

Simon Hart and Alyn Morice postulated that the use of arbitrarily chosen points from the Kaplan-Meier curve could lead to exaggerated conclusions. Although 2-year survival was not chosen arbitrarily, we have taken this important point into consideration and have performed an additional analysis to improve guidance to clinicians for routine use of thoracic radiotherapy.

One stratification factor in the study was the presence or absence of residual intrathoracic disease after chemotherapy, which was assessed in 97% of all randomised patients using a CT scan of the thorax.¹ We did an additional analysis of overall survival and progression-free survival in patients with and without residual intrathoracic disease. Of 495 patients included in the ITT analysis, 434 had residual intrathoracic disease at baseline (of whom 215 were allocated to the thoracic radiotherapy group and 219 to the control group), and 61 patients had no residual intrathoracic disease (of whom 32 were allocated to the thoracic radiotherapy group and 29 to the control group). Since residual intrathoracic disease was a stratification factor, we found no differences in patient characteristics between the two groups. In patients with residual intrathoracic disease, the overall survival was significantly longer in the thoracic radiotherapy group (hazard ratio 0.81, 95% CI 0.66–1.00, $p=0.044$). Survival rates at 1 year were 33% (95% CI 27–40) in the thoracic radiotherapy group and 26% (95% CI 21–33) in the control group. At 2 years, the survival rates were 12% (95% CI 8–19) in the thoracic radiotherapy group and 3% (95% CI 1–8) in the control group. Progression-free survival was significantly longer in the thoracic radiotherapy group (0.70, 0.57–0.85, $p=0.0002$). Intrathoracic progression, either with or without progression elsewhere, was reported in 43.7% of the thoracic radiotherapy group and in 81.3% in the control group ($p<0.0001$).

Additional analysis indicates that patients with persistent intrathoracic

disease after chemotherapy have significant improvements in overall survival, progression-free survival, and risk of intrathoracic progression if they undergo thoracic radiotherapy. No such benefit for thoracic radiotherapy was seen in patients without residual intrathoracic disease, suggesting that the presence of residual intrathoracic disease after chemotherapy is a factor that should be considered in patient selection.

We declare no competing interests.

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COHRED Fairness Index for international collaborative partnerships

Every year a substantial amount of global expenditure is drawn towards improving global health through partnerships and yet research

partnerships have not always been free of inequity and unfair practices. As a result, decades of global support for health research in low-income and middle-income countries (LMICs) have not substantially improved the systems that countries need to prioritise or translate results into effective policy, practice, and products. Availability of global health funds and resources alone is not enough to resolve health research issues in these countries. Many researchers in LMICs now demand for a change in approach. Indeed, increased involvement of LMICs in their national research and innovation agenda is a pre-requisite for making country-led strategies in health happen. While the investment in North–South partnerships has seen substantial advances in innovative strategies to address health needs, LMICs lag behind in their ability to sufficiently reap the benefits from research and innovation partnerships for systems building, capacity strengthening, and economic growth. Clearly, global health research is not merely about global health but also about reinforcement of economic activity, research competitiveness, employment, and growth—a benefit package that today appears to stream more into high-income countries than into LMICs.^{1,2}

As an expansion of its Fair Research Contracting (FRC) initiative³ for better global impact, the Council on Health Research for Development (COHRED) has embarked on the development of a standard: the COHRED Fairness Index that would serve as basis for a certification mechanism by providing guidelines for best practices in international collaborative partnerships in research for health. The COHRED Fairness Index will not be about naming and shaming but rather a mechanism that would encourage improvement of practices in international collaborative research partnerships for health. The COHRED Fairness Index will thus include indicators, a measurement process, and a reporting system that



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For more on the COHRED Fairness Index see <http://cfi.cohred.org>

is independent, transparent, and that can address the key problems, potentials and challenges of collaborative research partnerships. Increased capacity of LMICs to perform research, enhanced ownership of data and results, reduction of harm of research to people, and reduction of reputational risk to all partners in the research process are a few examples of the ultimate impact of the implementation and use of the COHRED Fairness Index. The index can make a major contribution to increase research for health capacity in LMICs—in a low-cost, high-impact manner. In doing so, it supports the call for more emphasis on research in the post-Millennium Development Goals development agenda, and supports the eight elements of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, that is strongly endorsed by WHO Member States.⁴

A multisector consultation involving representatives from non-governmental organisations, international organisations, philanthropies, donors, the public and private sector, as well as academic institutions has provided the basis to establish the principles and scope of the COHRED Fairness Index. In order to gain broad approval of these, the Fourth COHRED Colloquium will bring together on April 16–17, about 100 key representatives of stakeholder groups at the Wellcome Trust, London, UK, to discuss, endorse, and set in motion the COHRED Fairness Index. This will be followed by a pre-launch at the Global Forum on Research and Innovation for Health in August, 2015, in Manila, Philippines.

With implementation planned for January, 2016, we hope the COHRED Fairness Index will serve its stakeholders to improve the alignment of interests among partners in global health research, and in the long term contribute to improve health, reduce inequity, and stimulate socioeconomic development.

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A tribute to NHS staff volunteering overseas

On June 24, 1859, Napoleon III's forces overwhelmed the Austrian army in the Italian village of Solferino, resulting in more than 40 000 casualties.¹

Henry Dunant retold the horrors of what he had witnessed in his book, *A Memory of Solferino*, proposing the need for medical societies to provide neutral and impartial relief to the wounded during times of war. The Swiss businessman's moving memoirs were disseminated across Europe, providing the foundations for the First Geneva Convention which recognises the right to provide humanitarian aid in conflict zones.¹ More than one and a half centuries later, the National Health Service (NHS) has played an important role in providing care to those in greatest need irrespective of circumstance, akin to the principles it was founded upon.

The International Emergency Trauma Register (IETR) has facilitated specialist training for more than 1000 members of NHS staff ready to be deployed to crisis zones.² Inspirational individuals such as David Nott have

dedicated their surgical skills to high-risk, resource-poor settings such as Syria, as well as helping to train local surgeons in the region.³ In response to the conflict in Gaza in July, 2014, NHS England demonstrated its support by offering treatment to the worst-affected civilians across any of the nation's 16 dedicated trauma centres.⁴ Public Health England has recently played an important role in supporting health systems affected by the Ebola epidemic, highlighting the nation's long-term commitment to humanitarian causes.⁵ However, it is imperative that similar efforts displayed in managing acute emergencies are matched by long-term reconstruction plans for the affected areas to avoid complacency.

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The Lancet. Hepatitis C: only a step away from elimination? *Lancet* 2015; **385**: 1045—In this Editorial, Daniel Webster's name was written incorrectly. The online version has been corrected as of March 23, 2015.



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