

maintaining smoke-free policies in these circumstances is a major challenge that needs substantial investment and sustained commitment to train and support staff, and provision of cessation and temporary abstinence treatments for smokers.^{9,10} However, health benefits to staff and to this vulnerable group of patients, who are frequently excluded from mainstream health provision, are substantial.

Had the appeal succeeded, the whole process of making mental health units smoke free would have been undermined, perhaps fatally so. Instead, this judgment clears the way for full implementation of smoke-free law across mental health units in England from July, 2008. Whether the trusts involved rise to the challenge by showing the commitment, leadership, and investment necessary to ensure success remains to be seen.

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AM co-authored the national guidance for smokefree hospital trusts. This guidance was profiled in a letter that Louis Appleby, the National Clinical Director for Mental Health, wrote to all Mental Health Trusts in February, 2007. ER, GAD, and JB declare that they have no conflict of interest.

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HIV/AIDS estimates and the quest for universal access

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Recent debates about trends in HIV infections have overshadowed genuine achievements in addressing the pandemic.¹ WHO, UNAIDS, and UNICEF have recently issued a series of reports that assess progress towards universal access to HIV prevention, treatment, and care.^{2,3} Leaders of the G8 countries had committed to this ambitious goal in Gleneagles, UK, in 2005 and in the political declaration made at the UN General Assembly.^{4,5} On the basis of data from 143 countries, by the end of 2007, almost 3 million people in low-income and middle-income countries were being maintained on antiretroviral therapy—1 million more than the previous year. Almost three-quarters of the individuals on therapy lived in sub-Saharan Africa, where measurable reductions in AIDS mortality are occurring, and 200 000 were children. Treatment coverage globally was estimated at 31%; the total estimated need for therapy under current treatment recommendations⁶ is 9.7 million people.

Coverage for antiretrovirals in HIV-positive pregnant women for prevention of mother-to-child transmission in low-income and middle-income countries increased

from 9% in 2004 to 34% in 2007. In such countries, the percentage of young people having sex before age 15 years is decreasing in all regions, a continuation of trends detected earlier this decade.³

Despite these gains, huge gaps in access remain. Only 20% of people with HIV in low-income and middle-income countries are aware of their infection status. Surveys indicate that 40% of men and 38% of women at ages 15–24 years had accurate and comprehensive knowledge about HIV and about how to avoid transmission. In countries with epidemics that are concentrated within the populations most at risk, HIV prevention programmes fail to reach many people at risk of acquiring HIV, including most men who have sex with men and injecting drug users.³

Focusing scale-up of services where they are needed requires “knowing your epidemic”, globally and locally.⁷ According to the 2007 UNAIDS/WHO AIDS epidemic update,⁸ at the end of 2007, 33.2 million people (range 30.6–36.1) were living with HIV. Some 2.5 million people became newly infected that year, and 2.1 million

died of AIDS. AIDS remains the leading cause of death in Africa. These latest estimates reflect expanded sets of data, including the use of population-based surveys, and improved methods of analysis, and are better than nearly all other estimates for other global health problems.

Sub-Saharan Africa, with two-thirds of those living with HIV, has seen self-sustaining HIV epidemics with very high levels of HIV prevalence in the general population of many countries. In most of the rest of the world, HIV has occurred in concentrated epidemics that affect specific groups at risk (men who have sex with men, injecting drug users, female commercial sex workers) and their partners. The recent *Report of the Commission on AIDS in Asia*⁹ supports the concept of predominantly concentrated epidemics in that populous region.

Compartmentalising the world into concentrated and generalised epidemics usefully conveys likely trends, yet incompletely captures the complexity and heterogeneity of the epidemic. The probability of heterosexual HIV spread is influenced by local HIV prevalence, sexual networks, rates of partner change, and types of partner selected. Risk of heterosexual acquisition of HIV varies enormously internationally, though even very low risk is not zero risk.

