High-Profile Journals Not Worth the Trouble

RAFF, JOHNSON, AND WALTER ("PAINFUL publishing," Letters, 4 July, p. 36) make some excellent points about how peer reviewers for journals should conduct themselves. There is a fine line between being too demanding by requiring a lot of extra work and making sure a paper with important results gets out to the scientific public in a timely way.

In my laboratory, there is no pressure to publish in journals like *Science*, *Nature*, or *Cell* because we simply do not send our manuscripts to them anymore, no matter how important or high-impact we think the work may be. We have found that there is an excellent group of other, first-line journals of cell biology for which we do not need to subject ourselves to the type of competition required for publication in these three journals.

When I have served on peer-review panels, I have fought against the common practice of relating grant awards to publication in high-profile journals such as *Science*, *Nature*, and *Cell*. It is the impact and importance of the work that matters (thereby requiring the peer reviewers to read the applicant's papers quite thoroughly), not where the work is published.

JOEL L. ROSENBAUM

Department of Molecular, Cellular, and Developmental Biology, Yale University, New Haven, CT 06520–8103, USA.

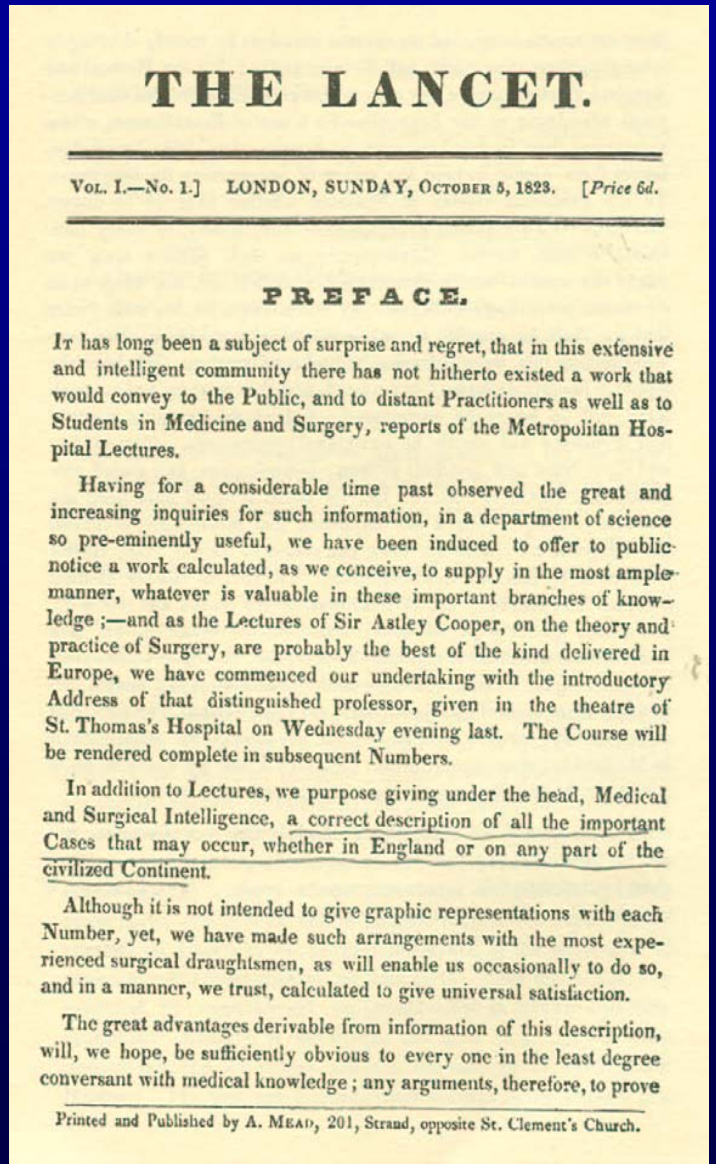
CREDIT: BORIS LYUBNER/ILLUSTRATION WORKS/CORBIS

The Global Doctor: Scientific Medicine and Social Movements

McGill University
Montreal, Canada

Richard Horton
October 29, 2008

In the beginning…



THE LANCET.

Vol. I.—No. 1.] LONDON, SUNDAY, October 5, 1823. [*Price 6d.*

PREFACE.

It has long been a subject of surprise and regret, that in this extensive and intelligent community there has not hitherto existed a work that would convey to the Public, and to distant Practitioners as well as to Students in Medicine and Surgery, reports of the Metropolitan Hospital Lectures.

Having for a considerable time past observed the great and increasing inquiries for such information, in a department of science so pre-eminently useful, we have been induced to offer to public notice a work calculated, as we conceive, to supply in the most ample manner, whatever is valuable in these important branches of knowledge;—and as the Lectures of Sir Astley Cooper, on the theory and practice of Surgery, are probably the best of the kind delivered in Europe, we have commenced our undertaking with the introductory Address of that distinguished professor, given in the theatre of St. Thomas's Hospital on Wednesday evening last. The Course will be rendered complete in subsequent Numbers.

In addition to Lectures, we purpose giving under the head, Medical and Surgical Intelligence, a correct description of all the important Cases that may occur, whether in England or on any part of the civilized Continent.

Although it is not intended to give graphic representations with each Number, yet, we have made such arrangements with the most experienced surgical draughtsmen, as will enable us occasionally to do so, and in a manner, we trust, calculated to give universal satisfaction.

The great advantages derivable from information of this description, will, we hope, be sufficiently obvious to every one in the least degree conversant with medical knowledge; any arguments, therefore, to prove

Printed and Published by A. Mead, 201, Strand, opposite St. Clement's Church.

To Colonial Practitioners"!

"…a correct description of all the important cases that may occur, whether in England or on any part of the civilised Continent."

A revolution in knowledge

World Health Organization

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International Clinical Trials Registry Platform (ICTRP)

WHO > Programmes and projects > Clinical Trials

Welcome to the WHO ICTRP

The mission of the WHO International Clinical Trials Registry Platform is to ensure that a complete view of research is accessible to all those involved in health care decision making. This will improve research transparency and will ultimately strengthen the validity and value of the scientific evidence base.

WHO/P. Virot

The registration of all interventional trials is a scientific, ethical and moral responsibility.

What is a clinical trial?

For the purposes of registration, a clinical trial is any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes. Interventions include but are not restricted to drugs, cells and other biological products, surgical procedures, radiologic procedures, devices, behavioural treatments, process-of-care changes, preventive care, etc.

Trial Registration

:: Why is Trial Registration Important?
:: How to Register a Trial
:: What is the difference between a clinical trials register and registry?

:: Registry Network

World Health Organization INTERNATIONAL CLINICAL TRIALS REGISTRY PLATFORM SEARCH PORTAL

:: Search for Trials

USEFUL RESOURCES

:: ICTRP FAQ
:: ICTRP Glossary
:: ICTRP eNote
:: Acknowledgements
:: Queries & Comments

CONTACT DETAILS

ICTRP
World Health Organization
Avenue Appia 20
1211 Geneva 27
Switzerland
ictrpinfo@who.int

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ClinicalTrials.gov
A service of the U.S. National Institutes of Health

Home Search Study Topics Glossary
Search

ClinicalTrials.gov is a registry of federally and privately supported clinical trials conducted in the United States and around the world. ClinicalTrials.gov gives you information about a trial's purpose, who may participate, locations, and phone numbers for more details. This information should be used in conjunction with advice from health care professionals. Read more...

Search for Clinical Trials

Find trials for a specific medical condition or other criteria in the ClinicalTrials.gov registry. ClinicalTrials.gov currently has 62,532 trials with locations in 158 countries.

Investigator Instructions

Get instructions for clinical trial investigators/sponsors about how to register trials in ClinicalTrials.gov.

Background Information

Learn about clinical trials and how to use ClinicalTrials.gov, or access other consumer health information from the US National Institutes of Health.

Resources:

Understanding Clinical Trials
What's New
Glossary

Study Topics:

List studies by Condition
List studies by Drug Intervention
List studies by Sponsor
List studies by Location

U.S. National Library of Medicine, Contact Help Desk
U.S. National Institutes of Health, U.S. Department of Health & Human Services,
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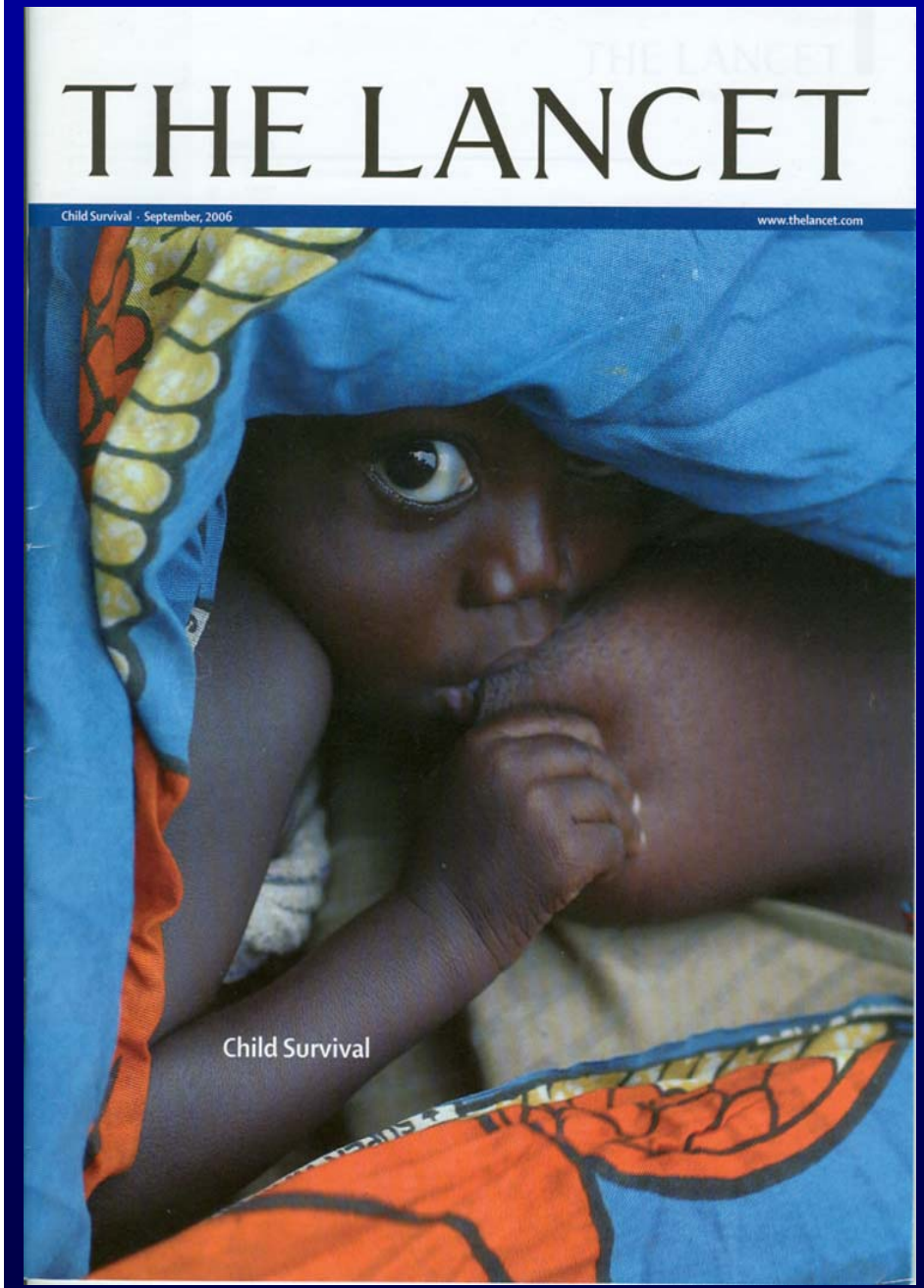
NATIONAL INSTITUTES OF HEALTH NLM



- **Science is a catalyst for policy change**
- **Global partnerships deliver global impact**
- **Doctors can trigger social action**
- **Doctors can be leaders of political as well as clinical change**

MDGs

1. Eradicate poverty
2. Achieve universal education
3. Promote gender equality
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV, malaria, TB
7. Ensure environmental sustainability
8. Develop global partnerships

Global Development Organisation

What does globalisation mean to medicine?

"To advocate for global action on human development; to be the lead scientific and technical agency for development; to co-ordinate bilateral and multilateral development programmes; and to set standards for development work."

- Sustainable human development
- MDGs
- Collect evidence
- Build institutions
- Create partnerships
- Disseminate information
- Promote research
- Strengthen information capacity

Lancet 2002; **360:** 582-83

MDG 4

Reduce child mortality

Reduce under 5 mortality rate by two-thirds (1990-2015)

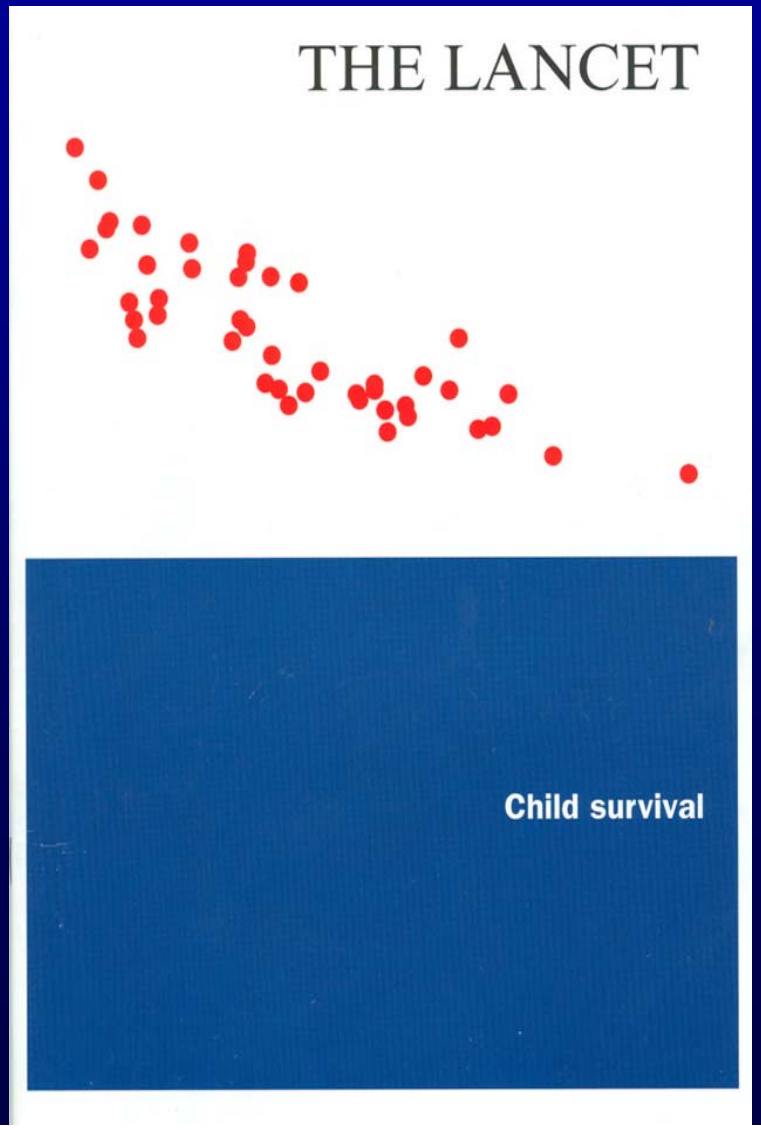
MDG 5

Improve maternal health

Reduce maternal mortality ratio by three-quarters (1990-2015)

