharmacological treatments for opioid dependence that are used in developed countries (and in WHO’s Model List of Essential Medicines)—ie, oral agonist maintenance treatment with methadone and buprenorphine.3 The preferred forms of so-called treatment in these countries have often been imprisonment, enforced opioid withdrawal, and a coerced form of drug-free rehabilitation in prison-like settings. The ineffectiveness of detoxification as a treatment in itself4 and the probable ineffectiveness of coerced drug-free treatment have prompted some countries to use the opioid antagonist naltrexone in oral form for relapse prevention after enforced detoxification. This method has been used despite no evidence from randomised trials that oral naltrexone is better than placebo5 and an increased risk of overdose when patients on oral naltrexone relapse to opioid use, as most do.6

The use of oral naltrexone is often an indicator of moral disapproval of substitution treatments with opioid agonists because they stabilise addicts rather than attempt to produce abstinence.7 This disapproval might be justified by concerns about the risks of diversion of methadone and buprenorphine to the...