Hidden tobacco Since April 6, large shops (>280 m²) in the UK have had to hide tobacco displays from view in accordance with governmental plans. The legislation aims to reduce the number of smokers, to lower young people's exposure to tobacco promotion, and to change general attitudes towards smoking. Other shops will be affected from 2015.

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Vaccine expansion The Global Alliance for Vaccines and Immunization (GAVI) is to include human papillomavirus vaccine and combined measles–rubella vaccine in its latest funding round for the first time. The move has a "huge potential impact for the health of millions of women and families in the developing world", said GAVI's Chief Executive Officer Seth Berkley.

Mercury ban Chile has become the first developing country to commit to stopping the use of mercury-containing preservatives in vaccines. Despite WHO's assertion that the amount of the mercury-based preservative thiomersal used in vaccines does not pose a health risk, concerns remain. WHO is discussing a global treaty on the medical uses of thiomersal.


Michael Bradley/AP/Press Association Images

Swedes take the lead The Swedish Government has appointed Anders Nordström as the world's first Global Health Ambassador. Nordström will represent Sweden in discussions with international organisations within the UN, EU, and regional development banks. The appointment symbolises the major role of global health issues in Sweden's development policy.

Mental health boost New Zealand's Prime Minister John Key has launched a NZ$62 million package to tackle youth mental health in the country. He hopes the series of initiatives—involving schools, the internet, families, communities, and the health system—will lead to better, faster, and more modern help for young people with mental illnesses.

Pacific sexual violence In a report on sex equality and development, the World Bank has stated that the Solomon Islands represent the worst country in the world for sexual violence against women. 64% of Solomon Island women have reported domestic violence, which is common across the Pacific region; officials recommend implementation of new legislation in many countries.

Mental health admissions The number of people involuntarily admitted to mental health services in Ireland rose in 2011, according to a report from the country's Mental Health Commission. 2057 adults were admitted last year, an increase of 5% from 2010. The number of child admissions rose 50% to 20 in the same period.

Screening expansion England is to pilot an expansion of neonatal genetic screening. Diseases currently screened for are sickle-cell anaemia, cystic fibrosis, phenylketonuria, congenital hypothyroidism, and deficiency in medium-chain acyl-CoA dehydrogenase. Five regions will now also screen for maple syrup urine disease, homocystinuria, glutaric acidaemia type 1, isovaleric acidaemia, and long-chain fatty acidaemia.

CHMP resignation The Chairman of Europe's Committee for Medicinal Products for Human Use (CHMP) has resigned suddenly. Eric Abadie's spokesperson said that the decision is related to his position at AFSSAPS, the French health-care regulator currently under scrutiny over scandals involving the anti-diabetic drug benfluorex and PIP breast implants.

Up in smoke China's Ministry of Science and Technology is currently considering research into low-tar and low-nicotine cigarettes for China's National Science Prize, much to the opposition of local health bodies. The Chinese Center for Disease Control and Prevention stated that low tar and nicotine cigarettes are misconceived to pose fewer health risks than do regular ones.

Undernutrition widespread One in three children younger than 5 years in Vietnam is undernourished, according to the results of a national survey. 17·5% of those surveyed in 2009–10 were underweight, and 29·3% had stunted growth, together accounting for around 3·4 million children. Stunting rates were twice as high in remote areas as in more developed regions of the country.

Rights ignored Peru's Government is ignoring UN guidelines on the protection of isolated tribes in the Amazon by allowing oil and gas projects to expand into the territories of uncontacted Indians. The guidelines state that indigenous land should be untouchable, yet controversial exploration projects by international gas companies continue.

