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Universal health coverage is needed to deliver NCD control

President Vázquez and Tedros Ghebreyesus (Sept 23, p 1473)[1] rightly highlight the urgent global need for fiscal, trade, environmental, and political actions against non-communicable diseases (NCDs). Sania Nishtar suggests that scope exists for a new NCD agency because such diseases "have exploded around the world".[2] However, hyperbole around NCDs is unhelpful. Premature NCD mortality (ie, mortality in individuals aged 30–69 years) is estimated to be decreasing across all sociodemographic quintiles (figure). Simultaneously, middle and late adult age groups are facing rapid demographic expansion worldwide, partly due to health and development successes that are extending life expectancy. The biological risk of NCDs increases with age. Therefore, as populations age, the prevalence of NCDs increases, and subsequently demand for treatment and the number of NCD-related deaths increase.

Global successes against infectious and external causes of death postpone eventual mortality into age groups in which NCDs are the primary risk. Therefore, because everyone will die of something eventually, and the individual chance of an NCD causing death increases with age, the number of NCD-related deaths is likely to increase. Thus, NCDs will never be eradicated. However, the WHO 25×25 strategy[4] and Sustainable Development Goal 3.4[5] wisely target premature NCD mortality. Decreases in premature NCD mortality probably reflect decreased exposure to risks, improved disease management, and healthier lifestyles. NCD risk factors need to be reduced further and improvements in clinical care and health promotion are needed to successfully decrease the burden of NCDs. One consequence of galvanising political will for universal health coverage—as championed by Tedros and WHO—will be improved action against NCDs. Establishing a separate NCD agency would add confusion to this central aim.

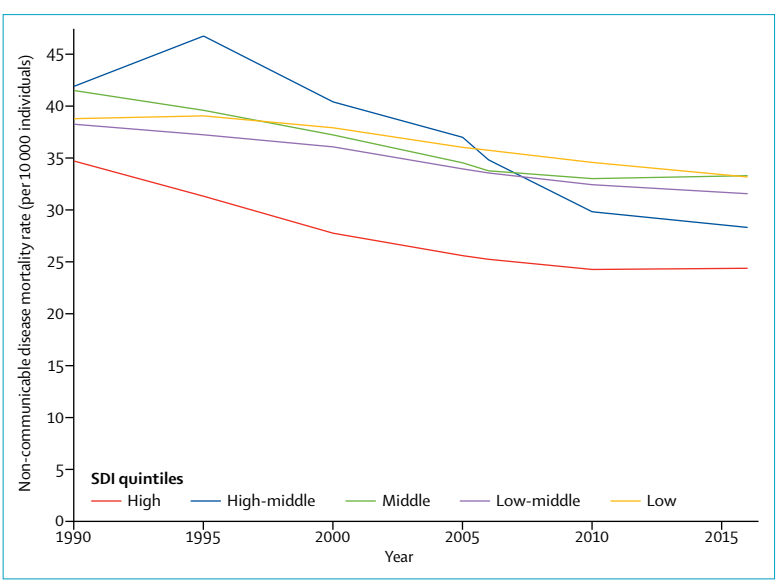

Figure: **Global Burden of Disease[3] estimates of mortality due to non-communicable diseases in the 30–69 year age group between 1990 and 2016**
SDI=Socio-Demographic Index.

I declare no competing interests.

Peter Byass
peter.byass@umu.se

Epidemiology and Global Health, Umeå University, Umeå 90187, Sweden; and Medical Research Council-Wits Agincourt Unit, School of Public Health, University of the Witwatersrand, Johannesburg, South Africa

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Women helping women prevent HIV in resource-limited settings

Almost a third of the total HIV-infected population in Nepal are women, and this female population is the fastest growing HIV-infected population in the rural areas of Nepal.[1] Along with illiteracy and poverty, gender inequality and an inability to successfully negotiate safer sex with their partners have been noted as reasons for the increase in the burden of HIV among women.[2] Realising that they are at risk of HIV infection because of sociocultural factors, women in rural areas of Nepal are helping to prevent HIV at the local level; however, their role in HIV prevention is often unrecognised. In this Correspondence, I want to highlight how local women, individually or in groups, are helping each other to prevent HIV in rural areas of Nepal.

