Health-care delivery for long-term survivors of childhood cancer

In their Article in *The Lancet* (Dec 9, p 2569),[1] Bhakta and colleagues provide compelling data and novel statistical analysis to quantify the overwhelming lifetime cumulative burden of chronic health conditions caused by curative paediatric cancer therapies. As a 27-year survivor of Hodgkin's lymphoma, I applaud the authors' suggestion that it might be time to rethink the methods by which we provide care for long-term childhood cancer survivors. As a patient, I have had numerous encounters over the past three decades that have left me frustrated by the scarcity of easy access to coordinated comprehensive care for survivors. As a physician and paediatric oncologist, I also possess the knowledge that has allowed me to advocate for my care. I survived open-heart surgery at age 35, and a mild stroke at age 38—two of the many late health effects that impact my life. My good fortune is that I have been immersed in the medical system throughout my lifespan as a survivor, which has positioned me to receive the very best medical care. But what about survivors that do not have easy access to health care? Most survivors face financial obstacles and have difficulty finding high-quality coordinated care. Our current system does not effectively manage this medically underserved population. Childhood cancer survivors are frequently used to highlight the amazing successes of modern medicine. We owe it to these patients to develop more robust and comprehensive care systems to help address their ongoing chronic health needs.

I declare no competing interests.

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1 Bhakta N, Liu Q, Ness KK, et al. The cumulative burden of surviving childhood cancer: an initial report from the St Jude Lifetime Cohort Study (SJLIFE). *Lancet* 2017; **390:** 2569–82.

Political determinants of Sustainable Development Goals

We read with interest the article by the GBD 2016 SDG Collaborators[1] (Sept 16, p 1423), which presents a comprehensive analysis of the potential gaps and gains in the health-related Sustainable Development Goals by 2030.

Among the issues that caught our attention when reading the Article was the fact that, if current trends continue, Latin American countries will not fulfill the sustainable development goal for teenage pregnancy. Remarkably, data show that underperformance on adolescent pregnancy in Latin America happened despite positive developments towards meeting family planning needs and universal health coverage goals. This projection for adolescent pregnancy concurs with other reports showing Latin America as the only region globally where adolescent pregnancies are not decreasing,[2] and provides strong evidence for the need for in-depth analysis of political determinants of health.

Over the past two decades, a massive wave of pro-family mobilisation has swept Latin America. An example of this new wave of conservative mobilisation is the campaign against so-called gender ideology in school curriculums. Ministers of Education from Brazil (2015), Colombia (2016), and Peru (2017) faced strong disapproval, including rallies from conservative groups, who opposed the inclusion of gender and sexual education in school curriculums. In Colombia, the Minister of Education (Gina Parody) lost her job. In Peru, Jaime Saavedra and his successor, Marilú Martens, were censored by the majoritarian conservative parliament. In Brazil, school material prepared by the Ministry of Education, which addressed diversity and homophobia in schools, was recalled after strong pressure from conservative and evangelical congressmen. Since then, the fight to eliminate gender and sexual education from national plans of education has intensified. In September, 2017, the Brazilian Supreme Court authorised religious teaching in public schools.[3] In many countries in Latin America, protests against sexual education and other anti-gender and anti-abortion-inspired mobilisations have become the core of political opposition.[4]

Understanding the political determinants of health, including the new wave of conservative mobilisation, is necessary to evaluate the effect on women's and adolescents' most basic human rights and on the Latin American political process. This evaluation requires a fuller understanding of the backlash against sexual and reproductive rights in Latin America over the past few years. Regressive legislation has been approved in some countries. Enforcement of criminal law on abortion in El Salvador and Mexico has generated perverse outcomes for vulnerable women. Women are forced to carry to term and give birth to fetuses that have no chance of survival outside the womb.[5] Furthermore, girls as young as 9 and 10 years old, who have been impregnated through sexual assault, are forced to carry to term pregnancies that their small bodies simply cannot sustain without dire health consequences. Banning gender and sexuality education in the curriculum denies us the opportunity to prevent gender-based violence, to promote gender equality, and to implement measures to prevent adolescent pregnancy. These measures are crucial to reach the health-related Sustainable Development Goals.

We declare no competing interests.

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See **Articles** page 2569
See **Editorial** page 2527

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Anonymity in HIV testing: implications for public health

To end the HIV epidemic, UNAIDS has set an ambitious target: by 2020, 90% of the people living with HIV will be diagnosed, 90% of those diagnosed will receive antiretroviral therapy (ART), and 90% of those receiving ART will be virally suppressed.[1] The test and treat strategy will ensure care and treatment for almost 36·7 million people living with HIV, potentially saving millions of lives; however, the implementation of the strategy comes with multiple programmatic challenges.

The first step towards universal care and treatment requires the diagnosis of people living with HIV, and linkage of these people to adequate medical services. Worldwide, new HIV testing and counselling (HTC) strategies have emerged to achieve the first 90% goal; however, after HIV diagnosis, rates of linkage to care and treatment are low—from 26% to 61%.[2] In eastern and southern Africa, only 60% of people living with HIV are estimated to be receiving treatment;[3] therefore, interventions to improve linkage to medical services and ensure ART are needed.

In most countries in southern Africa, HIV diagnosis and care is provided at a rural level, and patient clinical records are mainly paper based. At the beginning of the epidemic, voluntary anonymous HIV testing was recommended to decrease fear, stigma, and discrimination associated with infection, by eliminating the social and psychological risks associated with HIV. This anonymity introduces several impediments to successful patient management, including the inability to: identify people living with HIV who undergo multiple HIV tests, despite being aware of their positive status;[4] monitor the frequency of HIV seronegative individuals who undergo retesting; track individuals who test seropositive but are not enrolled in care, and therefore not on ART;[5] test sexual partners and children of non-enrolled index cases; and, obtain accurate indicators of new HIV diagnoses, retained patients, or patients lost to follow-up. Countries such as South Africa, Malawi, and Mozambique have modified their HTC policies to include non-anonymous testing, thus acknowledging the shortcomings of anonymity; however, the historical weight of anonymity remains, and, many health facilities continue this practice. The widespread application of the HTC recommendations should include approaches to destigmatise and normalise HIV infection.

"It will be impossible to end the epidemic without bringing HIV treatment to all who need it."[1] This statement by UNAIDS highlights the need for governments of HIV-endemic countries to support the abrogation of anonymous testing and facilitate linkage to care,[6] as with other chronic conditions, and leave no one behind in the fight to end the HIV epidemic.

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Overestimation of cardiovascular outcome incidence

We read with interest the study by Michael Böhm and colleagues (June 3, p 2226),[1] in which they investigated the associations between blood pressure and cardiovascular outcomes and suggested that the lowest blood pressure possible is not the best goal for high-risk patients. Böhm and colleagues[1] used Kaplan-Meier curves and Cox regression for the outcomes, stratified by different values of systolic blood pressure and diastolic blood pressure. However, because this study[1] regards prediction of cardiovascular outcomes for patients, we caution about overestimation of the cumulative incidence of each outcome in the presence of competing events.[2]