Achieve, by 2015, universal access to reproductive health

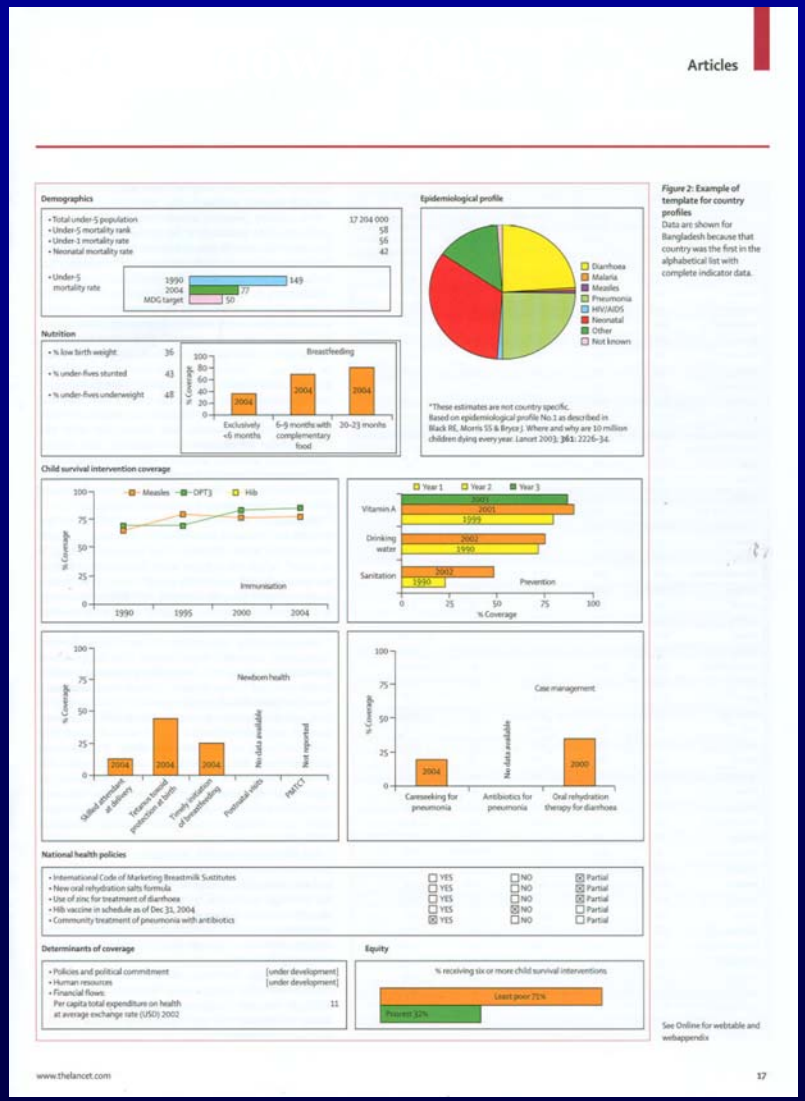
Child survival: science, advocacy, and a call to action



"We, a group of concerned scientists and public-health managers, call on: WHO, UNICEF, the World Bank, the UNDP, and their other UN partners to act on behalf of children by putting child survival at the top of their list of priorities."

Lancet 2003; **362:** 323-27

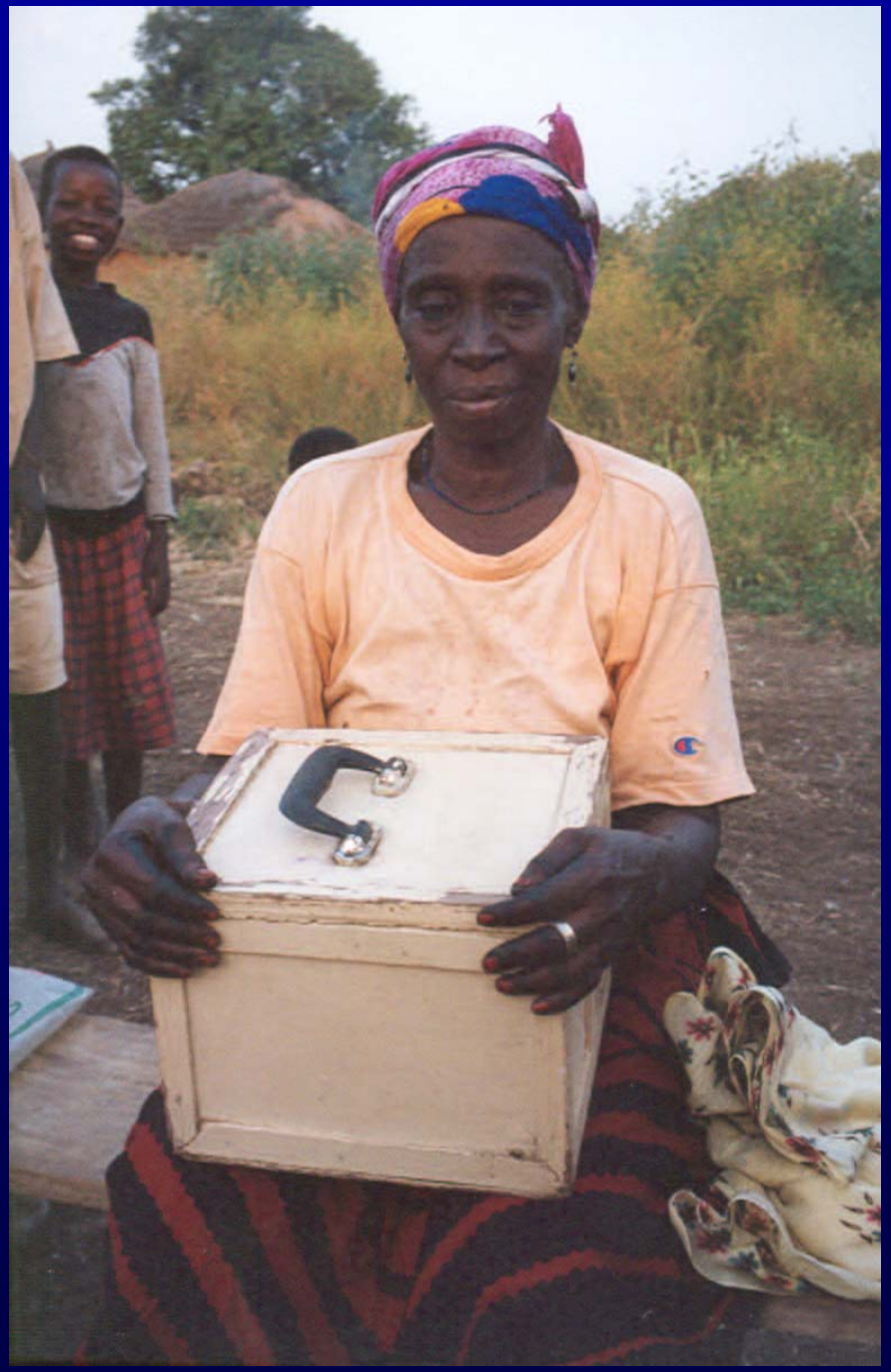
The result?

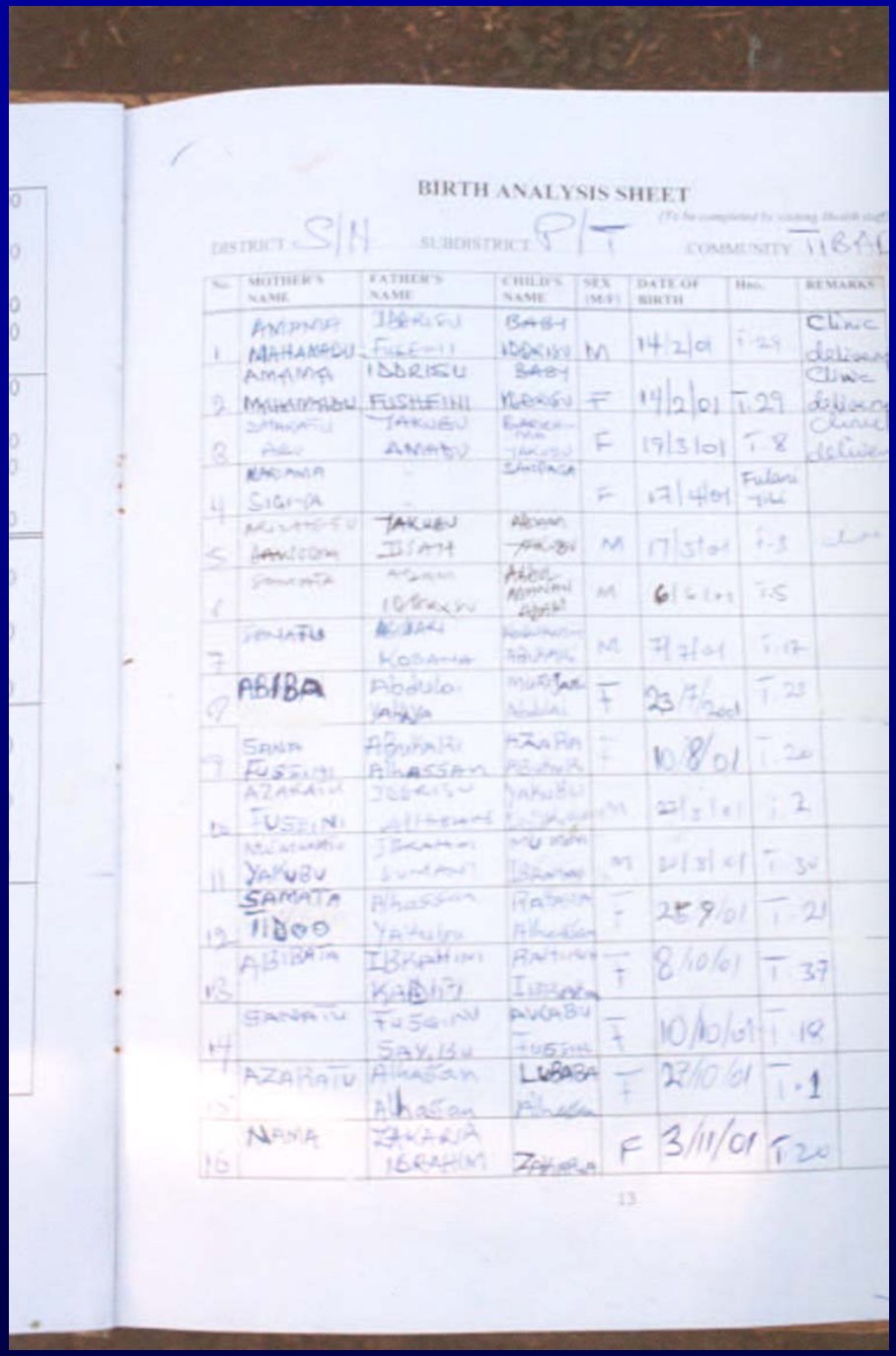


Newborn health

- Profile
- Policy
- Partnership
- Financial support
- Programme monitoring

Lawn JE et al
Lancet 2006; **367:** 1541-47





BIRTH ANALYSIS SHEET

DISTRICT S/H SUBDISTRICT P/T COMMUNITY TIBALI

S/No.	MOTHER'S NAME	FATHER'S NAME	CHILD'S NAME	SEX (M/F)	DATE OF BIRTH	Hosp.	REMARKS
1	AMINU MAHAMADU	IBERIU FUSEINI	BABY MOSES	M	14/2/01	T-29	Clinic delivery
2	AMAMA MUHAMADU	IDDRISU FUSHEINI	BABY MOSES	F	14/2/01	T 29	Clinic delivery
3	SAMATU ADU	JAKUBU ANABU	BABY JAKUBU SAMATA	F	17/3/01	T 8	Clinic delivery
4	KACANA SIGMA	-	SAMATA	F	17/4/01	Fulani yili	
5	MUSAHOFU LAMIDOM	JAKUBU ISAH	ADAM JAKUBU	M	17/5/01	T-3	
6	SAMATA	ADAM IDRISU	ABDUL MUMINI ADAM	M	6/6/01	T-5	
7	SAMATU	ABARI KOSANA	MUSAH MAHAMA	M	7/7/01	T-17	
8	ABIBA	Abdulai MAMA	MARIAM Abdulai	F	23/7/2001	T 23	
9	SANA FUSEINI	ABUBAKARI ALHASSAN	HAWA ALHASSAN	F	10/8/01	T 20	
10	AZARATU FUSEINI	IDDRISU ALHASSAN	JAKUBU ALHASSAN	M	21/8/01	T 2	
11	MUSAHOFU YAKUBU	IBRAHIM SUMANI	MUSAH IBRAHIM	M	21/8/01	T 30	
12	SAMATA TIBOO	Alhassan Yakubu	MARIAM Alhassan	F	25/9/01	T-21	
13	ABIBATA	IBRAHIM KABIRI	MARIAM IBRAHIM	F	8/10/01	T 37	
14	SANATU	FUSEINI SAYIDU	AWABU FUSEINI	F	10/10/01	T 19	
15	AZARATU	Alhassan Alhassan	LUBABA Alhassan	F	22/10/01	T-1	
16	NANA	ZAKARIA IBRAHIM	ZAKARIA	F	3/11/01	T 20	

13

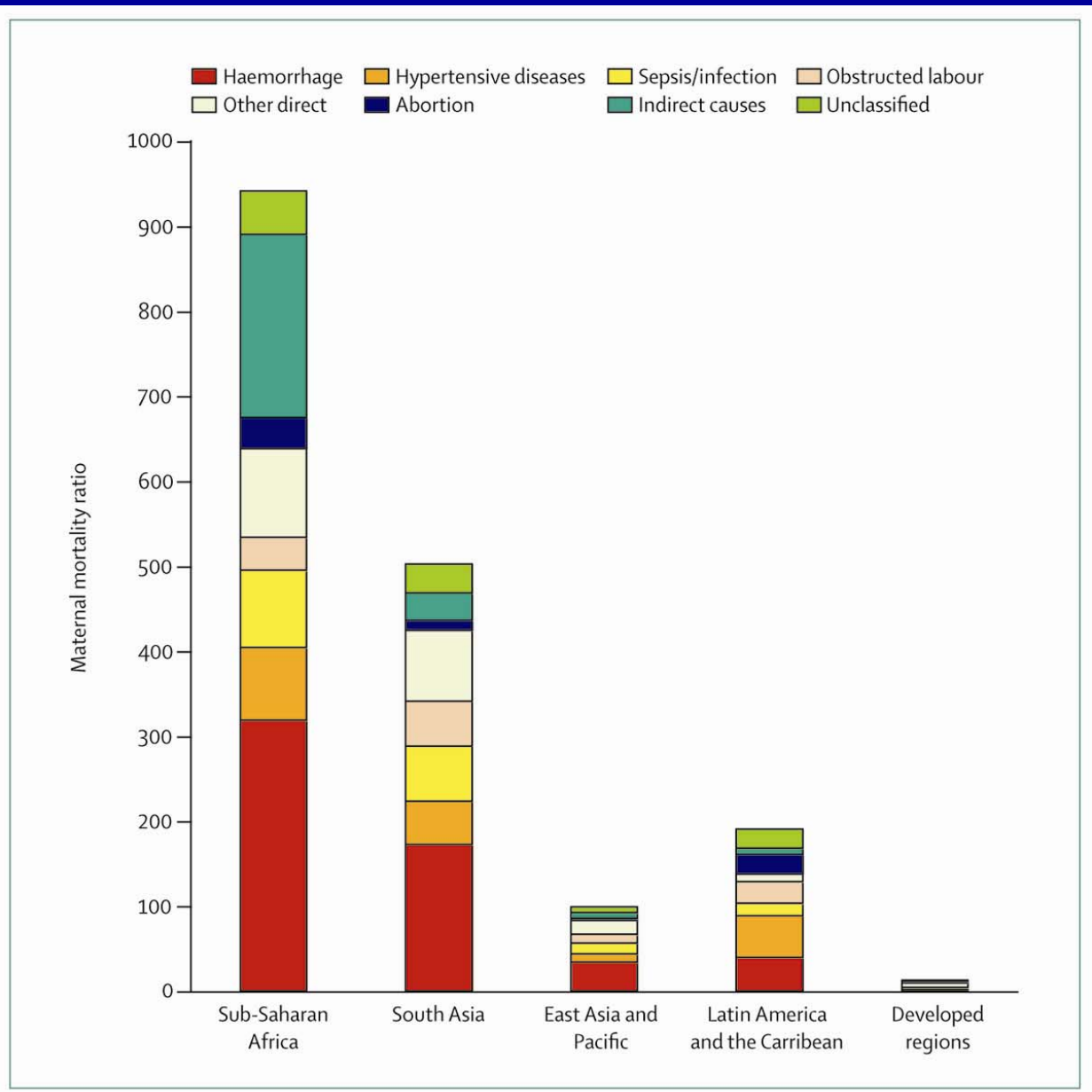


Figure 5: **Maternal mortality ratios for 2000 by medical cause and world region**
Ratios were obtained by applying proportional mortality from reference 22 to regional estimates of maternal mortality in 2000 (reference 2).

