text, and to secure independent and comprehensive assessments of the health and human rights consequences of the proposed agreement for each nation. The assessments should evaluate the direct and indirect—and short-term and long-term-effects of the TPPA on public health policy and regulation, publicly funded health systems, the cost of medicines, and health equity; they should also be openly released to allow full public and legislative discussion before any political trade-offs are made and the agreement is signed.

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Violence and homicide in Mexico: a global health issue

Homicide rate in Mexico more than doubled between 2007 and 2012, from 9.34 to 18.57deaths per 100 000 people.1 In 2012, 25 967 murders per year were recorded,1 and 33 040 had already been reported by Nov 30, 2014.2 By comparison, in England and Wales 552 murders were recorded in 2013, 0.98 per 100 000 individuals.3 Although these figures might not be the highest in Latin America, they hide important regional and sex differences, with murder rates of men ten times higher than those of women, and reaching 164 deaths per 100 000 in the state of Chihuahua, and 94 per 100 000 in Guerrero.1 According to official statistics 136234 people have been murdered since 2007,2 with at least another 30 000 individuals missing.4

In Mexico, little attempt has been made to investigate this issue—this epidemic—from a public health perspective, nor to understand the social, political, economic, and structural causes in the contexts of both victim and perpetrator. Analysis of national databases suggests that homicide rates are highest in men aged 20–39 years. In 2010, homicide represented 12·2% of all deaths nationally, but this proportion reached 45·6% of deaths in men in Chihuahua state and 32·4% of deaths in men in Guerrero.¹

A multivariate analysis⁵ done by researchers at Guadalajara University found lawlessness (or failing judicial system), drug trafficking, alcohol or drug consumption, and basic education dropout to be the key determinants (in this order) of increased rates in some states. However, Cunjama and Garcia⁶ suggest that it is poverty and economic inequality and not the judicial system that are the principal determinants of

violence.⁶ The Mexican Government seems unable to guarantee the safety of its population or to address the structural causes of this epidemic.

Although the international global health community does look at the public health implications of violence, its focus has mainly been on gender-based and domestic forms of violence. It now needs to turn its attention to other forms of violence and particularly the form that mainly affects men, in whom the largest burden of mortality lies. We, the global health community, are in a position to exert pressure on the Mexican Government to deal with this crisis in two ways. First, by recognising homicide as a public health problem, and one that is inextricably linked to poverty, inequality, educational attainment, impunity, and corruption. This epidemic cannot be dismissed simply because it is linked to organised crime and we need to discuss this issue in terms of its real underlying causes. Second, we need to better understand this violence, and potentially learn from other experiences. Finally, international justice systems are in a position to take a more active role regarding state violations of human rights, genocide, and ethnocide, and support from the global health community would greatly strengthen their case. Now is the time for us to talk about Mexico's epidemic of homicide.



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For the **full list of signatories** see appendix

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Access to cardiac surgery in sub-Saharan Africa

Rheumatic heart disease remains a major public health issue in developing countries.1 Last year, Zühlke and colleagues reported the results of the first multicentre, international, hospital-based register for rheumatic heart disease.² Their study was done in tertiary centres across 12 sub-Saharan African countries, India, and Yemen, mainly including patients at an advanced stage of the disease. However, only a few patients were offered either percutaneous or surgical procedures, particularly in low-income countries, where only 11% of patients were operated on.2

The fact that access to cardiac interventions is restricted in low-income countries is not new.3.4 The ratio of cardiac surgery centres per million of inhabitants in sub-Saharan Africa is 1:33 (when excluding South Africa).4 In Uganda, a country that still has insufficient cardiac surgery facilities, 85 patients were diagnosed by visiting cardiologists with symptomatic rheumatic or congenital heart disease between 2009 and 2013. Intervention was scheduled in 38 patients with rheumatic heart disease (median age 19 years) and in 36 patients with congenital heart disease (median age 4 years). 27 patients were eventually operated on overseas (median waiting time of 10 months).5

Worldwide, millions of young patients with rheumatic or congenital heart disease are likely to be declined treatment each year.4 Cardiac surgery is a complex specialty that needs infrastructure and skills of a multidisciplinary team. Surgical non-governmental organisations either provide interventions overseas or on-site with visiting teams. These organisations should focus their efforts on comprehensive programmes that include prevention (especially in the setting of highly prevalent rheumatic heart disease), implementation of high standards of medical practice (eg, proper use of oral anticoagulants), and sustainability. Only visiting teams allow capacity building. Instead of resources being used to treat a few patients, essentially overseas, they should be used for North-South transfer of knowledge, for the development of techniques applicable in low-resourced settings, and for the enhancement of South-South collaborations, in the aim to establish national or regional referral centres. A handful of well-meaning, non-governmental organisations with restricted budgets are unlikely to take up this task. In countries such as Ghana and Namibia, government funding has contributed to a local cardiac surgery programme after an initial partnership with visiting teams.4 Effective approaches still need to be designed and assessed within the priority health-care agenda for development of sustainable cardiac surgery programmes. Political will and interest from big funders are needed to address the scarcity of cardiac surgery facilities in developing countries.

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Department of Error

The ENOS Trial Investigators. Efficacy of nitric oxide, with or without continuing antihypertensive treatment, for management of high blood pressure in acute stroke (ENOS): a partial-factorial randomised controlled trial. . Lancet 2015; **385:** 617–28—In figure 1 in this Article, the number of patients assigned to the GTN patch who completed assessment on day 7 should have been 1996 rather than 1966. Data for TICS-M score and verbal fluency score for both analyses in table 2 were incorrect: the table has been corrected. In figure 3, the p value for carotid stenosis should have been 0.33 and the p value for feeding status should have been 0.34. These corrections have been made to the online version as of Feb 13, 2015, and the printed Article is correct.

Sundström J, Jackson R, Woodward M, Baigent C, Neal B. Blood pressure lowering and cardiovascular risk-Authors' reply. Lancet 2014; **384:** 1746–47—In this Letter (Nov 15, 2014) the competing interests statement should have read "JS is an advisory board member for Itrim. MW is on a trial advisory committee for Novartis and is a consultant for Amgen. CB's institution receives grant funding from Merck, Novartis, Abbott, Bayer and Pfizer for research he is engaged in. BN is on trial steering committees for Janssen, Dr Reddy's Laboratories, and Servier: his institution has received grant funding from Abbvie, Janssen, Novartis Dr Reddy's Laboratories Roche and Servier; and his institution has received honoraria for meeting presentations he has made at the invitation of Abbott, AstraZeneca, Novartis, Pfizer, Roche, and Servier, IR declares no competing interests." This correction has been made to the online version as of Feb 13, 2015.