

In 2014–15 alone, Cancer Research UK (CRUK) invested £341 million in cancer research, information, public policy, and advocacy.² However, CRUK remains restrictive about the sources and level of funding awarded to specific types of cancer. This characteristic is unique among major funders in the UK and USA, from a previous analysis of more than 200 organisations.³ Without this information, it is difficult to compare investments with other national and international funders of cancer research and development.

The consensus is that public institutions and philanthropic organisations should openly publish their research funding data. Philanthropic research funders, such as the Wellcome Trust, and public research funders, such as the Medical Research Council in the UK and the National Cancer Institutes in the USA, routinely publish data for sponsored research and directly link the awarded funding to the respective study focus or health need.

At a 2016 symposium hosted by the Gurdon Institute at the University of Cambridge (Cambridge, UK), representatives from the Wellcome Trust and CRUK shared their views and policies on data management—and agreement on the expansion of data sharing.^{4,5} These funders, among many others, openly agreed and actively encouraged that research data should be “available, accessible, and discoverable”, and the same principle should apply to research funding.

Offering of research data for open review is a social and public health imperative. We urge CRUK to reform its approach to open funding data, and to make steps for information sharing to be aligned with its publicly declared policy of open research data.

We declare no competing interests.

*Joseph R A Fitchett, Nour Sharara, Michael G Head, Franklin Huang, Rifat Atun
joseph@mail.harvard.edu

Harvard T H Chan School of Public Health,
Harvard University, Boston, MA, USA (JRAF, RA);

Dana-Farber Cancer Institute, Boston, MA, USA (NS, FH); and Global Health Research Institute, University of Southampton, Southampton, UK (MGH)

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Austerity threatens universal health coverage in Brazil

Michael Temer, Brazil's new interim president from the centre-right Brazilian Democratic Movement Party (PMDB), has unveiled an agenda of austerity measures to stimulate economic growth. In the manifesto *Uma Ponte Para Futuro* (October, 2015), he announced plans to reduce public spending, including the education and health-care sector. The minimum budget guaranteed by the constitution (3.8% of gross domestic product at present) would be abolished. The new Health Minister, Ricardo Barros, has revealed plans to end the monitoring of private health-care quality by the National Supplementary Health Agency (Agência Nacional de Saúde Suplementar), while encouraging Brazilian citizens to seek private health care instead of relying on the Brazilian National Unified Health System (Sistema Único de Saúde [SUS]).¹ Personnel cuts among top executives of the National Department of Internal Auditing of the Unified Health System (Departamento Nacional de Auditoria do SUS [DENASUS]),² who were responsible for monitoring and evaluating SUS, also

suggest the government's attempts to deregulate and diminish the role of public health care.

Furthermore, Barros announced on July 21, 2016, a reduction of participation by foreign professionals in the country's More Physicians (Mais Médicos) programme,³ which was introduced in 2013 by Dilma Rousseff's Government in response to protests across the country by people demanding better access to physicians. Participation of foreign physicians in Brazil, mainly Cubans, has benefited the 63 million Brazilians living in remote and vulnerable areas, which previously had shortages of health professionals. In a country where about 80% of the population relies exclusively on SUS, such policies might cause widespread negative consequences. In the midst of severe economic crisis, with the unemployment rate at over 11% and gross domestic product having fallen by 5.4% from the preceding year, more people will be unable to pay for private health care and more will be dependent on the increasingly stressed public system. As a result, the great achievements of the past 10 years (increased coverage of universal health care, decreased infant mortality, and reduced mortality from chronic illnesses)⁴ are likely to be reversed.

Most members of congress supported the impeachment of the president, so the “neoliberal” policies of the interim government are likely to be approved. The intended resurrection of the economy through austerity will bring public health disasters in some or all of the aspects mentioned above. The effects of recessions depend mostly on the response of politicians to the early indicators.⁵ However, the protests in June and July, 2016, in defence of universal health care have a capacity to influence the government's policies.