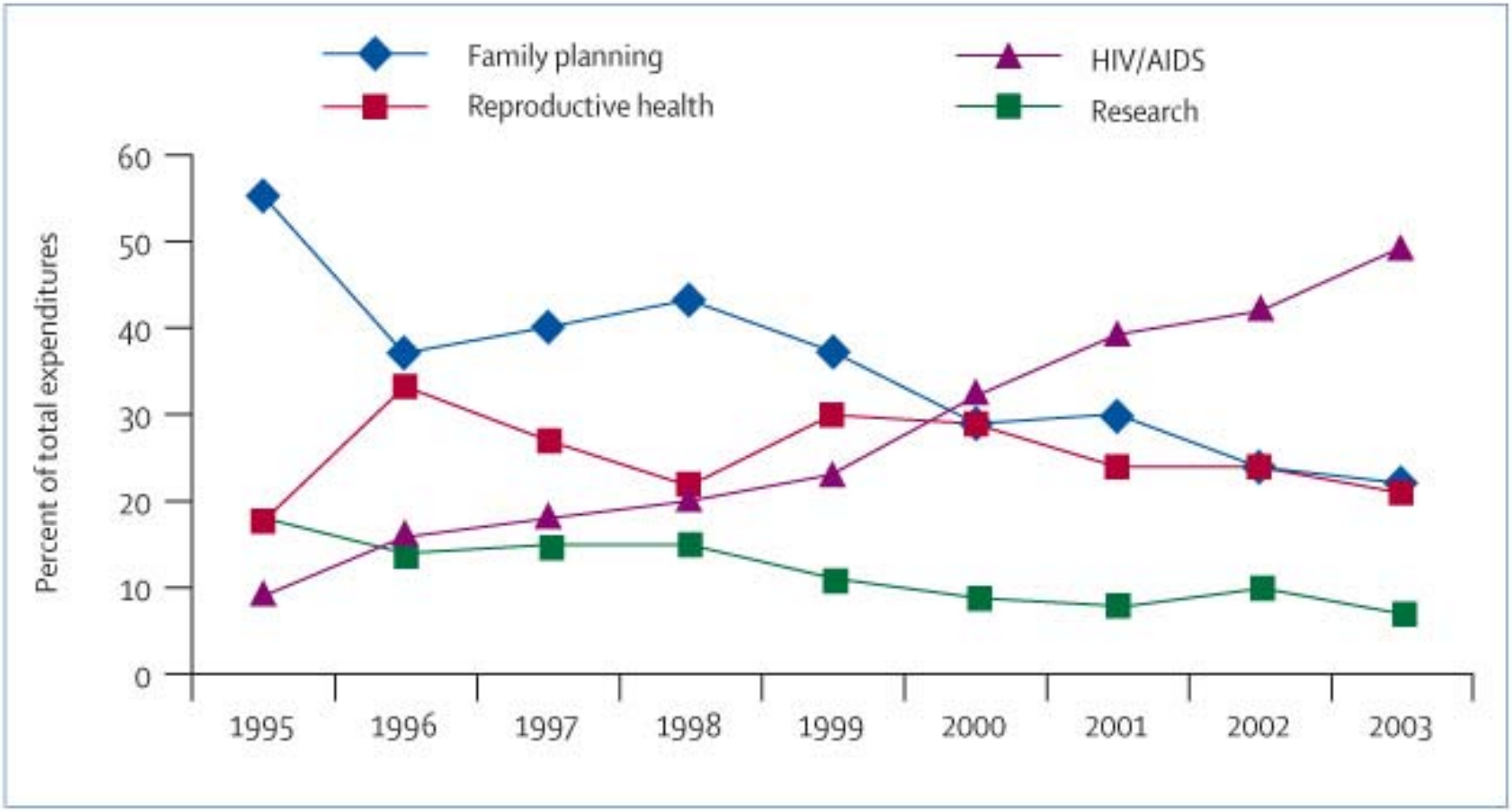


Figure: Resources for family planning and basic service for reproductive health[10]

Series

Child development in developing countries 1

Developmental potential in the first 5 years for children in developing countries

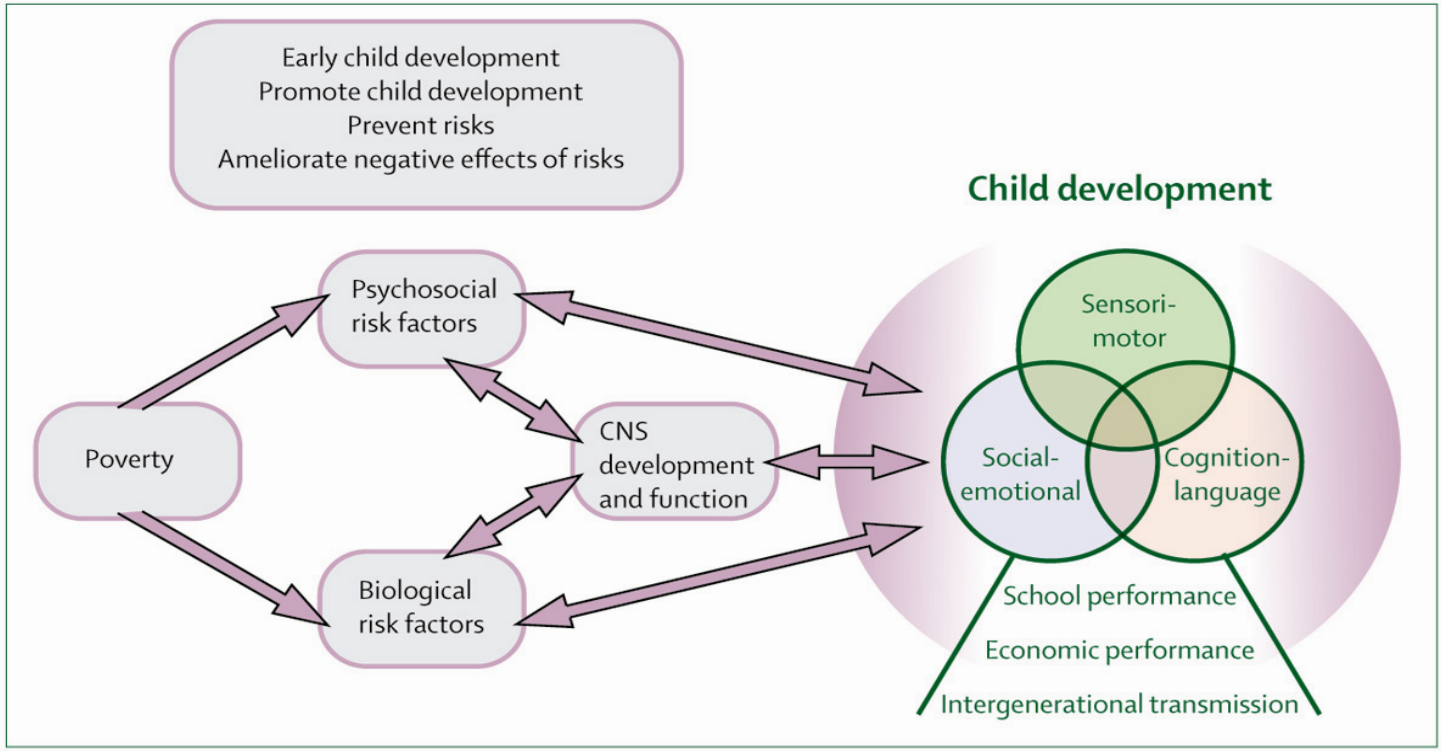


Figure 1: **Conceptual model of how interventions can affect early child development**

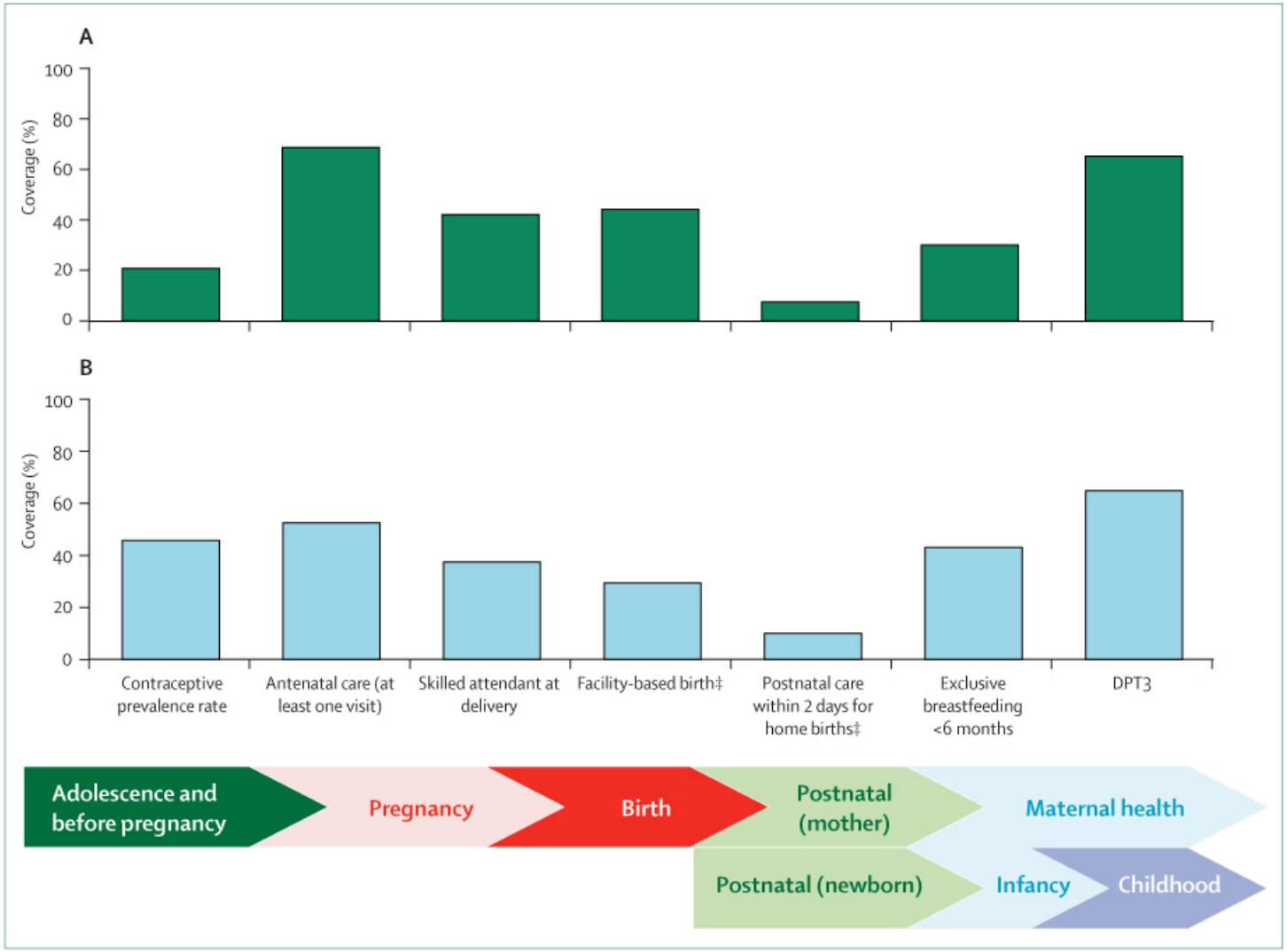


***Figure 3*: Coverage along the continuum of care in sub-Saharan Africa* (A) and South Asia† (B) between 2000 and 2006**

Adapted from reference 5, which used data from Demographic and Health Surveys (DHS), 2000–2006,[51] with permission. *Sub- Saharan Africa includes Benin, Burkina Faso, Cameroon, Chad, Congo, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Tanzania, Uganda, and Zambia; these countries have 74% of the region's annual births. †South Asia includes Bangladesh, India, and Nepal; these countries have 82% of the region's annual births. DPT3=three doses of diphtheria, pertussis, and tetanus. ‡DHS have assumed that all women who had a facility-based birth received postnatal care; therefore, only women whose most recent birth was outside a health facility were asked about a postnatal visit within 2 days.

Maternal and child undernutrition

	Proportional reduction in deaths before			Relative reduction in prevalence of stunting at			Millions (%) of DALYs averted at
	12 months	24 months	36 months	12 months	24 months	36 months	36 months
General nutrition interventions	14·8%	13·9%	13·4%	21·7%	17·8%	15·5%	33·8 (13·3%)
Micronutrient interventions	10·0%	11·3%	12·1%	10·3%	15·9%	17·4%	31·3 (12·3%)
Disease control interventions	3·0%	2·7%	2·6%	3·7%	2·9%	2·7%	6·6 (2·6%)

Table 14: Effect of combinations of nutrition-related interventions on mortality and stunting in 36 countries (99% coverage)

	Proportional reduction in deaths before			Relative reduction in prevalence of stunting at			Millions (%) of DALYs averted at
	12 months	24 months	36 months	12 months	24 months	36 months	36 months
99% coverage with all interventions	24·0%	24·4%	24·7%	33·1%	35·8%	35·5%	63·4 (25·1%)
90% coverage with all interventions	22·0%	22·2%	22·4%	31·1%	32·4%	32·1%	57·5 (22·7%)
70% coverage with all interventions	17·3%	17·3%	17·3%	22·7%	24·1%	23·6%	44·3 (17·5%)

Table 15: Effect of all nutrition-related interventions on mortality and stunting in 36 countries, by coverage level

THE LANCET

Volume 371 · Number 9620 · Pages 1215–1308 · April 12–18, 2008 www.thelancet.com

Countdown to 2015 for maternal, newborn, and child survival:

"Rapid progress is possible, but much more can and must be done."

