Van Schaik *et al.* reply: We agree that adequate and regular quality control of HIV test kits as well as adequate training in performing HIV tests are extremely important.

HIV tests performed at the mobile clinic, community clinic and hospital are all rapid HIV tests, performed outside a laboratory by nursing staff, and are subject to the same quality control issues.

Staff working on the mobile unit are all trained in the use of the rapid tests and our standard operating procedures. We have our own quality control programme and are part of an external quality assurance programme run by the National Health Laboratory Service (NHLS), where to date we have scored 100%. In addition we have an informal quality control method in that we see many known HIV-positive individuals who request re-testing. Any discrepant results are confirmed with laboratory HIV enzyme-linked immunosorbent assay (ELISA)/polymerase chain reaction (PCR).

HIV test kits are stored at temperatures of less than 30ºC in our offices and only enough for that day's testing are taken out on the mobile unit.

For our own quality control programme, samples from known positive and known negative individuals (confirmed by laboratory HIV ELISA testing) are run with each new batch and monthly thereafter. The control samples must give the intended response (i.e. positive or negative). The staff member who performed the quality control procedure records the results on the rapid HIV testing quality control log sheet, which then gets filed. Any control problems are immediately reported to the project manager and acted on.

Disaster preparedness – looking forward

To the Editor: I refer to the article 'Haiti: The South African perspective'[1] in the *SAMJ* of August 2010.

It is timeous that the authors have opened the debate on the South African medical rescue response to disasters, particularly at home and on our continent. The problems are succintly set out, real and need to be addressed meaningfully and rapidly. While the challenges are clear, the way forward as suggested in the article is less so. Given the less than organised, if praiseworthy, efforts of the two organisations mentioned in the article, it seems to be compounding the issue by suggesting that the future disaster response be placed under the auspices of the Emergency Medicine Society of South Africa (EMSSA) – another non-statutory body.

South Africa, as one of the most developed countries on the continent, will be expected internationally to respond meaningfully to natural and other disasters in Africa. To be able to do this will at least require government approval and resource support if there is to be a rapid and effective deployment of medical rescue assistance.

At the end of the day, most of the material and human resources required either belong to or work for one or other government department, provincial and national, including a large number of volunteers. In this particular context, I believe the National Department of Health in conjunction with those provinces that possess the requisite assets, which will include departments of emergency medicine, should take the lead. Together they successfully mobilised for the 2010 Soccer World Cup – surely an African disaster response is no less deserving of this kind of effort.

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1. Van Hoving DJ, Smith WP, Kramer EB, de Vries S, Docrat F, Wallis LA. Haiti: The South African perspective. S Afr Med J 2010;8:513-515.

Schistosomiasis – an endemic but neglected tropical disease in Limpopo

To the Editor: After malaria, schistosomiasis is the second most prevalent tropical infection, but is first among the neglected tropical diseases (NTDs).[1] Worldwide, an estimated 750 million people are at risk of schistosomiasis, and 200 million have the disease; 85% of the latter and all 20 million with severe disease are concentrated in Africa.[2,3]

We conducted a study that describes the pathology of biopsy diagnosed schistosomiasis, silent or symptomatic, in Limpopo Province to call attention on an NTD with potentially severe morbidity and mortality. This is especially important in view of the HIV/AIDS epidemic that poses a higher burden on women than men. Evidence is accumulating that female genital schistosomiasis (FGS) acts as a co-factor in the genesis of cervical pre-invasive and invasive lesions and/or as an entry point for the HI virus.

Over the period 2008-2009, all new cases of biopsy diagnosed schistosomiasis were prospectively recorded. The diagnosis was made in the presence of viable (embryonated) and/or non-viable (calcified) ova; *Schistosoma haematobium* in the presence of a terminal spike and *S. mansoni* if the spike was lateral.

The patients' age, gender, geographical origin, anatomical site and type of lesion, if any, were recorded. There were 266 females, and 45 males (F/M ratio 5.9/1). Table I illustrates the relative distribution by gender and affected organs. FGS accounted for 233 (87.6%) of the female cases; of the 127 cases involving the cervix, 29 (22.8%) were HIV-seropositive. Only 44 cases were asymptomatic, namely the incidentally found ova in bilateral tubal ligation (N=40) and prolapsed fibromyomas (N=4). In males, the appendix was the most common site – 30 (66.6%). The overall *S. haematobium* to *S. mansoni* ratio was 5.1/1. The ratio was 6.1/1 with urogenital pathology, and 3.2/1 with digestive tract pathology. These figures show an overlap of the two subtypes in urogenital and digestive lesions, and an overall predominance of *S. haematobium*. Of the cases of known geographical origin, 91% were from the northern and north-eastern parts of the province bordering Zimbabwe and Mozambique.

Failure in the supply of safe water sources and sanitation, and failure to control snail intermediate hosts, lead to the continued transmission of the infection.[2,4] Control interventions require economic progress, political will and stability, and adequate public health structures and programmes.[2] School-based health programmes

Table I. Relative distribution by affected organ and gender

Organ	Females (266)	Males (45)
Upper genital organs*	74	
Lower genital organs†	127	
Perineum	32	2
Bowel	16	30
Bladder	15	10
Varia	2	3

*Uterine body, adnexae.
†Cervix.