For **GAVI's vaccine expansion** see http://www.gavialliance.org/library/news/press-releases/2012/new-vaccine-support-against-cervical-cancer-rubella/

For more on **Anders Nordström's appointment as Global Health Ambassador** see http://www.sweden.gov.se/sb/d/16086/a/189944/

For **New Zealand's youth mental health package** see http://www.national.org.nz/Article.aspx?articleId=38252

For more on **England's expanded neonatal screening programme** see http://mediacentre.dh.gov.uk/2012/04/08/430000-babies-to-be-screened-for-five-extra-rare-conditions-in-newborn-screening-pilot/

For the **survey on malnutrition in Vietnam** see http://www.unicef.org/vietnam/summary_report_gsn.pdf

For more on **Peru's flauting of UN guidelines on isolated tribes** see http://www.survivalinternational.org/news/8245

For the **UN guidelines on isolated Amazonian tribes** see http://acnudh.org/wp-content/uploads/2012/03/Final-version-Guidelines-on-isolated-indigenous-peoples-february-2012.pdf


Gleison Miranda/AP/Press Association Images

South Africa's AIDS response: the next 5 years

No South African is untouched by HIV/AIDS. Many are infected with the virus, whether they are aware of their status or not, many have family or friends living with HIV, and many know someone who has died from an AIDS-related disorder. From the early 1990s, it was clear that South Africa's HIV/AIDS crisis had reached epidemic proportions. But the country's response at the time was hampered by denialism, a lack of political will, and poor implementation of evidence-based programmes. Thankfully, this situation has radically changed, and South Africa has since achieved some good results in tackling HIV, such as a 50% reduction in mother-to-child transmission. But the country is still underperforming in its control efforts. The AIDS accountability country scorecard for 2008 showed that South Africa was doing worse or no better than some of its neighbours.

April 1, however, marked an important milestone in the country's response to tackling not only its HIV crisis but also its tuberculosis epidemic with the start of its new *National Strategic Plan on HIV, STIs and TB 2012–2016*. The plan has several broad goals: to reduce new HIV infections by at least 50%; to start at least 80% of eligible patients on antiretroviral treatment; to reduce the number of new tuberculosis infections and deaths by 50%; to ensure a legal framework that protects and promotes human rights to support implementation of the plan; and to reduce self-reported stigma related to HIV and tuberculosis by at least 50%.

Additionally, a major strategic objective of the plan will be to address the social and cultural barriers to HIV, sexually transmitted infection, and tuberculosis prevention and care. The plan states that key vulnerable populations (eg, women between the ages of 15 years and 24 years, people from low socioeconomic groups, and men who have sex with men) will be targeted with different but specific interventions under each goal to achieve maximum impact.

The new focus on tuberculosis in the strategy is welcome, and the plan as a whole is ambitious, which it needs to be. An estimated 5·6 million people were living with HIV/AIDS in South Africa in 2009—the highest number of people in any country. In the same year, 310 000 people in the country died of AIDS-related causes. South Africa also has one of the world's worst tuberculosis epidemics with 482 000 people living with the disorder, 70% of whom are co-infected with HIV.

Marring the start of the new strategy, however, has been the news reported in local media that South Africa's National AIDS Council (SANAC) has sacked its entire staff on the eve of the implementation of the plan. In truth, SANAC is undergoing a planned restructure involving new governance structures, a new organisational home, new tasks, and new staff. The change is much needed. SANAC was established in 2000 to provide multisectoral leadership, political oversight, and guidance to South Africa's HIV/AIDS programme. In 2007, it endorsed a *National Strategic Plan for HIV and AIDS and STIs 2007–2011* with the job of overseeing continual monitoring and assessment of all aspects of the plan. But a mid-term review of implementation of the plan identified serious problems with SANAC. The review found that the high number and lack of definition of targets, weak coordination between different implementers, and between implementers and SANAC, had seriously hampered reporting on national progress in the strategic plan. The message was stark: SANAC structures were not fit for purpose.

But reform is now underway. SANAC's new chief executive of 2 months, Fareed Abdullah, is leading the organisation's restructure, which will crucially strengthen the Monitoring and Evaluation Unit within the secretariat. Abdullah, former Africa Unit Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, is widely respected in South Africa and beyond. He led the initiative to provide azidothymidine to pregnant women in the Western Cape years before the government was forced by the Constitutional Court to provide antiretroviral treatment to prevent mother-to-child transmission of HIV in the rest of the country. Abdullah is a capable leader for SANAC.