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*Katarzyna Doniec, Rafael Dall'Alba, Lawrence King
kd353@cam.ac.uk

For more on **principles of data policy** see <http://www.rcuk.ac.uk/research/datapolicy/>



Vanielei Almeida/Staff/Getty

For the **manifesto** see http://pmdb.org.br/wp-content/uploads/2015/10/RELEASE-TEMER_A4-28.10.15-Online.pdf

For more on the **economic crisis and health care in Brazil** see **Word Report** *Lancet* 2016; **387**: 1603–04

University of Cambridge, Department of Sociology, Free School Lane, Cambridge, CB2 3RQ, UK (KD, LK); and Federal University of Rio Grande do Sul, Porto Alegre, Rio Grande do Sul, Brazil (RD'A)

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Prospective Zika virus disease cohort: systematic screening

In December, 2015, the first imported case of Zika virus (ZIKV) infection was diagnosed in French Guiana in a group of 136 travellers returning from Suriname. No autochthonous cases had been detected in French Guiana at that time. To prevent secondary cases, we systematically screened co-travellers 1, 10, and 30 days after their return (clinical examination, urine samples, and blood samples). One case of ZIKV infection was confirmed when viral RNA was detected by real-time PCR (rtPCR) in blood or urine or when ZIKV IgM antibodies and neutralising antibodies were found in serum. Malaria was excluded by thin and thick blood smears; dengue and chikungunya were excluded by blood rtPCR.

Ten patients were positive for ZIKV in urine, and only two were also positive in serum (appendix). The median time between onset of symptoms and the earliest ZIKV RNA

detection was 13 days (range –1 to 16 days). The tests confirmed that urine is a valid alternative to the blood for ZIKV detection up to 2 weeks after onset.^{1–3}

Serological analysis confirmed these ten cases of ZIKV infection and allowed us to detect one additional presumptive case (appendix). Cross-reaction with dengue IgM was observed in only one patient. Therefore, it can be anticipated that most patients with ZIKV will not have cross-reacting IgM, which will assist in making early presumptive diagnoses in IgM-positive patients.

11 ZIKV infections (8%) were confirmed in 136 people in the group. Three were asymptomatic (27%, 95% CI 6–61), which is lower than the 81% (95% CI 77–85) commonly admitted based on investigation results from Yap island.⁴ This retrospective study would probably have overestimated the asymptomatic proportion.

The median incubation period was 9.5 days (IQR 7.5–11.0). Only two patients visited a physician by themselves. Symptoms were cutaneous rash (eight of eight symptomatic patients), fever (seven of eight patients), myalgia (four of eight patients), fatigue (four of eight patients), arthralgia (three of eight patients), headache (three of eight patients), conjunctivitis (two of eight patients), pruritus (two of eight patients), diarrhoea (one of eight patients), retro-orbital pain (one of eight patients), and lymphadenopathy (one of eight patients). As previously reported, median durations of rash and fever were respectively 4.0 days (IQR 3.3–5.0), and 2.0 days (1.5–5.0).⁵ Laboratory examinations were normal except for one patient who had thrombocytopenia.

Finally, ten patients agreed to provide semen samples for rtPCR testing between 128 and 146 days after symptom onset. None of the samples were positive, suggesting that use of condoms might only need to continue to be used for 4 months to prevent sexual transmission of ZIKV.

This systematic screening approach allowed application of strict vector and sexual control measures in patients with ZIKV infection, and might have helped prevent secondary cases.

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*Franck de Laval, Séverine Matheus, Marianne Maquart, Emmanuel Yvrard, Nicolas Barthes, Cédric Combes, Dominique Rousset, Isabelle Leparc-Goffart, *Sébastien Briolant*
sbriolant@wanadoo.fr

Military Centre for Epidemiology and Public Health, Camp Militaire de Sainte Marthe, Marseille, France (FdL); French Armed Forces Health Service in French Guiana, Quartier La Madeleine, BP 6019, 97306 Cayenne Cedex, French Guiana (FdL, NB, CC, SB); Institut Pasteur of French Guiana, Laboratory of Virology, National Reference Centre for Arboviruses (SM, DR), and Unit of Medical Entomology (SB), Cayenne, French Guiana; French Armed Forces Biomedical Research Institute, National Reference Centre for Arboviruses (MM, EY, IL-G), and Unit of Parasitology and Medical Entomology (SB), Hôpital d'Instruction des Armées Laveran, Marseille, France; Research Unit in Emerging Infectious and Tropical Diseases, UM 63, CNRS 7278, IRD 198, and INSERM 1095, Faculté de Médecine La Timone, Aix-Marseille Université, Marseille, France (SB)

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Bipolar disorder: defining symptoms and comorbidities

I enjoyed the comprehensive and thoughtful *Lancet* Seminar on bipolar disorder by Iria Grande and colleagues (April 9, p 1561).¹ However, an historical correction concerning some statements on bipolar depression is

See Online for appendix