See Articles page 1247

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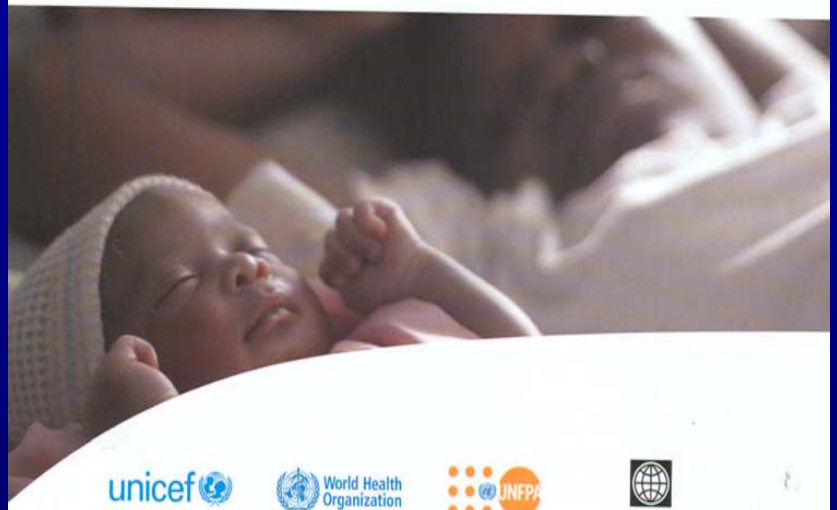
Founded 1823 · Published weekly

Countdown to 2015
Maternal, Newborn & Child Survival



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The Partnership for Maternal, Newborn & Child Health · FAMILY CARE INTERNATIONAL · Save the Children. · THE LANCET

Norad · Australian Government AusAID · USAID · DFID Department for International Development

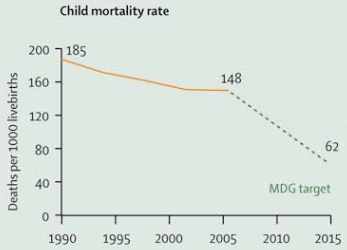
BILL & MELINDA GATES foundation · IPA · BASICS · JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

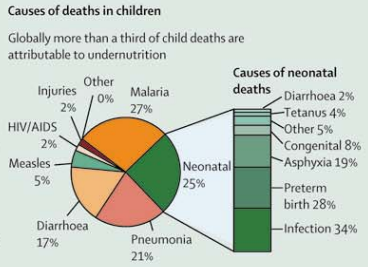
THE AGA KHAN UNIVERSITY · London School of Hygiene & Tropical Medicine · UNIVERSITY of ABERDEEN

www.countdown2015mnch.org

Demographics

Total population	8 760 000 (2006)
Total population younger than 5 years	1 488 000 (2006)
Births	358 000 (2006)
Birth registration	70% (2006)
Child mortality rate (per 1000 livebirths)	148 (2006)
Infant mortality rate (per 1000 livebirths)	88 (2006)
Neonatal mortality rate (per 1000 live births)	38 (2000)
Deaths in children younger than 5 years	53 000 (2006)
Maternal mortality ratio (per 100 000 livebirths)	840 (2005)
Lifetime risk of maternal death	1 in 20 (2005)
Total maternal deaths	2900 (2005)

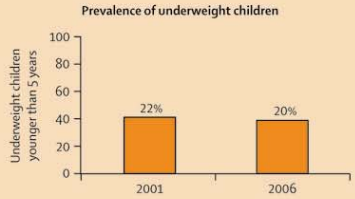


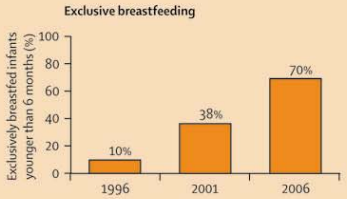


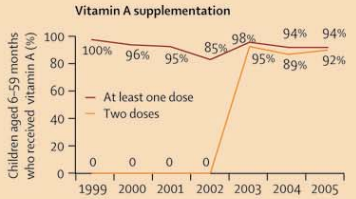
Intervention coverage for mothers, newborn babies, and children

Nutrition

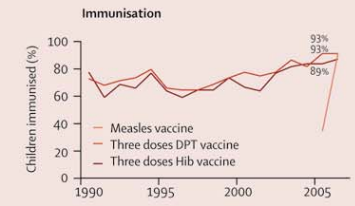
Stunting prevalence (moderate and severe) 44% (2006)
Wasting prevalence (moderate and severe) 9% (2006)
Complementary feeding rate (6–9 months) 50% (2006)
Low birthweight incidence 16% (2001)

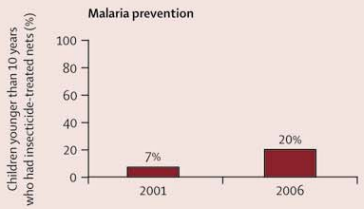


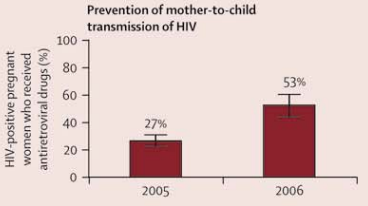


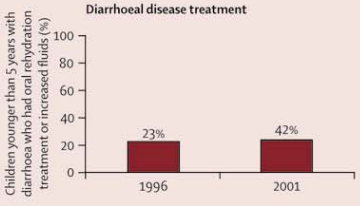


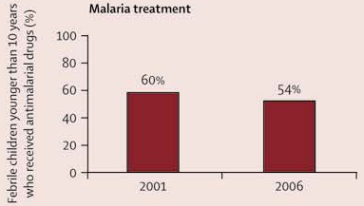
Child health











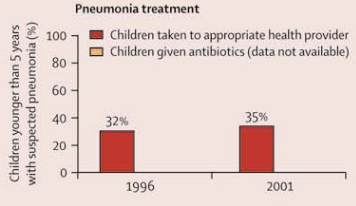


Figure 2: **Country profile for Benin**
The profiles for all 68 priority countries are in the Countdown report, with details of sources and methods for each data type.[10] DPT=diphtheria, pertussis, and tetanus toxoid. HiB=*Haemophilus influenzae* type B.

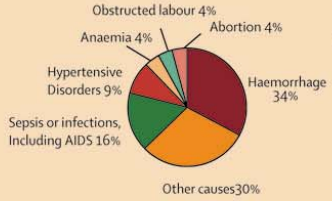
Maternal and newborn health

Unmet need for family planning	27% (2001)
Antenatal visits for woman (four or more visits)	62% (2001)
Intermittent preventive treatment for malaria	3% (2006)
Rate of caesarean section (total*)	3% (2001)
Rate of caesarean section (urban)	6% (2001)
Rate of caesarean section (rural)	2% (2001)
Early initiation of breastfeeding (within 1 hour of birth)	49% (2001)
Postnatal visit for baby (within 2 days for home births)	..

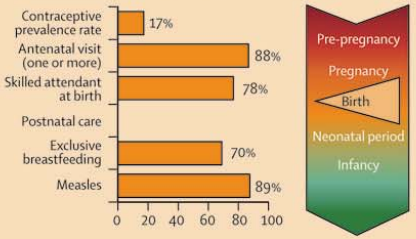
*Target is a minimium of 5% and maximum of 15%

Causes of maternal deaths

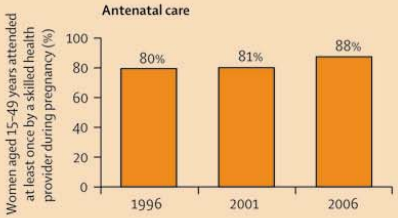
Regional estimates for Africa, 1997–2002



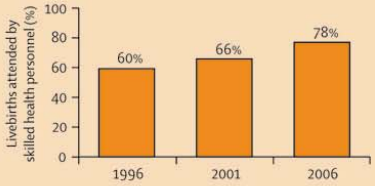
Coverage along the continuum of care



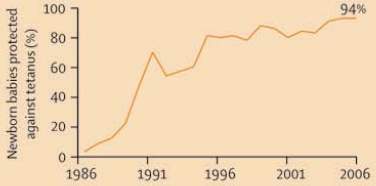
Antenatal care



Skilled attendant at delivery

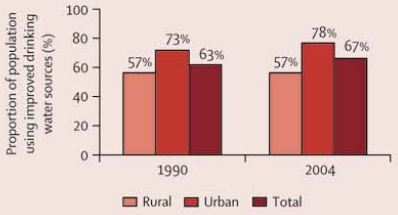


Neonatal tetanus protection

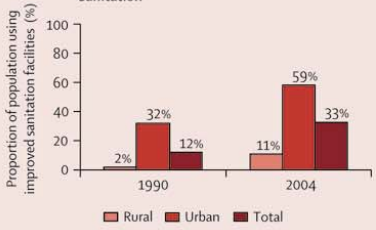


Water and sanitation

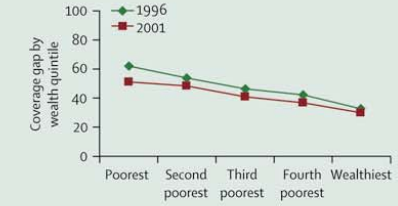
Water



Sanitation



Equity



	1996	2001
Coverage gap	48·0%	41·0%
Ratio (poorest/wealthiest)	1·9	1·7
Difference (poorest–wealthiest)	29·0%	22·0%

Policies

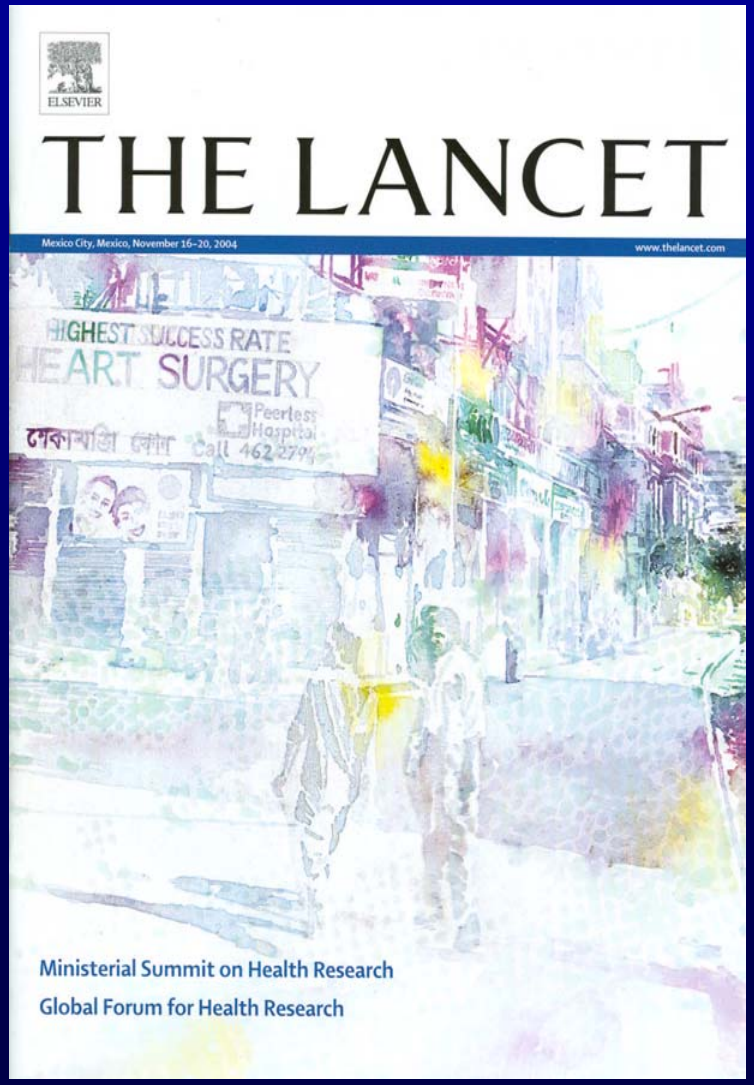
International Code of Marketing of Breastmilk Substitutes	Yes
New formula for oral rehydration salts and zinc for management of diarrhoea	Yes
Community treatment of pneumonia with antibiotics	Partial
Integrated Management of Childhood Illnesses adapted to cover newborn babies (0–1 week of age)	Yes
Costed implementation plan or plans for maternal, newborn, and child health available	Yes
Midwives be authorised to administer a core set of life-saving interventions	Partial
Maternity protection in accordance with International Labour Organisation Convention 183	No
Specific notification of maternal deaths	Yes

Systems

Financial flows and human resources

Expenditure on health per person	US$40 (2007)
Proportion of total government expenditure spent on health	10% (2007)
Out-of-pocket expenditure as proportion of total expenditure on health	49% (2007)
Density of health workers (per 1000 population)	0·9 (2004)
Official Development Assistance to child health (per child)	US$7 (2005)
Official Development Assistance to maternal and neonatal health (per livebirth)	US$4 (2005)
National availability of Emergency Obstetric Care services (proportion of recommended minimum)	66% (2002)

Strategic partnerships



- Ministerial Summit on Health Research
- Global Forum for Health Research
- Mexico: Nov 2004

	Births (in thousands)	Proportion of unregistered children	Number of unregistered children (in thousands)
South Asia	37 099	63%	23 395
Sub-Saharan Africa	26 879	55%	14 751
Middle east and north Africa	9790	16%	1543
Commonwealth of Independent States and Baltic States	5250	23%	1218
East Asia and Pacific	31 616	19%	5901
Latin America and Caribbean	11 567	15%	1787
Industrialised countries	10 827	2%	218
Developing countries	119 973	40%	48 147
Least developed countries	27 819	71%	19 682
World	133 028	36%	48 276

Table: **Estimated annual number and proportion of unregistered births by region, 2003**[7]

THE LANCET

Volume 372 · Number 9642 · Pages 863-1008 · September 13-19, 2008 www.thelancet.com

Alma-Ata 30 years on:

"Health for all need not be a dream buried in the past."

See Editorial page 863

£5.00 Registered as a newspaper · ISSN 0140-6736
Founded 1823 · Published weekly

The World Health Report **2008**

Primary Health Care

Now More Than Ever

World Health Organization

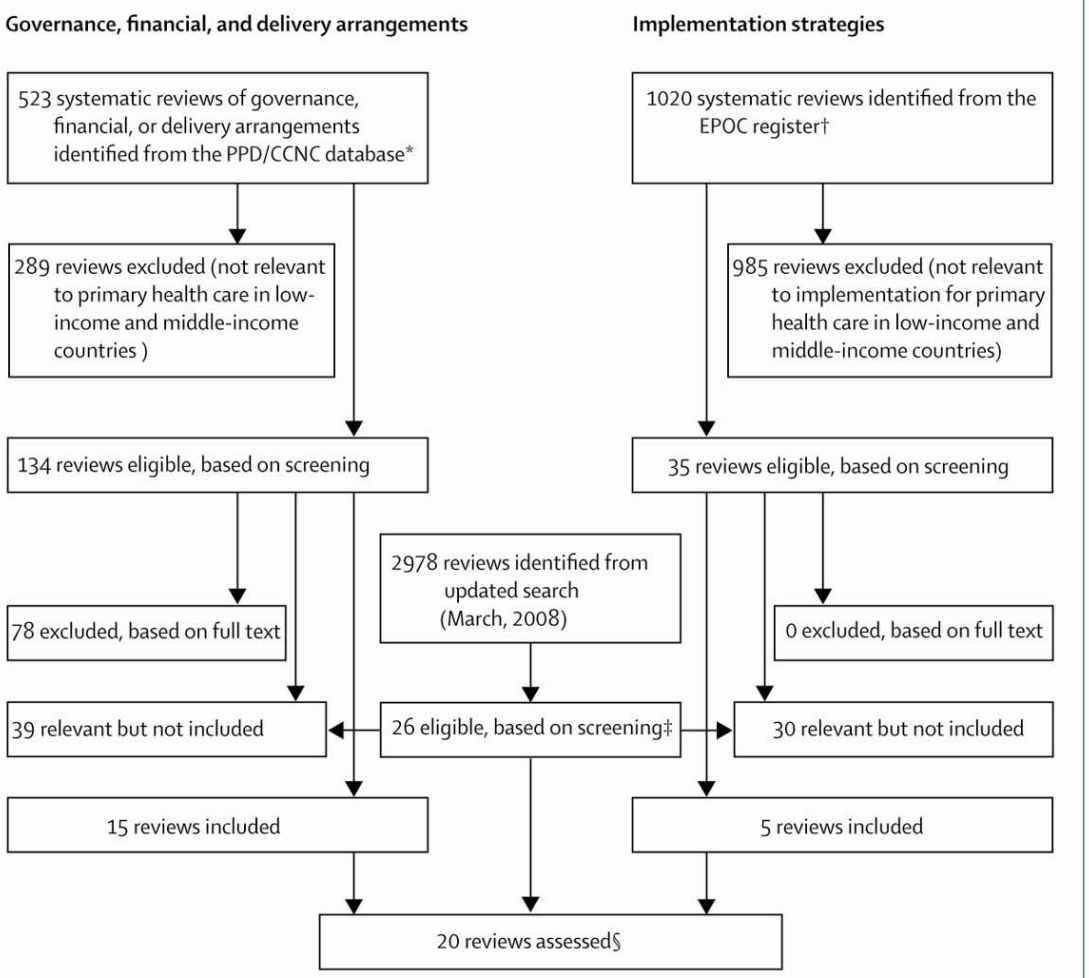


Figure: **Flow diagram of review selection**

*Reviews from the EPOC register and the Cochrane Database of Systematic Reviews were screened. The PPD/CCNC database (http://www.researchtopolicy.ca) included a total of 684 systematic reviews; however, not all of the reviews were reviews of effects. †Over 20 000 references were screened, of which 1020 reviews were included in the EPOC register. ‡26 reviews from the updated search (15 reviews of health system arrangements and 11 reviews of implementation strategies) were relevant but not included since they were not considered high priority. Two health system reviews that had already been included were also identified by the updated search. §We included reviews that we considered to be the most relevant to primary health care in low-income and middle-income countries. Relevant but not included reviews are listed in webtable 1.