Although the council's restructuring is likely to affect its work in the short-term, the upheaval will be short-lived. SANAC needs to weather any fallout from the changes. It must be a strong, effective organisation to provide leadership for the next era of the country's AIDS and tuberculosis response. The next 5 years will be crucial for South Africa to prove that it can not only take responsibility for its epidemics of HIV/AIDS and tuberculosis, but that it can also achieve impressive results in controlling them. ■ *The Lancet*

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For the ***National Strategic Plan on HIV, STIs and TB 2012–2016*** see http://www.doh.gov.za/docs/stratdocs/2011/hiv_nsp.pdf

For the **mid-term review of the 2007–2011 plan** see http://www.irinnews.org/pdf/Mid_Term_Review_of_the_NSP_(preliminary_report).pdf

For more on **HIV and tuberculosis in South Africa** see **Series** *Lancet* 2009; **374:** 921–33

Making haemophilia a global priority

See Review page 1447

Haemophilia belongs to a family of inherited lifelong bleeding conditions that prevent blood from clotting properly. Patients with these disorders bleed for longer than normal, either as a result of injury or spontaneously without an external cause. The severity of bleeding depends on the amount of clotting factor that is missing or not functioning properly, which in haemophilia A and B—the most common types of haemophilia—is the coagulation factors VIII and IX, respectively. In addition to external bleeding, patients more commonly have internal bleeding around the joints and muscles, which can be extremely painful and cause permanent disability. Bleeding into major organs such as the brain is especially difficult to manage and can be fatal.

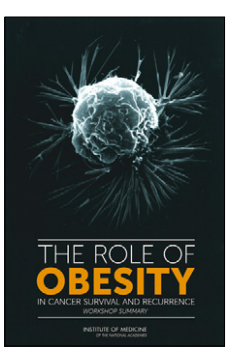
The past two decades have seen tremendous progress in approaches and therapies for treating haemophilia. In this week's *Lancet*, Eric Berntorp and Amy Shapiro review the latest advances in haemophilia care, focusing on long-term prophylaxis and treatment of the body's inhibitors that block the effectiveness of standard recombinant clotting factor replacement therapy. However, many of these advances will only be available in resource-rich countries. Indeed, current recommended haemophilia treatment is expensive, diagnosis is specialised, and a multidisciplinary framework and team of trained specialists to deliver optimum care are essential.

April 17 is World Hemophilia Day. This year's theme, *Close the Gap* highlights the disparities in care and unmet need if treatment for all—the goal set by the World Federation of Hemophilia—is to become a global reality. Of the estimated 400 000 people with haemophilia worldwide, only about a third have been diagnosed. 75% of haemophiliacs receive inadequate treatment or no treatment at all because of the use of older, less effective treatments and lack of accessibility and affordability of recombinant therapy.

At a time when non-communicable diseases have moved up the global health agenda, governments need to be more aware of chronic genetic diseases, such as haemophilia, which are complex conditions and poorly understood by policy makers. ■ *The Lancet*

For more on the **World Hemophilia Day** see http://www.wfh.org

Obesity and cancer outcome



Institute of Medicine

12 million Americans are cancer survivors and a staggering two-thirds of Americans are currently considered overweight or obese. On April 3, the National Cancer Policy Forum of the US Institute of Medicine released a welcome report entitled *The Role of Obesity in Cancer Survival and Recurrence*. Many epidemiological studies have identified obesity as a factor in cancer risk and prognosis. Obesity is associated with higher cancer incidence, recurrence, progression, and death. The report emphasises how little is still known about the precise cellular mechanisms that link obesity with cancer.

Adipose tissue can behave as an endocrine organ by generating hormones, growth factors, and cytokines that can disrupt regulation of cell growth and survival—the hallmark of malignancy. Knowing the precise cellular targets involved in this interplay could lead to targeted therapeutic approaches for controlling both cancer and obesity. For example, appropriate animal models could allow investigation of mechanisms of obesity and diabetes in precise genetic models of human cancers.

What is not yet known is whether weight management changes the prognosis and outcome in different cancers. The simple solution of tracking individuals' BMI and bodyweight during clinical trials to analyse effect on cancer outcomes needs to become standard practice. Another area of clinical controversy is related to proper chemotherapy dosing in obese cancer patients. Total body-surface area is used to calculate the chemotherapy dose, which does not take into account the body's composition (such as an individual's fat percentage). This approach often leads to suboptimum doses of chemotherapy.