It is this complexity around the likelihood and extent of heterosexual HIV transmission that is at the root of extreme claims in the mass media¹ that false information has been conveyed or that HIV/AIDS poses no risk to heterosexuals outside Africa. Generalised epidemics have occurred in Haiti and Papua New Guinea, and heterosexual transmission drives the epidemic in sex workers, their partners, clients, and their clients' partners in Asia and elsewhere. Such observations do not predict extensive or generalised spread, but neither do they indicate lack of any heterosexual transmission beyond the populations most at risk. As with hepatitis B virus infection, many heterosexual patients with HIV seem not to belong to any population that is most at risk, but still became infected.

Conveying the heterogeneity of risk is a challenge in public health in general. HIV/AIDS epidemiology changes slowly, current trends providing the basis for appropriate targeting of prevention and treatment efforts. Just like other sexually transmitted infections, HIV/AIDS should be an integral component of sexual and reproductive health interventions and education, but targeting efforts aimed at the risk populations and settings where HIV transmission is most intense



Kicosehp, a non-governmental organisation in Kibera, Kenya
Peer education to enhance AIDS awareness and prevention measures.

is crucial. Accurate size estimation and mapping of populations most at risk in concentrated HIV/AIDS epidemics can be difficult, with underestimation as well as overestimation possible. More investment in surveillance and epidemiology is required for the continued and objective documentation of trends.

Of ongoing concern is the long-term sustainability of efforts in terms of the future burden of HIV and availability of the necessary funding. In addition to the debate around epidemiology, arguments are being made that too much funding is going to HIV/AIDS compared with other health priorities.¹⁰ Recent data show how far we are from universal access, and the problem is not excessive funding for HIV/AIDS, but continued inadequate funding for all major challenges in global health, and the need for their accurate measurement. In 2008, protection against major infectious diseases, such as malaria, tuberculosis, and HIV/AIDS, should be seen as a universal obligation, and universal access refers to everybody in need, everywhere.

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Lancet International Fellowships 2008 and 2009



Anna Checkley



Alena Shantsila

We are delighted to announce the winners of our International Fellowship scheme for 2008: Dr Anna Checkley, a specialist registrar in infectious diseases at St George's Hospital in London, UK, and Dr Alena Shantsila, a specialist in echocardiography and vascular ultrasound at the Republican Research and Practical Centre in Minsk, Belarus.

Since *The Lancet's* Fellowship scheme launched in 1998, we have assisted 17 doctors to work in settings very different to their usual experience. This year Anna and Alena were the clear winners of the 12 applicants for the award. Anna Checkley is using the award in combination with a fellowship from the UK's Medical Research Council to undertake a project on the effects of environmental non-tuberculous mycobacteria on immune responses to a new vaccine for tuberculosis, and will be working at the South Africa TB Vaccine Institute at the University of Cape Town in South Africa. The trial site is Worcester, in the Western Cape, where transmission levels of tuberculosis are exceptionally high; thus an effective tuberculosis vaccine could have a great effect on the control of this disease. Alena Shantsila's award will allow her to gain clinical experience in new echocardiographic and imaging techniques at the City Hospital in Birmingham, UK. She hopes to put these newly acquired skills into practice on her return to Belarus, where she will be the only such qualified clinician. Furthermore, she will gain

research experience through a project investigating the relation of myocardial contrast echocardiography with endothelial damage or dysfunction in hypertension.

We now invite applications for two *Lancet* International Fellowships—£25 000 each—to start in 2009. The aim of these fellowships is to help doctors to work in a country very different from their own. The differences may lie in a country's delivery of health care, research or health priorities, or educational facilities. To be eligible, you must be a medical graduate but there are no age limits. The fellowship should last at least 6 months. To apply, please send:

- Your curriculum vitae
- A proposal describing where you would like to go, when, and for how long, what you plan to do and why, and how you would spend your award
- Letters of support from your head of department and from the person who will be hosting your visit
- The names and addresses (including e-mail addresses and telephone numbers) of three referees.

Please send your application to Dr Astrid James, *The Lancet*, 32 Jamestown Road, London NW1 7BY, UK, in an envelope marked "International Fellowships". The deadline for submitting your application is Nov 1, 2008.

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