September 25, 2008, UNGA, NY

Comment

Innovative finance for women and children

outcome. A child dies every 3 seconds, a mother every minute. We have no time to lose.

*Jan Peter Balkenende, Jakaya Kikwete, *Jens Stoltenberg, Robert Zoellick*
Prime Minister, The Hague, Netherlands (JPB); President, Dar-Es-Salaam, Tanzania (JK); Prime Minister, Oslo, Norway (JS); and President, World Bank, Washington DC, USA (RZ)
Tore.Godal@smk.dep.no

World Health Organization · UNFPA · unicef · THE WORLD BANK

JOINT STATEMENT ON MATERNAL AND NEWBORN HEALTH

Accelerating Efforts to Save the Lives of Women and Newborns

Today, **25 September 2008,** as world leaders gather for the High-Level Event on the Millennium Development Goals (MDGs), we jointly pledge to intensify our support to countries to achieve Millennium Development Goal 5 *To Improve Maternal Health* — the MDG showing the least progress.

During the next five years, we will enhance support to the countries with the highest maternal mortality. We will support countries in strengthening their health systems to achieve the two MDG 5 targets of reducing the maternal mortality ratio by 75 per cent and achieving universal access to reproductive health by 2015. Our joint efforts will also contribute to achieving MDG 4 *To Reduce Child Mortality*.

Every minute a woman dies in pregnancy or childbirth, over 500,000 every year. And every year over one million newborns die within their first 24 hours of life for lack of quality care. Maternal mortality is the largest health inequity in the world; 99 per cent of maternal deaths occur in developing countries — half of them in Africa. A woman in Niger faces a 1 in 7 chance during her lifetime of dying of pregnancy-related causes, while a woman in Sweden has 1 chance in 17,400.

Fortunately, the vast majority of maternal and newborn deaths can be prevented with proven interventions to ensure that every pregnancy is wanted and every birth is safe.

We will work with governments and civil society to strengthen national capacity to:

- Conduct needs assessments and ensure that health plans are MDG-driven and performance-based;
- Cost national plans and rapidly mobilize required resources;
- Scale-up quality health services to ensure universal access to reproductive health, especially for family planning, skilled attendance at delivery and emergency obstetric and newborn care, ensuring linkages with HIV prevention and treatment;
- Address the urgent need for skilled health workers, particularly midwives;
- Address financial barriers to access, especially for the poorest;
- Tackle the root causes of maternal mortality and morbidity, including gender inequality, low access to education — especially for girls — child marriage and adolescent pregnancy;
- Strengthen monitoring and evaluation systems.

In the countdown to 2015, we call on Member States to accelerate efforts for achieving reproductive, maternal and newborn health. Together we can achieve Millennium Development Goals 4 and 5.

Margaret Chan
Director General, WHO

Thoraya Ahmed Obaid
Executive Director, UNFPA

Ann M. Veneman
Executive Director, UNICEF

Joy Phumaphi
Vice President Human Development, World Bank

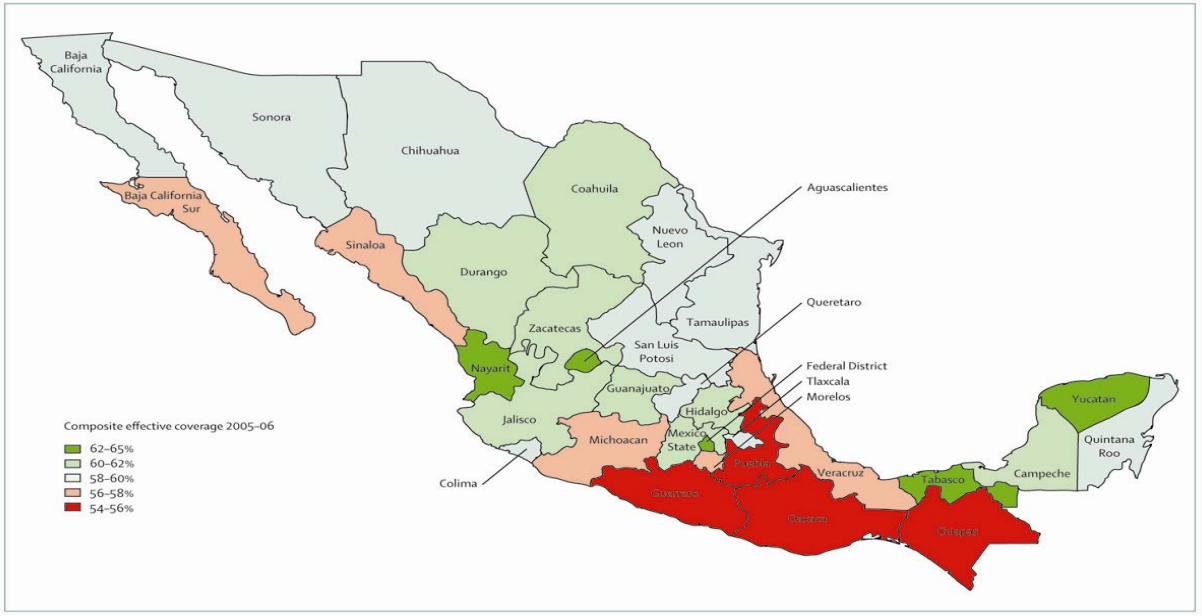


Figure 4: Map of composite effective coverage based on 14 interventions by state for 2005–06

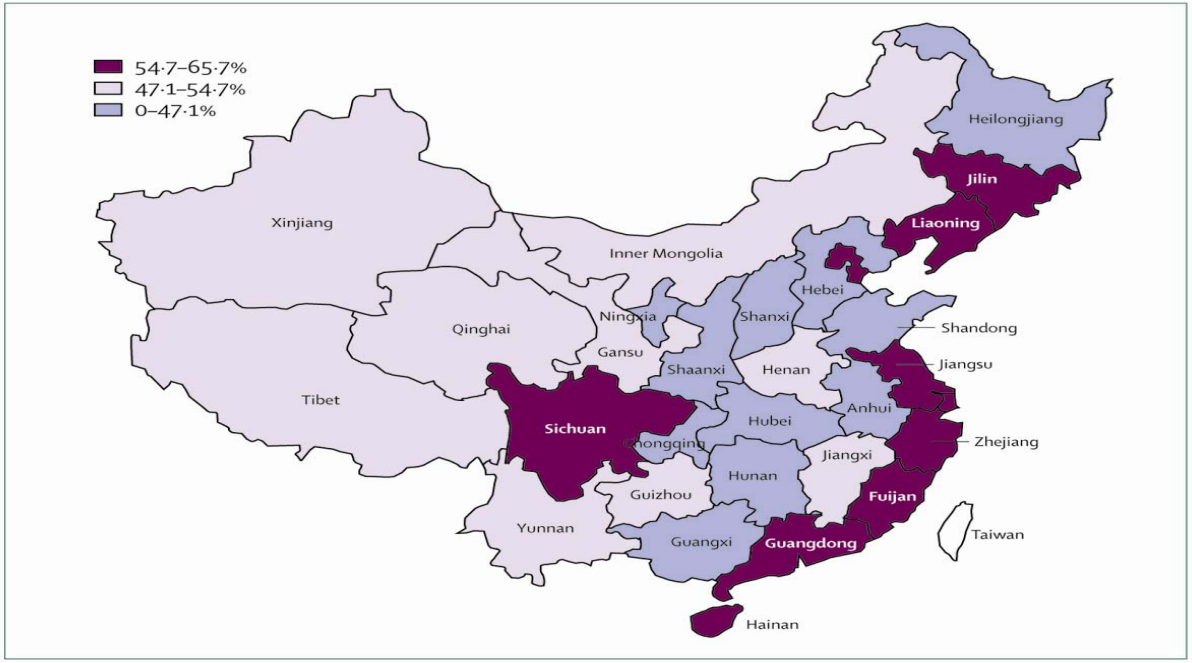


Figure 1: **Health-system coverage in Chinese provinces in 2003**

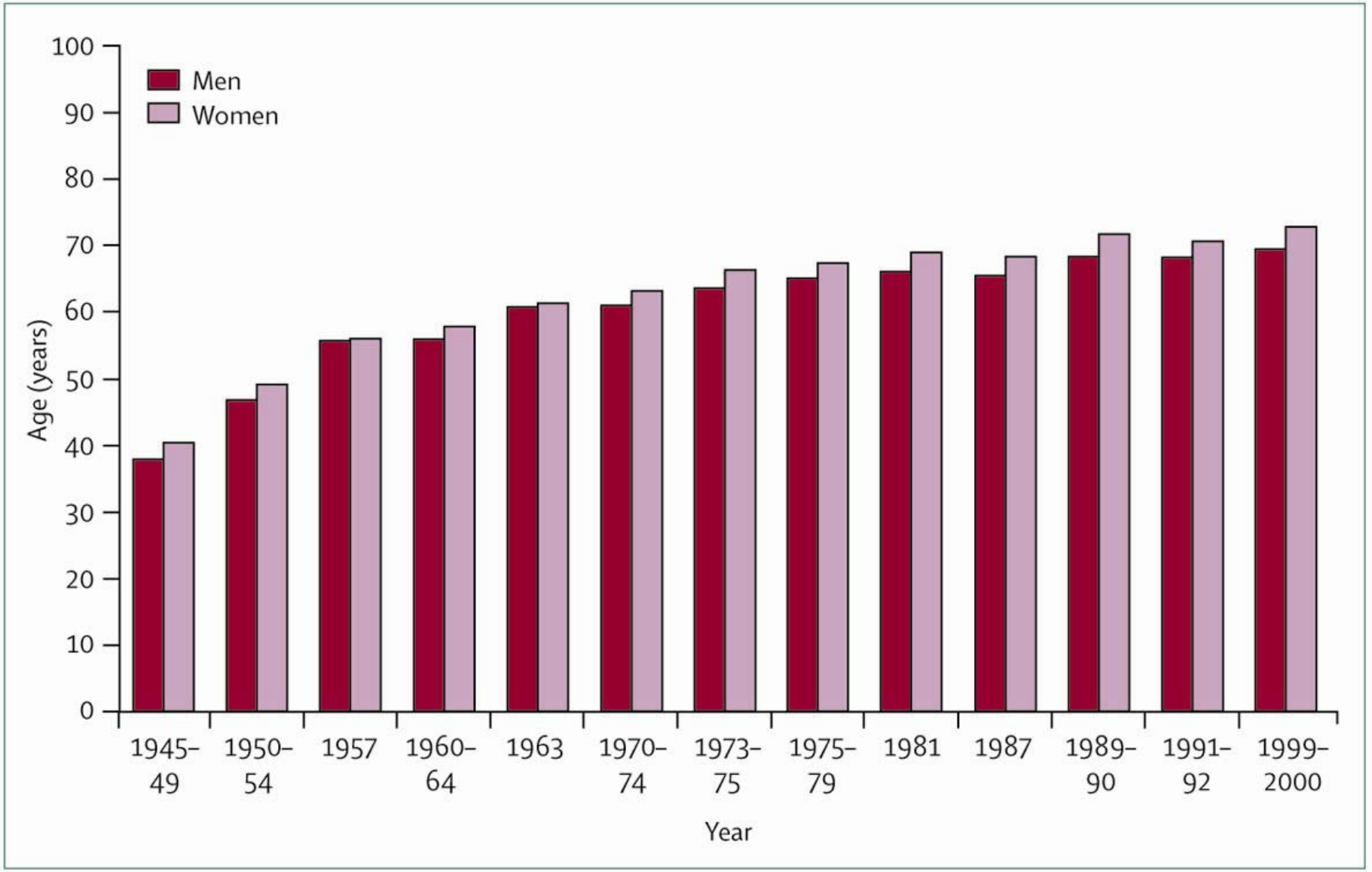


Figure 1: **Life expectancy at birth in some years in China**
Data are from references 6 and 30.

