

to the desert, where some die of thirst; and with Libya, the gift of coast guard boats to intercept inflatable dinghies whose passengers are then incarcerated. On the Balkans route (taken mostly by Afghan, Iranian, and Syrian people, who travel from Türkiye to Italy via southern Europe), Greece and Croatia, which the President of the European Commission has described as the shields of the continent,¹² have special forces that arrest migrants and refugees, beat them, dispossess them of their goods, submit them to forced undressing and other humiliations, before illegally pushing them back across the border.¹³ Despite being documented by official institutions, these practices are denied by the governments and ignored by the EU.¹⁴ Mistreatment of displaced people by police, military, and border forces of other countries has also been documented, such as in Calais, France.¹⁵ Externalisation and normalisation of violence, with both physical and mental health consequences, thus characterise the border regime. While non-governmental organisations such as Alarm Phone, SOS Méditerranée, Médecins Sans Frontières, Médecins du Monde, and others combat these issues, public health actions should also address them. It is indeed its role.

In the same way that structural violence affecting socioeconomically disadvantaged people has long been recognised as relevant to public health,¹⁶ so should be border violence affecting displaced people.

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Integrating HIV, hypertension, and diabetes primary care in Africa



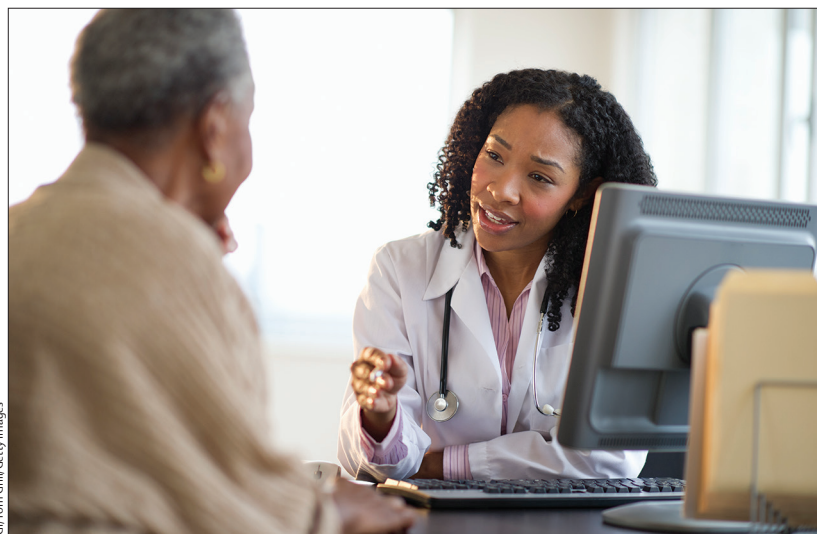
Hypertension and diabetes are to 2023 what HIV was to 2003—a global health crisis causing countless premature deaths and stunting global economic development with an epicentre in sub-Saharan Africa.

There is good news: in the past two decades, astounding progress has been made in averting HIV-related deaths globally. Proving wrong the pessimists who believed that HIV treatment would never be possible in Africa, we learned that the real problems were the

unreasonably high cost of antiretroviral therapy and the low standard of care in primary care health systems.¹ National governments partnered with global donors to build excellent, equitable HIV primary care systems where antiretroviral therapy is provided free of cost. The world set ambitious goals for HIV diagnosis (90% diagnosed), antiretroviral treatment (90% on treatment), and HIV viral load suppression (90% suppressed). Tremendous progress has been made towards those goals, particularly

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For the 90–90–90 goals see <https://www.unaids.org/en/resources/909090>



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in Africa, with approximately 25 million premature deaths averted.²

However, a dramatic wave of non-communicable diseases (NCDs) in Africa threatens to reverse the health gains made by combating HIV. According to WHO global health estimates, NCDs accounted for 17 million premature deaths in 2019, and 86% of these premature deaths occurred in lower-income countries. NCDs are projected to be the most common cause of premature death in Africa by 2030.³ Once again, the problem in Africa appears to be related to primary care health systems, which are currently much weaker for NCDs than for HIV,⁴ resulting in disturbingly low rates of diagnosis, treatment, and control for NCDs.⁵ Once again, pessimists believe that NCD care will be too complicated and too costly.