Firstly, across Nepal women have formed non-partisan groups to meet every month and discuss the empowerment and mobilisation of women and the alleviation of poverty.[3] These groups also discuss and learn

about health and social issues within their lives and offer resources for women to improve their situation.[3] Thus, the local women have been effectively addressing various health and social issues (such as drug and alcohol use), intimate partner violence, unstable housing, food insecurity, mental health and depression, and disease related stigma. In areas affected by HIV, women have also been distributing HIV information in their communities, and increasing the capacity of local women to take action toward HIV prevention.[4] As a result, the women can adopt practices to protect themselves from HIV infection, and some women living with HIV have access to antiretroviral treatment and can live as high a quality of life as possible.[5]

Secondly, women living with HIV are also helping other women to cope with HIV stigma, disclose their HIV status, and access antiretroviral treatment. In communities affected by HIV, women living with HIV have formed community support groups to encourage peer and community networks via small group and one-on-one discussions to adopt HIV prevention practices.[6]

Thirdly, in Nepal some local women are trained to provide general immunisations, vitamin A supplementation, and maternal and child health services in the community; these women are known as female community health volunteers (FCHVs).[1] Nearly 52 000 FCHVs are in Nepal and 97% of them are working voluntarily in rural areas. They visit every home in the community twice a year to give doses of vitamin A to breastfeeding women and children and provide education to the local women about maternal and child health practices. Additionally, in communities affected by HIV, FCHVs can provide information about HIV and help women to access condoms and HIV testing.

Finally, the women's groups, along with FCHVs and women living with HIV, help local health centres to offer HIV prevention services to hard-to-reach populations. They also provide support to people who fear identification when attending HIV prevention programmes by ensuring confidentiality when visiting health-care providers and health services. Because of a reduction in funding, many low-income and middle-income countries are having problems increasing access to HIV prevention services, particularly in rural areas, and these approaches to mobilise local women to continue HIV prevention initiatives at the local level could be the best way to continue controlling the burden of HIV.

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Subash Thapa
soobesh@gmail.com

Department of Public Health and Primary care, KU Leuven, 3000 Leuven, Belgium; and Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium

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Glaucoma

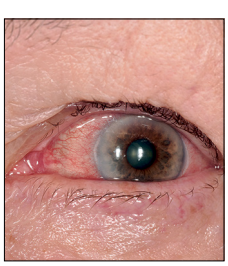
In their Seminar, Jost B Jonas and colleagues (Nov 11, 2017, p 2183)[1] do not include drugs as a possible trigger of glaucoma. Drug-induced glaucoma is potentially blinding but preventable.[2] Several classes of drugs, such as adrenergic agonists, cholinergics, anticholinergics, sulfa-based drugs, antidepressants, antipsychotics, anti-Parkinson's drugs, anticoagulants, and histamine H1 and H2 receptor antagonists, have been reported to induce or precipitate acute angle-closure glaucoma.[3,4] At least a third of cases of acute angle-closure glaucoma are associated with an over-the-counter or prescription drug.[5] Patients with a narrow iridocorneal angle are at high risk. Drugs that have sympathomimetic or parasympatholytic properties are the most common for inducing pupillary block angle-closure glaucoma.[4] Sulfa-based drugs such as topiramate, acetazolamide, chlortalidone, co-trimoxazole, sumatriptan, and hydrochlorothiazide have been reported to produce non-pupillary block angle-closure glaucoma.[2] These drugs induce an idiosyncratic lens swelling, shallowing of the anterior chamber, increased intraocular pressure, choroidal expansion, and retinal oedema resulting in acute angle-closure glaucoma and transient myopia. To manage increased intraocular pressure, sulfa-based drugs should be discontinued and intraocular pressure should be controlled by antihypertensive medicines.[3,4] Topical steroid, cycloplegic drugs, and aqueous suppressants could also be effective in treating this condition. However, topical miotics are contraindicated in this condition.

Drugs that cause or exacerbate open-angle glaucoma are mostly glucocorticoids, docetaxel, paclitaxel, and imatinib.[2,3] Glucocorticoids given systemically, topically, or intravitreally can lead to the development of open-angle glaucoma. Patients with primary open-angle glaucoma; elderly or young patients; and patients with type 1 diabetes, high myopia, and angle-recession glaucoma are at greater risk of glucocorticoid induced glaucoma than other patients.[2]

We declare no competing interests.

**Chaker Ben Salem, Neila Fathallah, Hanen Zayani*
bensalem.c@gmail.com

Pharmacovigilance Center of Sousse, Sousse 4002, Tunisia (CBS, NF); and Sahloul Hospital, Sousse, Tunisia (HZ)



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