But the most important lesson of this report comes from the basic science of obesity-associated cancer risk. Our population-level responses—which have largely failed—are based on a far too simplistic understanding of how obesity contributes to cancer. To address this challenge demands not more poorly thought out intervention trials. Instead, we need greater understanding of the biological mechanisms underpinning cancer and obesity. ■ *The Lancet*

For more on the **Obesity and cancer report** see http://www.iom.edu/Reports/2012/The-Role-of-Obesity-in-Cancer-Survival-and-Recurrence.aspx

A new resolution for global mental health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We commend the 130th session of the WHO Executive Board for adopting a resolution calling for a comprehensive response to the global burden of mental illnesses.[1] Mental disorders account for 13% of the global disease burden, and major depression alone is expected to be the largest contributor by 2030.[2] The economic effect is great, with mental disorders expected to cost nearly a third of the projected US$47 trillion incurred by all non-communicable diseases by 2030.[3] Meanwhile, the burden on people living with mental disorders is incalculable. Many of these disorders are lifelong and cross generations; they also affect neighbours, friends, and beyond in a ripple of concentric circles. A striking example of the effect on family members is the association between maternal depressive symptoms and underweight and stunting in children reported in many countries.[4]

The resolution for mental health, led by India, the USA, and Switzerland, is the result of a crescendo of political support for addressing mental illnesses and received unanimous support from countries on the WHO Executive Board. The resolution urges countries to protect and promote the rights of persons with mental disorders and to combat stigma against mental illness. Crucially, it prioritises the integration of mental health services within primary care and calls for the development of a plan that will address both health and social services, while seeking key involvement from people with mental disorders in its planning. This resolution is also a necessary first step to bringing mental, neurological, and substance use disorders to the highest level of discussion—a UN General Assembly Special Session.[5]

Once the resolution is adopted by the World Health Assembly in May 2012, WHO will develop a mental health action plan to be approved by UN member states in 2013. Once approved, this action plan will lead to further resource allocation for mental health. In developing this action plan, we recommend that WHO undertake in-person country and regional consultations to properly assess the needs of people with mental disorders in diverse geographical, cultural, and financial contexts.

WHO should also emphasise holistic recovery, including physical, mental, and social wellbeing, and involve relevant social sectors while developing the action plan. Over the past decade, public mental health research has yielded a robust evidence base for interventions on the level of the individual, family, school, community, and nation. Although there is a plethora of evidence on efficacious mental health interventions, little of this evidence has been disseminated or implemented. Studies have demonstrated the merits of screening for depression in primary care;[6,7] however, such integration has yet to become routine practice, even in high-income countries. While community-based treatment and recovery services often lie at the intersection of various domains, there is an absence of coordinated care for service users. Individuals living with mental illness not only need pharmacotherapy, but also effective psychosocial interventions and access to education, employment, and housing.

We urge UN member states to safeguard the human rights of persons with mental disorders and go a step further by empowering those who are mentally ill and involving them at all stages of decision making. In this regard, much can be learned from successful advocacy efforts to combat the HIV/AIDS pandemic. Largely because of leadership by people living with HIV/AIDS, there have been significant reductions in mother-to-child transmission, millions more are able to access antiretroviral medications, and new infections have decreased in many countries.[8] Understanding this history, we call for the outcomes of the resolution for global mental health to be based heavily on the knowledge, creativity, and experiences of those directly affected by mental illness. Charlene Sunkel, a South African advocate and person living with schizophrenia, underscores the importance of collaboration between health professionals and service users, as exemplified by the EMPOWER[9] project and the Guateng Consumer Advocacy Movement in South Africa.[10] We encourage service users to engage with their ministries of health, as well as WHO country and regional offices.

We call for a coordinated response to this resolution by all interested parties, including WHO, UN member states, service users, and caregivers, as well as civil society groups. At present, one fifth of countries allocate less than 1% of their health budgets to mental health care, while mental, neurological, and substance-use disorders account for a far greater share of the social and financial costs of health problems.[2] Let us capitalise on the momentum generated by this resolution and ensure that the world proportionately prioritises mental health.

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