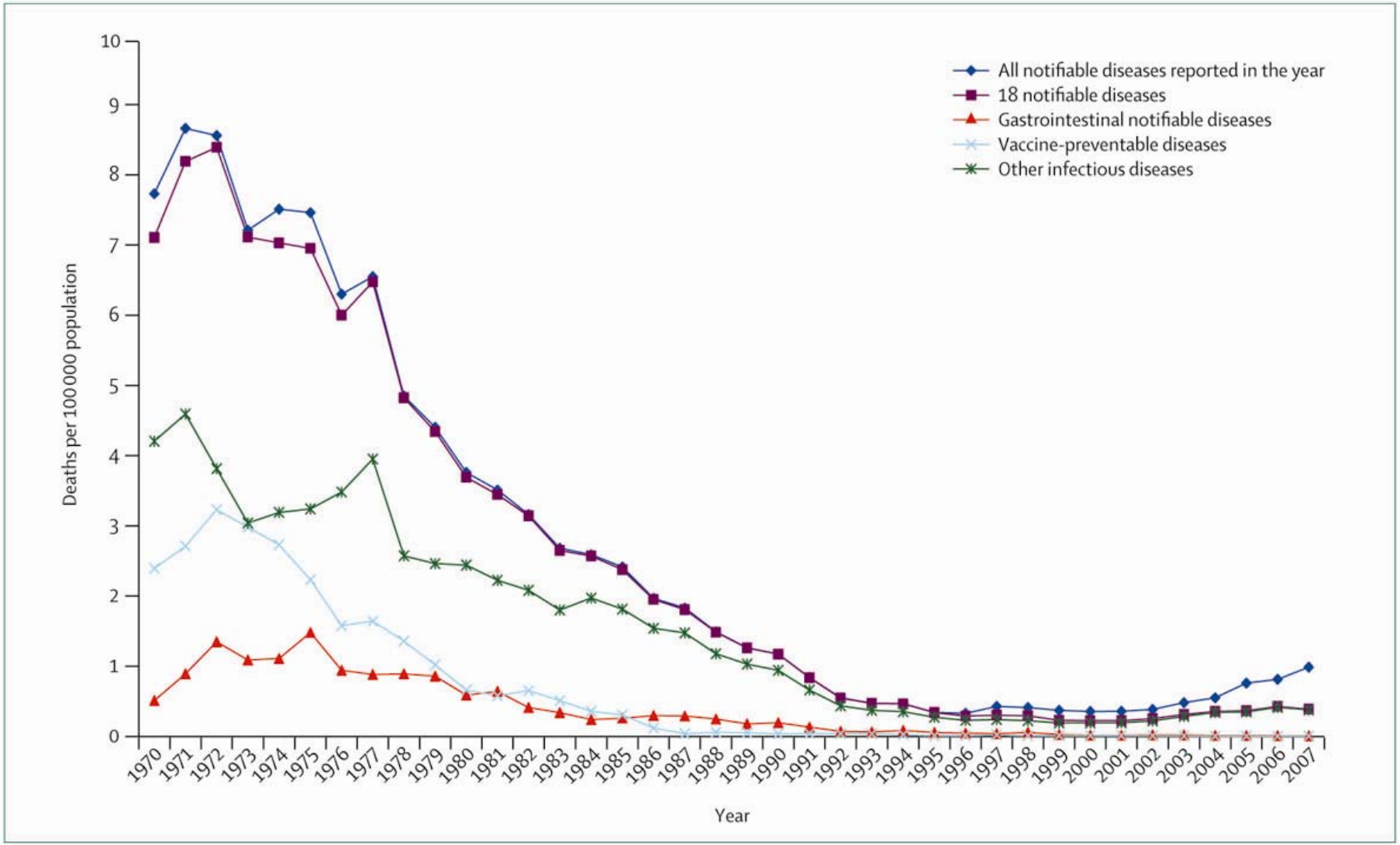


Figure 3: **Trends in deaths (per 100 000 population per year) from notifiable infectious diseases in China during 1970–2007**
Vaccine-preventable diseases were pertussis, diphtheria, polio, and measles. Gastrointestinal infectious diseases were cholera, dysentery, typhoid, and paratyphoid.

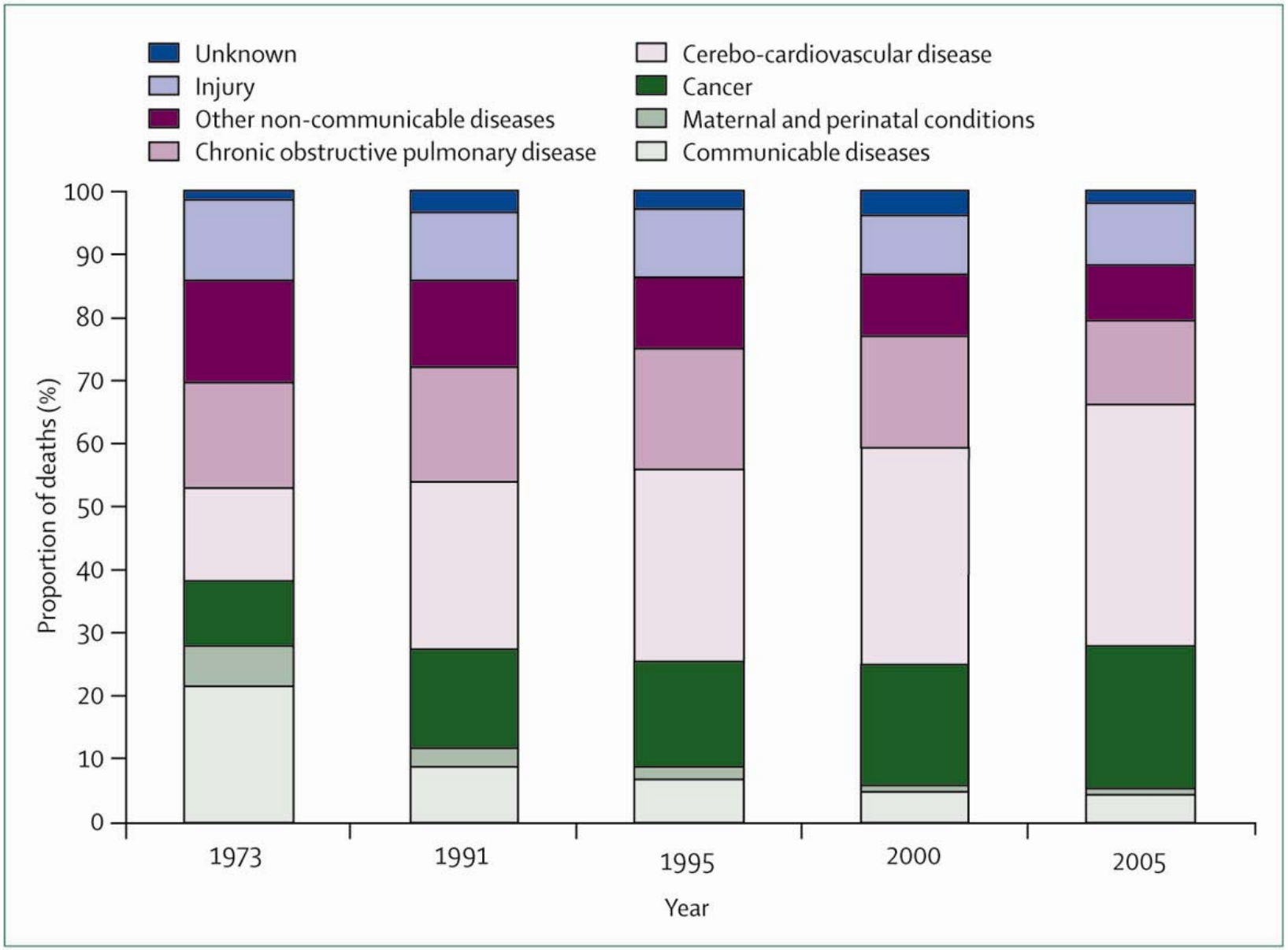


Figure 2: **Distribution of causes of death between 1973 and 2005**
Data are from references 7–9.

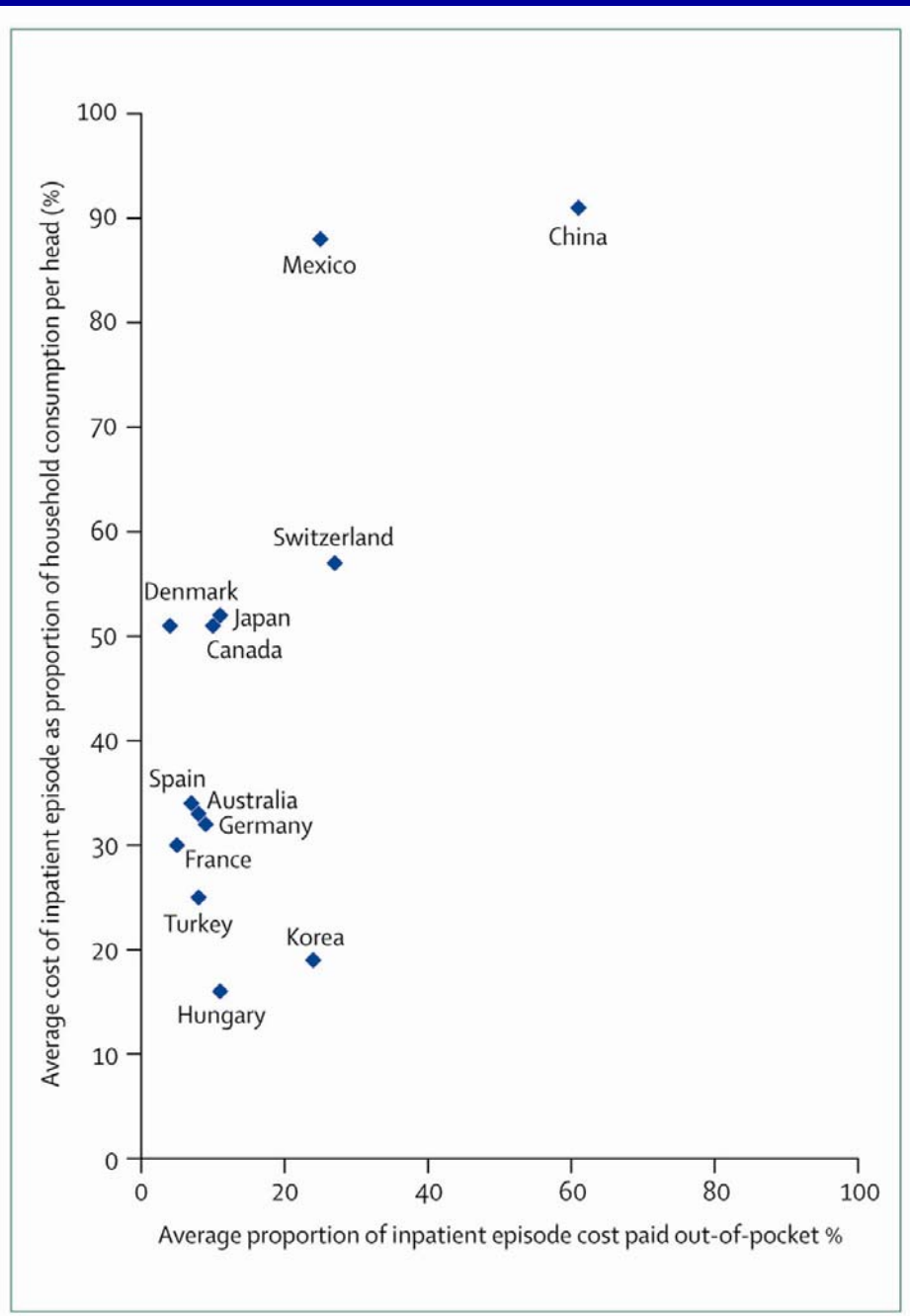


Figure 2: **Share of inpatient costs paid out-of-pocket**
Data from China National Health Accounts, Chinese Ministry of Health.

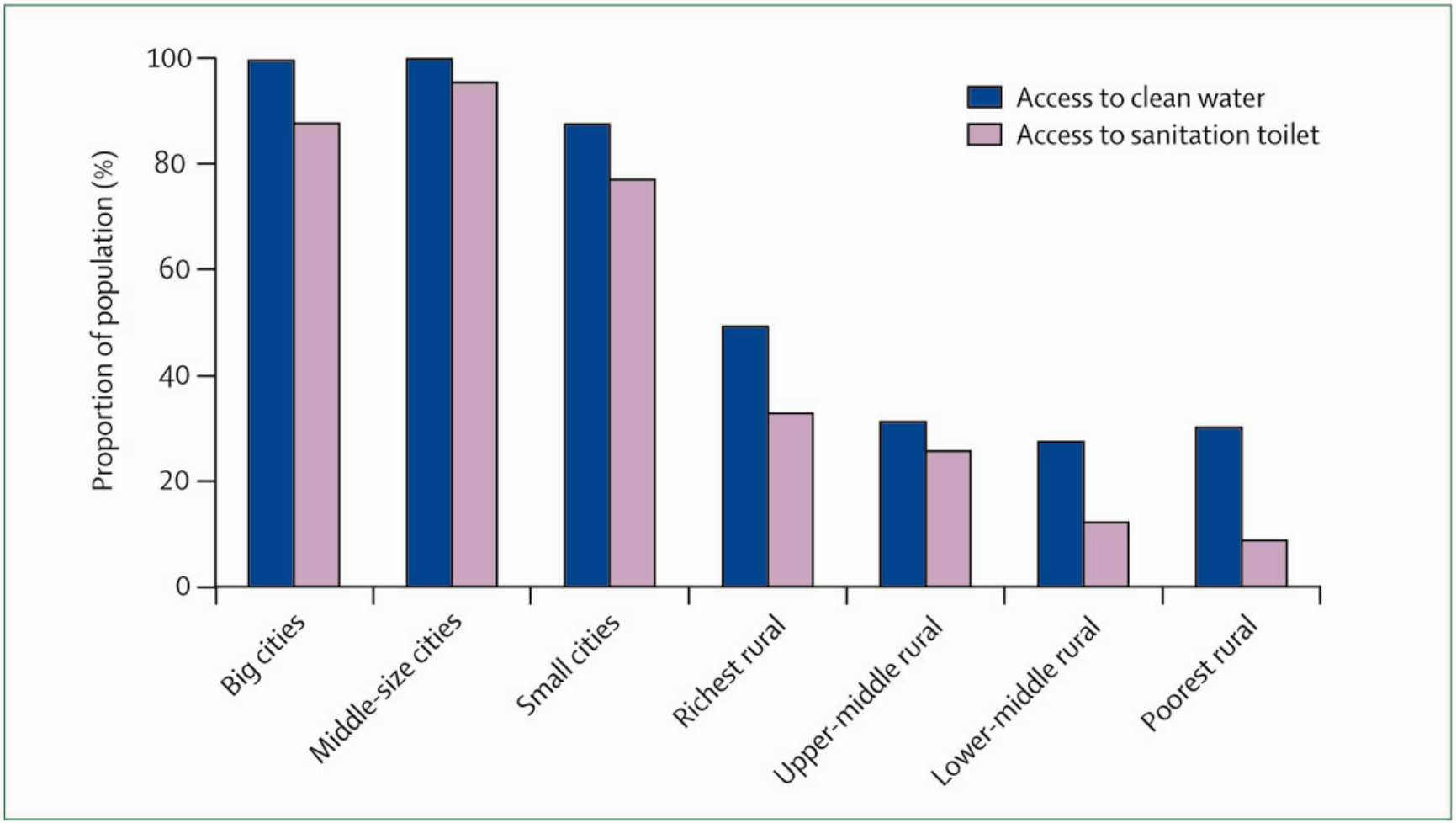


Figure 6: **Percentage of population with access to clean water and sanitation in different areas in 2003**[47]