The obvious questions are what can be learned from the highly successful HIV programmes in Africa to address the growing problem of NCDs, and can we build on existing HIV infrastructure to address NCDs without compromising HIV programmes? These questions have been reverberating but, until now, we did not have the clinical trial evidence to answer them.^{6,7}

In *The Lancet*, Sokoine Kivuyo and colleagues report the results of INTE-AFRICA,⁸ a pragmatic cluster randomised trial of integrated management of HIV, diabetes, and hypertension. 32 primary care clinics in Tanzania and Uganda were randomly allocated to provide either integrated care or an enhanced standard vertical care. In the integrated care group,

patients with HIV, diabetes, or hypertension were managed in a single clinic, and all participants shared the same waiting area, health-care workers, pharmacy, and a single medical records system. In the standard care group these services were delivered in separate clinics, which is the norm in most of sub-Saharan Africa. The coprimary trial outcomes were retention in care for participants with diabetes or hypertension (tested for superiority) and plasma viral load suppression for those with HIV (defined as a plasma viral load of <1000 copies per mL; tested for non-inferiority). The trial enrolled 7028 adult patients between June 30, 2020, and April 1, 2021. The mean age was 51·8 years, 72·9% were female and 27·1% were male.

Retention in NCD care did not differ by trial group but retention rates were remarkably high in both groups, with 1254 (89·0%) of 1409 in the integrated care group versus 1457 (89·8%) of 1623 in the control group. These rates of retention are much higher than previous reports from sub-Saharan Africa, where retention of care in hypertension and diabetes clinics rarely exceeds 50%.^{9,10} The authors make a persuasive argument that the higher-than-expected rates of retention are probably due the enhancement of both groups with strategies usually only deployed in HIV clinics.⁸ These strategies included active tracing of lost patients, stakeholder engagement, and greater involvement of pharmacies in patient care. Of course, systematic enrolment bias of participants who were more likely to be retained could not be excluded. Regardless, a major strength of this trial is that it represents a coordinated action by policy makers, researchers, and implementers that in all probability improved care for NCDs in both groups, and which should become a model for the future.⁶

Integration of care did not interfere with HIV treatment. Viral load suppression in the integrated group was non-inferior to viral load suppression in the usual care group after 1 year (1412 [97·0%] of 1456 vs 1451 [97·3%] of 1491 respectively), with a $p_{\text{non-inferiority}} < 0·0001$.

With regards to cost, the authors report that the average monthly provider cost per participant was lower in the integrated care group for participants with multiple conditions. Savings were primarily driven by reduced staff and overhead costs, associated with a reduced number of total visits for patients with

multimorbidity. This result is timely, as multimorbidity is an increasingly common challenge to clinical care.^{6,11} Further work is needed to determine the best way to ensure a constant supply of low-cost or free medications for NCDs, a major problem that was not addressed by this trial.

Many political questions remain. These results arrive at time when funding for HIV programmes in Africa is under threat.¹² Even if funding continues, it seems unlikely that current funding will expand to address the problem of NCDs. National governments in Africa need to define the best policies and funding mechanisms for integrating HIV care in their own countries, and particularly for the upfront investments that will be required for renovating clinic space, staff training, and medical record systems.

In conclusion, this landmark trial demonstrates that integration of services for NCDs into existing HIV primary care clinics has the potential to achieve excellent NCD outcomes without compromising HIV care, and could save both money and time for people living with multimorbidity. The status quo is no longer an option. Integration of NCD and HIV primary care provides us with a new standard of care through which governments and funding agencies can catalyse the next transformation in global health.

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PATHFINDER: another step on the uncharted path to multicancer screening



Following the publication of the SYMPLIFY study,¹ and in parallel to other multicancer early detection (MCED) studies, such as the NHS-Galleri randomised controlled trial,² Deborah Schrag and colleagues report in *The Lancet* the findings from PATHFINDER, a prospective cohort study.³

PATHFINDER investigated the feasibility of cancer screening with MCED testing, using next-generation sequencing of cell-free DNA in peripheral blood, with a focus on diagnostic investigations in participants who tested positive for a cancer signal. The study enrolled

6662 individuals aged 50 years or older. Among the 6621 participants with analysable results, 4204 (63.5%) were female, 2417 (36.5%) were male, 6071 (91.7%) were White, and most were highly educated. 3681 (56%) participants had additional risk factors such as smoking, germline cancer predisposition, or personal history of definitively treated cancer. The primary outcome was time to diagnosis and extent of testing.

A cancer signal from the MCED test was detected in 92 (1.4%) of 6621 participants, of whom 35 (38%) had cancer confirmed (true positives) and 57 (62%) did not

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