surveys can be exploited through the indirect link to the data from the first randomised survey.

Geostatistical analysis should recognise that disease prevalence varies continuously over both space and time. Fortunately, the geostatistical modelling framework readily assesses these aspects, albeit with a need for increased modelling choices to take into account spatial and temporal variations. Geostatistical modelling is a powerful tool, but study design still matters.

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Genesis of EDCTP2

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Dec 2, 2014, will mark a historic launch[1] in Cape Town, South Africa—under the auspices of the South African Department of Science and Technology—of the second European and Developing Countries Clinical Trials Partnership Programme (EDCTP2), which was recently approved by the European Union (EU).[2,3] At the launch, the role and strategic vision of the EDCTP2 programme will be shared, synergies with other worldwide initiatives for Africa explored, and successes of the previous EDCTP programme celebrated. Funding of around €1·4 billion for the next 10 years (2014–23) is available for the EDCTP2 programme.

EDCTP, based in The Hague, Netherlands—with the Africa office in Cape Town, South Africa—was established by the EU in 2003 in response to the worldwide health crisis caused by the three major poverty-related diseases—HIV/AIDS, tuberculosis, and malaria—and the EU's commitment to achieving the Millennium Development Goals. This initiative followed the Abuja Declaration,[4] in which African leaders outlined the urgent need to develop effective interventions to tackle the major poverty-related diseases. The first EDCTP programme was funded by a €200 million contribution from the EU, with matching funds from the European participating states. The initial setup of EDCTP was a partnership between 14 EU member states, Switzerland, Norway, and all sub-Saharan African countries.[5] The main focus of EDCTP was support of phase 2 and 3 randomised controlled trials of products that had potential to substantially advance the field of drugs, microbicides, diagnostics, and vaccines.[5,6] Parallel capacity development, including training, is central to the ethos of EDCTP. EDCTP is fundamentally different from other research funding models operating in Africa[6,7] because it is focused on creating equitable partnerships between developed and developing—and between developing—countries, with local ownership of demand-driven research on important health issues.[7] The initial advisory and governing bodies of EDCTP were the Developing Countries Coordinating Committee, consisting of a team of independent researchers from sub-Saharan Africa; the Partnership Board, an independent expert scientific panel; and the General Assembly, the ultimate decision making body of EDCTP, which consisted of all participating European states and four positions for African representation.

Despite a slow start, which generated pessimistic predictions,[8,9] EDCTP flourished and expanded, achieving substantial results.[10–15] From 2003 up to now, EDCTP has funded 254 projects: 54 for HIV/AIDS, 37 for tuberculosis, 13 for HIV and tuberculosis co-infections, 42 for malaria, 78 for regulatory and ethics frameworks, and 30 for crosscutting research topics and infrastructure for the conduct of clinical trials. Several hundred African researchers have received Master's degrees, PhDs, and postdoctoral fellowships from EDCTP. Of the 100 clinical trials funded for drugs, microbicides, diagnostics, and vaccines, there were 30 for HIV/AIDS, 27 for tuberculosis, nine for HIV and tuberculosis co-infection, and 34 for malaria.[16] More than 500 reports have been published and research data have been used by WHO and governments to develop new management and prevention guidelines. Substantial strengthening of the ethics and regulatory

For more on the **Pan African Clinical Trials Registry** see http://www.pactr.org/

framework capacity was achieved, including the creation of the Pan African Clinical Trials Registry (PACTR).

EDCTP2 has several novel features which provide further unique opportunities to sustain progress made so far, and enable further expansion of research, training, and capacity development networks across all African regions. Neglected diseases have been added to the existing portfolio of HIV/AIDS, tuberculosis, and malaria, and the remit has been expanded to other existing and emerging infectious diseases. All stages of clinical trials, from phase 1 to 4, and collaborative multicentre projects that combine clinical trials and capacity development, will now be eligible for funding. Closer collaboration with industry and other funding and development agencies will be strongly encouraged. As part of the preparatory process for EDCTP2, a series of thematic stakeholder meetings were held for HIV/AIDS, tuberculosis and other mycobacterial infections, malaria, neglected infectious diseases, ethics and regulatory affairs, and capacity building, to shape the organisation's future strategy and funding approach.

Importantly, EDCTP has changed its legal structure from a European Economic Interest Grouping to an association under Dutch law, enabling sub-Saharan African countries to become full members of EDCTP, in addition to all countries associated with Horizon 2020, the EU Framework Programme for Research and Innovation.This unique arrangement shows EDCTP's commitment to equal partnership built on joint ownership, leadership, and trust with mutual benefit. For EDCTP2, membership of the EDCTP Association includes 13 European countries (Austria, Denmark, Finland, France, Germany, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, and the UK) and 11 African countries (Cameroon, Congo, The Gambia, Ghana, Mozambique, Niger, Senegal, South Africa, Tanzania, Uganda, and Zambia). Other African and European countries are expected to join the EDCTP Association soon. All these participating states have voting rights in the EDCTP General Assembly. Under the EDCTP Association, the advisory structures have been streamlined with the establishment of the Strategic Advisory Committee, which provides both scientific and strategic advice to EDCTP, instead of the previous two separate EDCTP advisory structures, the Developing Countries Coordinating Committee and Partnership Board.

EDCTP2 represents a genuine partnership between developed and developing countries. The active involvement and contribution of African countries will ensure joint ownership of the EDCTP2 programme with European counterparts. This historic and unique advance for European–African partnerships will allow the momentum achieved over the past decade in the fight against infectious diseases to be enhanced with a multiplier effect, eventually leading to universal access to quality health care.

For more on **Horizon 2020** see http://ec.europa.eu/programmes/horizon2020/

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On this year's cover

The 2015 cover artist for The Lancet Infectious Diseases is Justin Gabbard, who replaces Darrel Rees. We thank Darrel for his thought-provoking covers throughout 2014. Justin is based in San Francisco, CA, USA. His work has been commissioned by a variety of publishers both in print and as animation. He illustrates regularly for The New York Times among others. When he is not busy teaching illustration at the California College of the Arts in San Francisco he enjoys spending time at his studio, which is a short bike ride away from the beach.

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Corrections

Brewer NT, Calo WA. HPV transmission in adolescent men who have sex with men. Lancet Infect Dis *2015;* ***15:*** *8–9*—The affiliations of this Comment should have been Department of Health Behavior (NTB) and Department of Health Policy and Management (WAC), Gillings School of Global Public Health, and Lineberger Comprehensive Cancer Center (NTB), University of North Carolina, Chapel Hill, NC 27599, USA. The online version has been corrected as of Dec 15, 2014, and the printed version is correct.

Omrani AS, Saad MM, Baig K, et al. Ribavirin and interferon alfa-2a for severe Middle East respiratory syndrome coronavirus infection: a retrospective cohort study. Lancet Infect Dis *2014; published online Sept 30. http://dx.doi.org/10.1016/S1473-3099(14)70920-X*—In this Article, the p value for 28-day mortality stated in the summary and main text should have been 0·054 not 0·54. This correction has been made to the online version as of December 15, 2014.