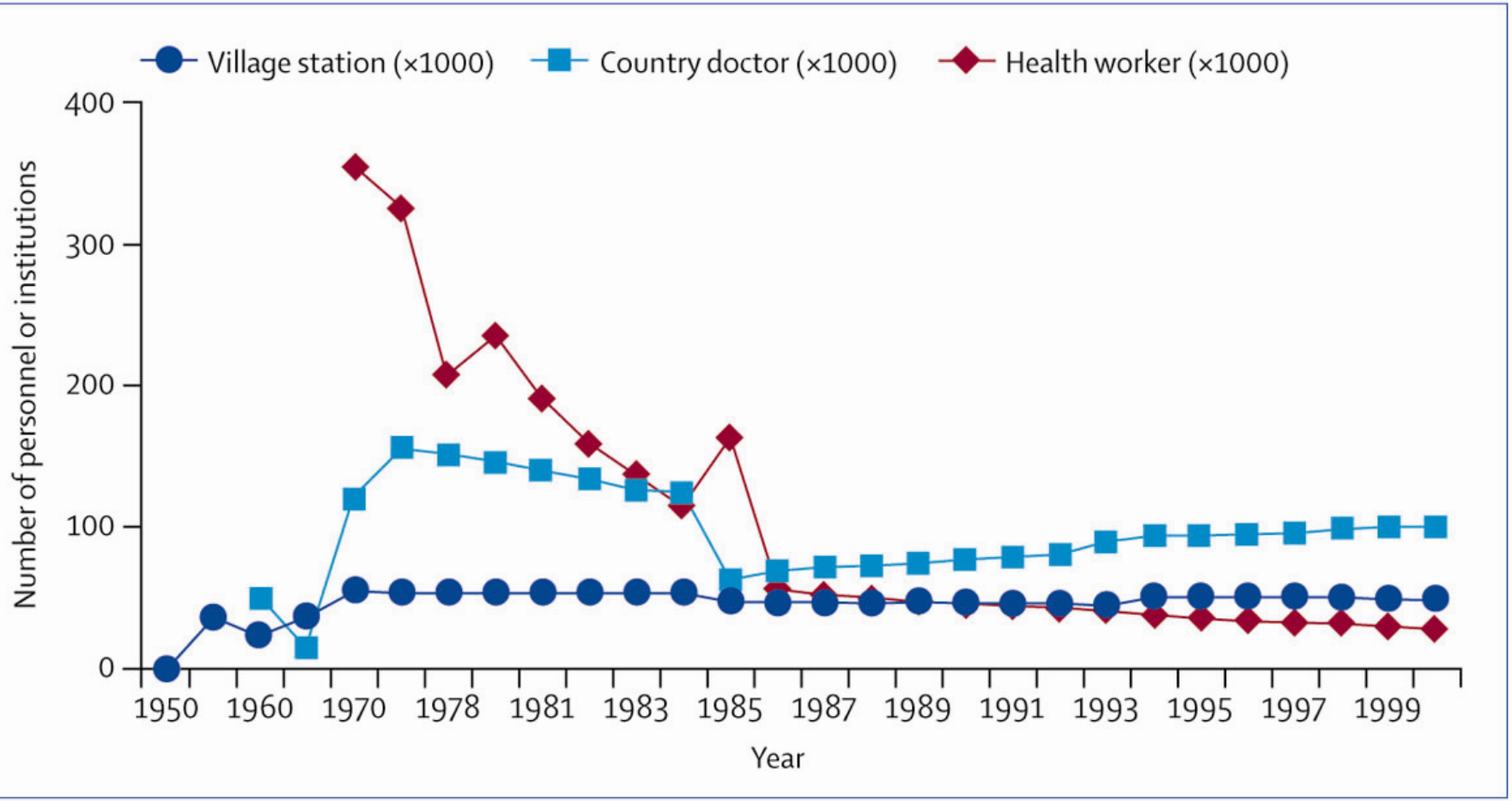


***Figure*: Rural health personnel and institutions in China, 1950–2000**

Note that x-axis is non-linear. Data are from references 6 and 7.

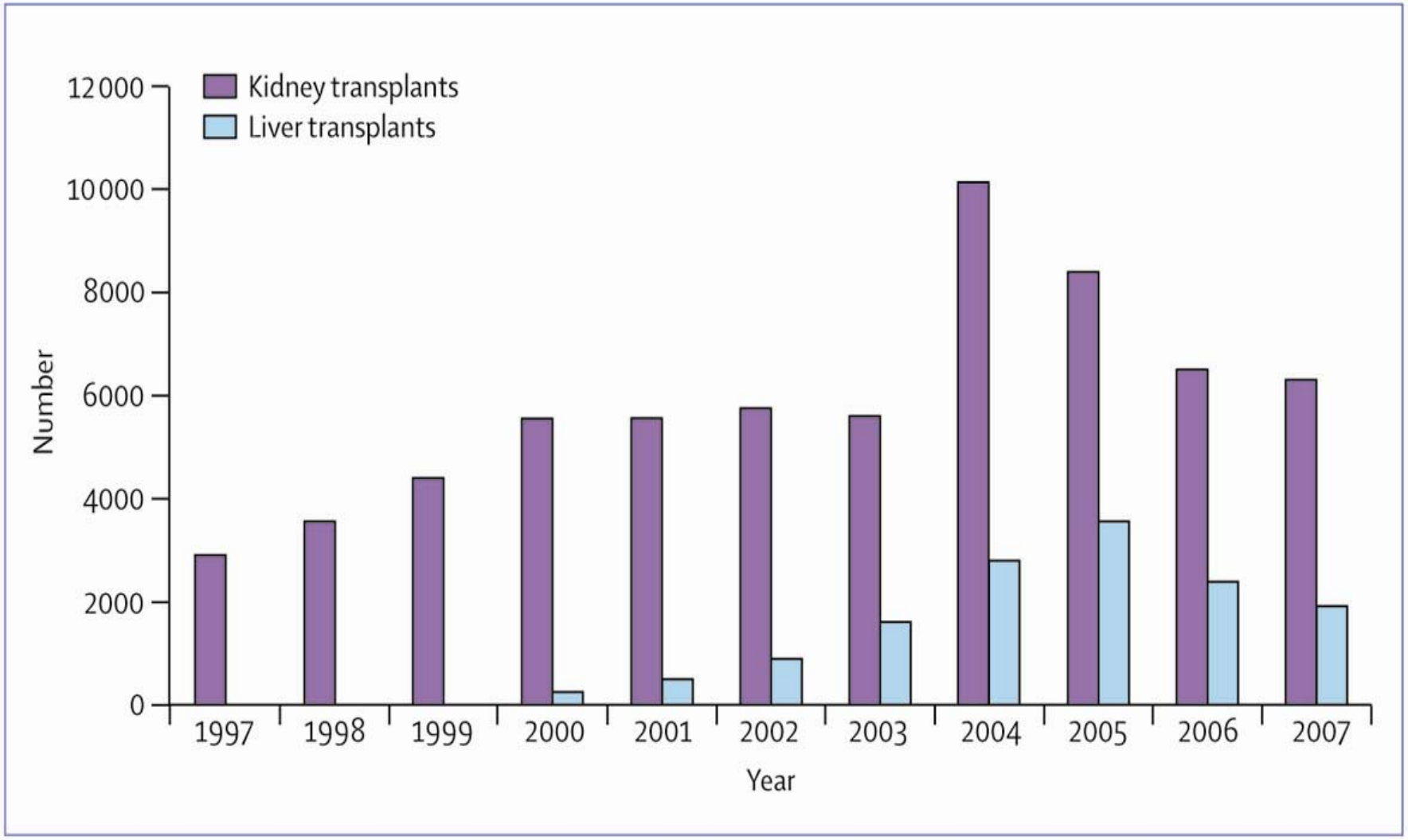


***Figure*: China—kidney and liver transplants for past decade**

Data from Chinese Ministry of Health.

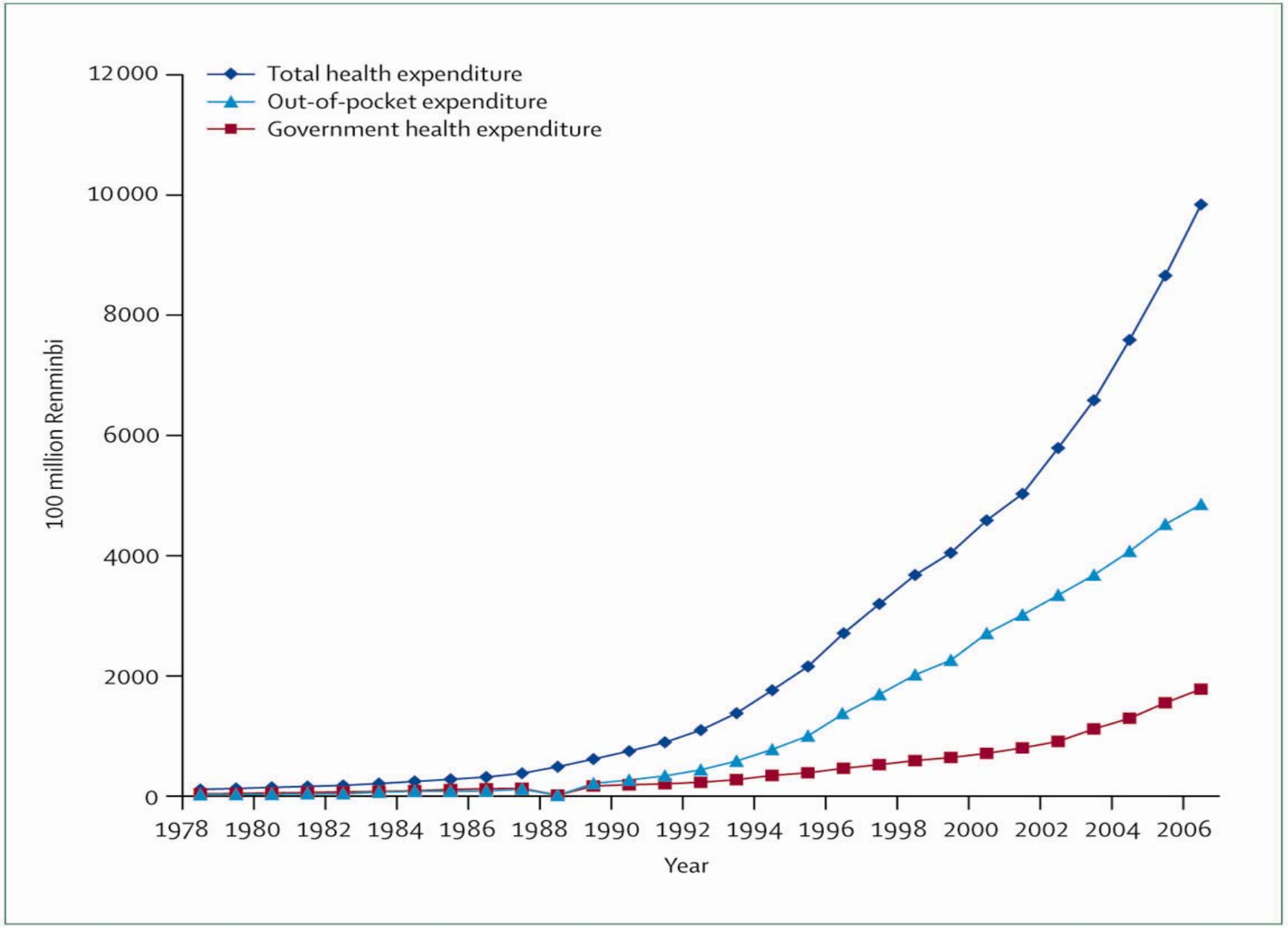


Figure 1: **Health expenditure in China since 1978**
Data from China National Health Accounts, Chinese Ministry of Health.

Global science for global policy

- **Chronic disease (2005, 2007)**
- **Indigenous health (2006)**
- **Energy and health (2007)**
- **Health and human rights (2007)**
- **HIV prevention (2008)**

***Pipeline*: 8 global health reports in progress (2008-2009)**

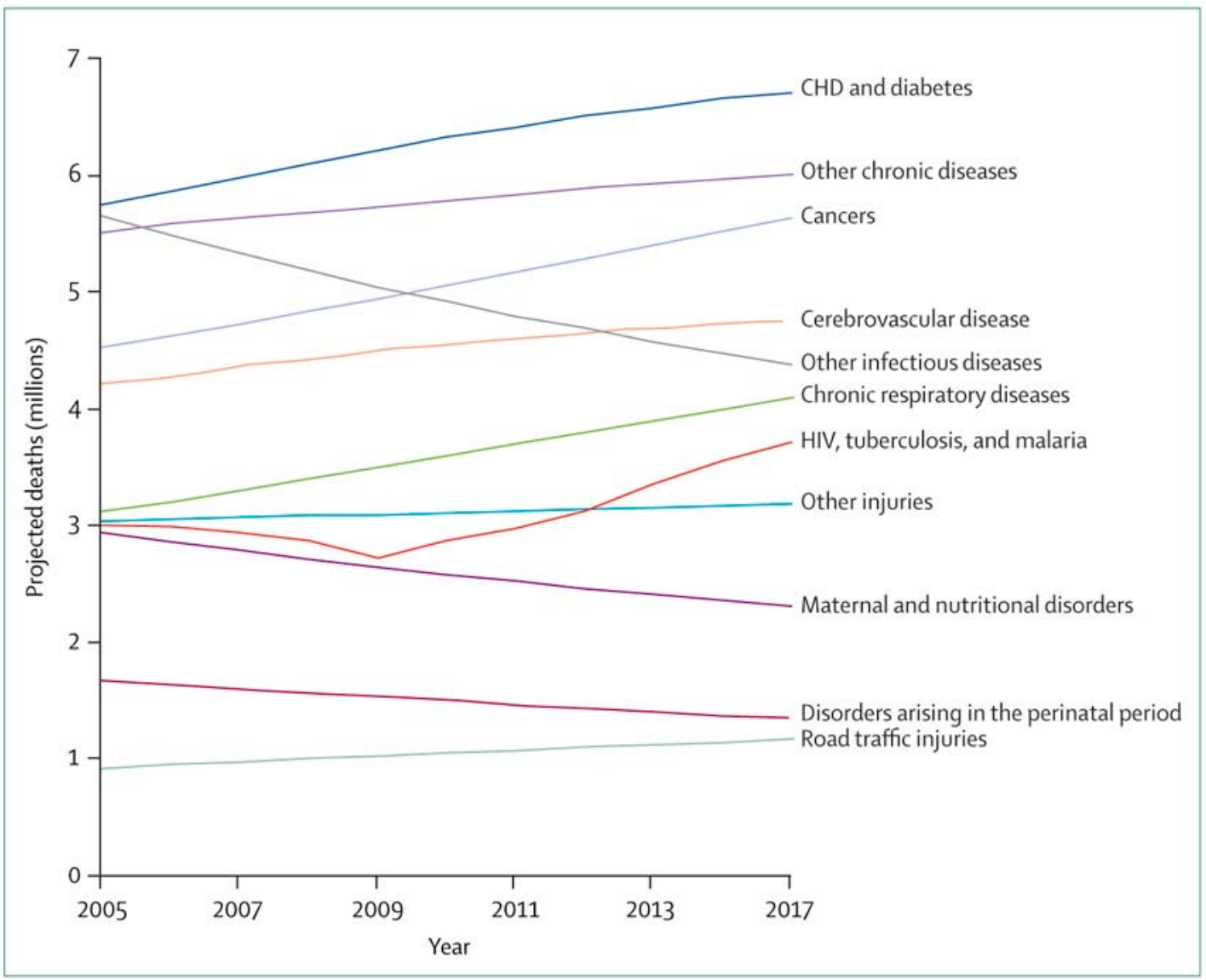


***Figure 3*: Projected global deaths (millions) for major chronic disease groups and other causes of death in 23 selected countries, 2005–15**

CHD=coronary heart disease.

	Baseline scenario				Cumulative GDP loss averted (US$billions) if global goal were achieved by 2015
	Foregone GDP (US$billions)			Cumulative GDP loss (US$billions) by 2015	
	2006	2015	2015 as proportion of 2006 estimates		
China	1·01	1·84	182%	13·81	1·36 (9·83%)
India	1·35	1·96	145%	16·68	1·64 (9·83%)
Russia	1·49	1·64	110%	16·09	1·49 (9·26%)
Brazil	0·33	0·50	150%	4·18	0·43 (10·23%)
Indonesia	0·33	0·53	158%	4·18	0·39 (9·33%)
Mexico	0·48	0·89	186%	7·14	0·75 (10·58%)
Turkey	0·39	0·52	133%	4·70	0·46 (9·72%)
Pakistan	0·15	0·21	140%	1·72	0·15 (8·62%)
Thailand	0·12	0·18	150%	1·49	0·15 (10·20%)
Bangladesh	0·08	0·14	175%	1·14	0·08 (7·14%)
Ukraine	0·13	0·13	100%	1·33	0·13 (9·43%)
Egypt	0·11	0·14	125%	1·26	0·11 (8·89%)
Argentina	0·13	0·16	125%	1·40	0·13 (9·09%)
Burma	0·03	0·06	200%	0·43	0·04 (9·09%)
Iran	0·08	0·13	167%	0·99	0·10 (10·53%)
Poland	0·17	0·23	133%	2·17	0·23 (10·53%)
South Africa	0·16	0·21	133%	1·88	0·21 (11·43%)
Philippines	0·06	0·07	133%	0·62	0·06 (9·09%)
Colombia	0·07	0·10	150%	0·82	0·07 (8·33%)
Vietnam	0·02	0·03	200%	0·27	0·03 (12·50%)
Nigeria	0·12	0·12	100%	1·17	0·12 (10·00%)
Ethiopia	0·03	0·03	100%	0·16	0·01 (7·50%)
Democratic Republic of the Congo	0·00	0·03	140%	0·15	0·01 (7·90%)
Total	6·8	9·8	1·5	83·8	8·1 (9·5%)

GDP=gross domestic product.

Table 2: **Projected foregone national income due to heart disease, stroke, and diabetes, and cumulative GDP gains through achievement of a global goal of an additional 2% annual reduction in mortality due to chronic diseases, 2006–15**

	30–44 years	45–59 years	60–69 years	70–79 years	80–100 years
Salt-reduction intervention					
Reduction in salt intake (g per day)*	1·70 (0·42)	1·69 (0·46)	1·68 (0·46)	1·68 (0·46)	1·68 (0·46)
Decrease in mean systolic blood pressure (mm Hg)†	1·24 (0·26)	1·70 (0·37)	2·34 (0·52)	2·83 (0·64)	3·46 (0·82)
Tobacco-control interventions‡					
Increase in real price of tobacco§	43·2% (15·8%)	43·2% (15·8%)	43·2% (15·8%)	43·2% (15·8%)	43·2% (15·8%)
Change in smoking prevalence caused by non-price interventions	12% (0·7%)	12% (0·7%)	12% (0·7%)	12% (0·7%)	12% (0·7%)
Change in smoking prevalence caused by combined price and non-price interventions‡	20·8% (0·6%)	20·8% (0·6%)	20·8% (0·6%)	20·8% (0·6%)	20·8% (0·6%)

Data are mean (SD). *15% decrease in mean sodium intake. †Values are for the final year of the intervention (2015). ‡Population-level tobacco policies were assumed to apply equally to all categories of smokers. §Increase in real price sufficient to reduce smoking prevalence by 10%.

Table 1: **Effect sizes of salt-reduction and tobacco-control interventions for different age-groups in 23 countries (2006–15)**

	Ischaemic heart disease (uncertainty range)	Cerebrovascular disease (uncertainty range)
Individuals without established disease		
Aspirin	0·68 (0·60–0·77)	0·84 (0·75–0·93)
Blood-pressure-lowering drug (ACE inhibitor and thiazide)	0·66 (0·60–0·71)	0·51 (0·45–0·58)
Cholesterol-lowering drug (statin)	0·64* (0·55–0·74)	0·94 (0·78–1·14)
Individuals with established disease		
Aspirin	0·66 (0·6–0·72)	0·78 (0·72–0·84)
β blocker	0·73† (0·75–0·87)	0·71 (0·68–0·74)
ACE inhibitor	0·80 (0·70–0·90)	0·68 (0·56–0·84)
Statin	0·71 (0·62–0·82)	0·81 (0·66–1·00)

*Risk is graduated by 0·89 at 1 year, 0·76 at 2 years, 0·67 at 3–5 years, and 0·64 in subsequent years. †Risk is graduated by 0·73 in first 3 years, 0·93 at 4–6 years, and 0·99 in subsequent years.

Table 3: **Effects of different individual drugs, measured as relative risk, on fatal and non-fatal ischaemic heart disease and cerebrovascular disease**

Call to Action

- WHO
- World Bank
- Countries
- NGOs
- Food and drinks industry
- Pharmaceutical industry
- Civil society
- Academic community

WHO: Getting political

World Health Organization

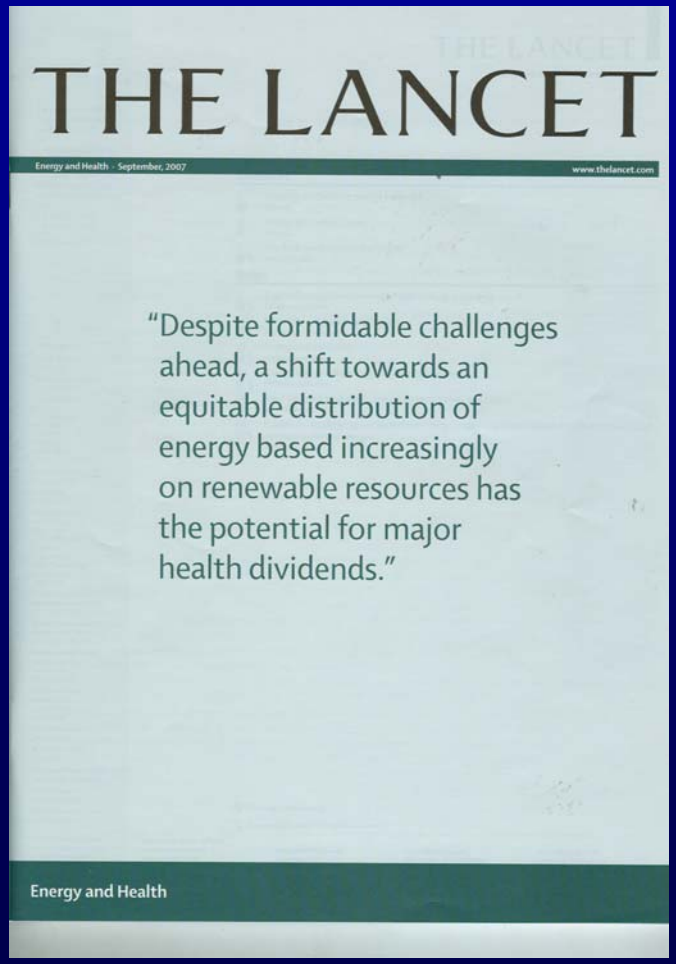
SIXTY-FIRST WORLD HEALTH ASSEMBLY
Provisional agenda item 11.5

A61/8
18 April 2008

Prevention and control of noncommunicable diseases: implementation of the global strategy

Report by the Secretariat

Energy and climate change

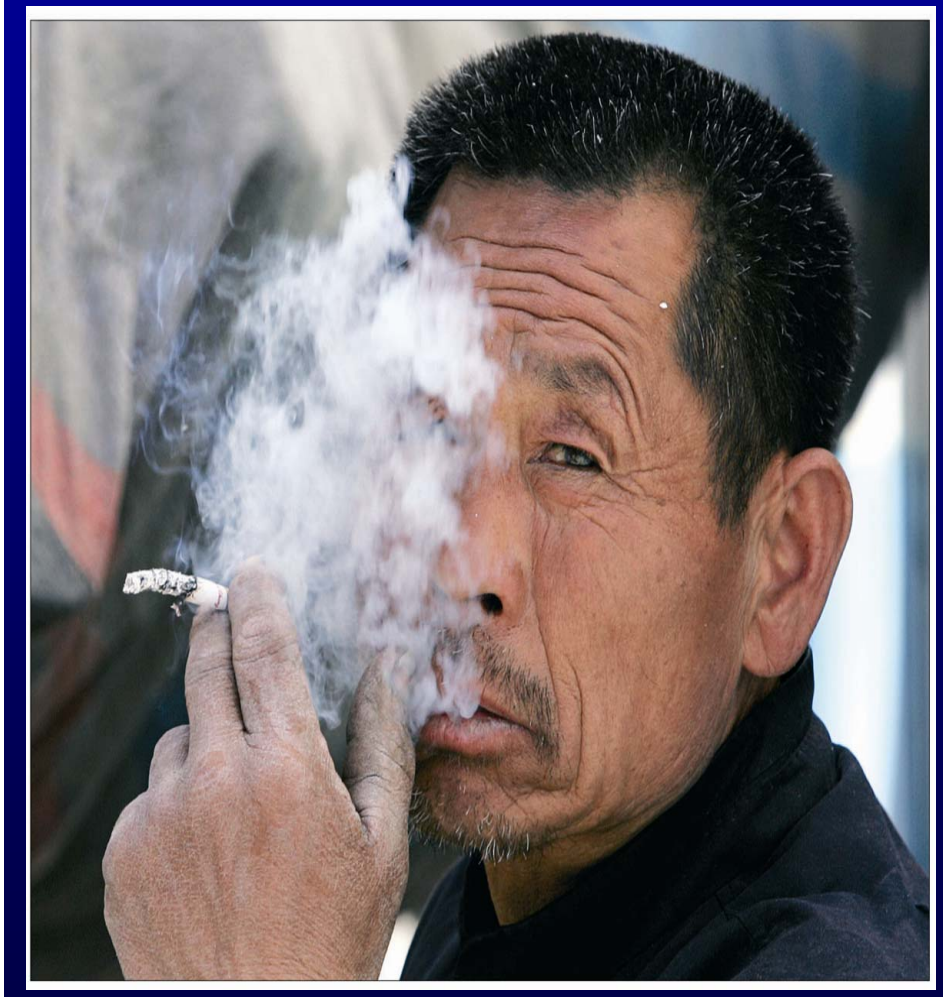


- **Climate change is a critical planetary issue**
- **It is part of a larger challenge: energy equity**
- **Health is a neglected aspect of energy**

1.6 billion people are exposed to adverse health risks because of lack of access to electricity

Wilkinson P. et al
Lancet 2007; **370:** 117-87.

Future reports: 2008-09



Right to health

Trade

Malaria

Cancer

India

Pakistan

South Africa

Palestine

Mental health

***Lancet* Mental Health Steering Group**

1. No health without mental health
2. Resource scarcity, inequity, inefficiency
3. Treatment evidence
4. Mental health systems
5. Barriers to change
6. Call to Action

Partners: MacArthur Foundation; KCL; WHO; LSHTM

Movement for Global Mental Health

Home | Packages of care | Capacity Building | Human Rights | Research | Monitoring & Indicators

- Lancet Series on GMH
- Call for Action
- Activities of the Movement
- Photo Gallery

Monthly Updates

Guidelines for mental health interventions for people living with HIV/AIDS

Upcoming Events

World Mental Health Day 02/10/2008

Making Mental Health a Global Priority – Scaling up services through Citizen Advocacy and Action

view all events

About the Movement for Global Mental Health

The Movement for Global Mental Health aims to improve services for people with mental disorders worldwide. In so doing, two principles are fundamental: first, the action should be informed by the best available scientific evidence; and, second, it should be in accordance with principles of human rights. The Movement is a global network of individuals and institutions who support this mission.

The Movement has emerged from the recent Lancet series of articles on Global Mental Health. Its goal is to implement the final Call for Action article of the Series which demands the scaling up of treatments for mental disorders, for the human rights of those affected to be protected, and for more research in low and middle income countries. We believe that the Movement for Global Mental Health will facilitate a vigorous and sustained response to the Call for Action. Furthermore, the Lancet will designate mental health as one of its 'campaign focal points' in the coming years. Ultimately we aim to ensure that, through a range of activities, the Movement for Global Mental Health takes its place alongside those promoting HIV/AIDS treatment and maternal and child survival, and is identified as one of the great public health successes of our times.

About this website | The Advisory Group | Institutional Partners | Charter of the Movement | Funder form |

If you have any suggestions to improve this website, Please Click here.

Members

- → Join the movement
- → Institutional partners
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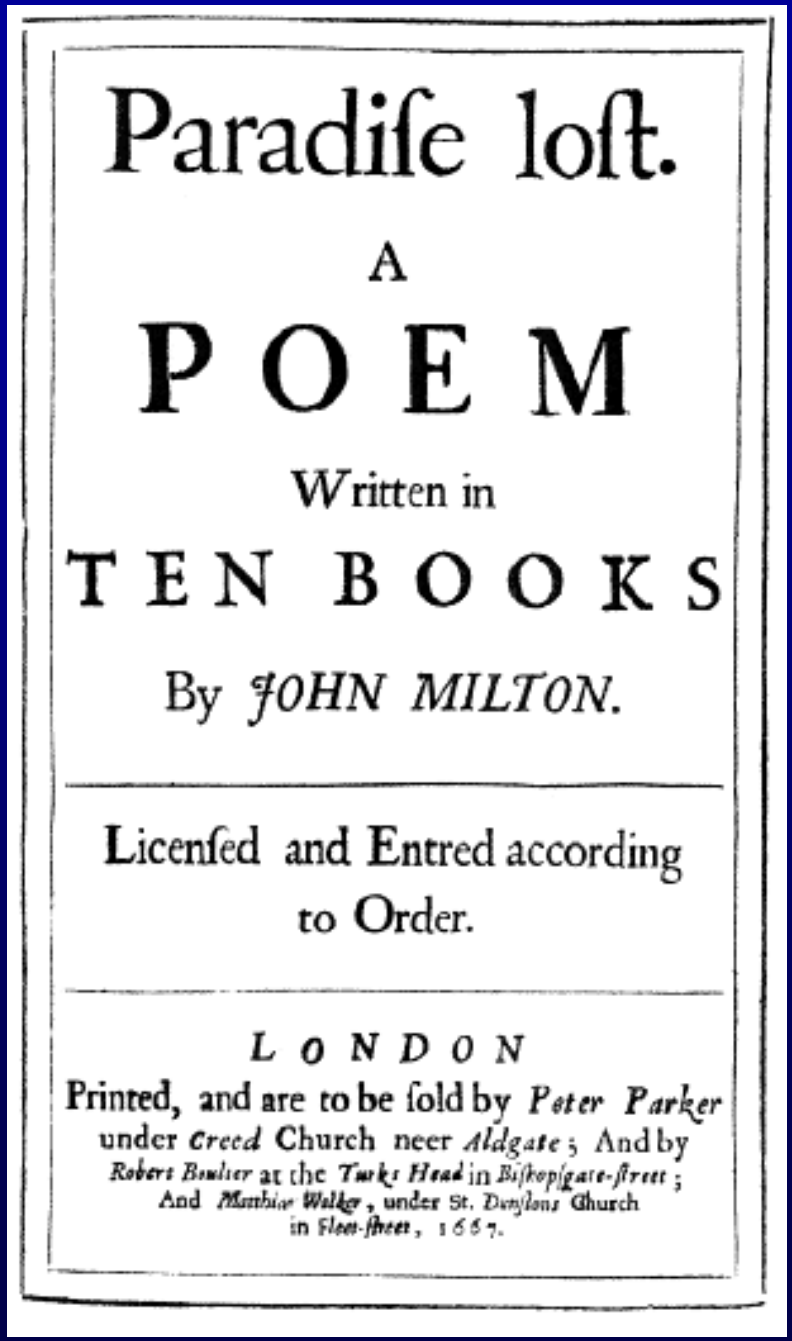
Advocacy

Pledge your support to our Global Advocacy Campaign More...



Paradiſe loſt.

A

POEM

Written in

TEN BOOKS

By *JOHN MILTON.*

Licenſed and Entred according to Order.

LONDON

Printed, and are to be ſold by *Peter Parker* under *Creed* Church neer *Aldgate*; And by *Robert Boulter* at the *Turks Head* in *Biſhopſgate-ſtreet*; And *Matthias Walker*, under St. *Dunſtans* Church in *Fleet-ſtreet*, 1667.

“And fast

by hanging in

a golden chain

This pendent world…”