comprehend that expression, and in so doing perhaps to give a new perspective and appreciation, that seems to make a real difference. And if the acknowledgments at the end of the book are anything to go by, the patients, teenagers, and students achieve the recognition and sense of value that Perlis intended at the project's inception.

Helen Penny

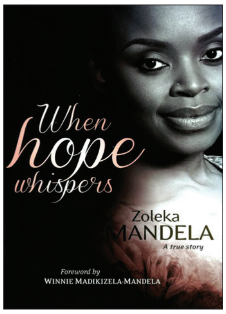
When Hope Whispers

"Dr Benn recommended a course of treatment, but I was so wounded and angry that I left the Breast Care Centre of Excellence with no intention of returning." So writes Zoleka Mandela, Nelson Mandela's granddaughter, in her book *When Hope Whispers*, which began as an autobiography until her diagnosis with breast cancer took over both her life and book. Until this point, Mandela's life was not unmarked by tragedy. The first half of the book chronicles her experiences of sexual and physical violence as a child, her subsequent substance abuse, addiction, and depression, and her heart-break after the death of her daughter and newly born son. Breast cancer was too much further to bear—and Mandela initially refused treatment. Consumed with pain, she writes: "losing my life to cancer would mean that I no longer had to deal with my two children's passing, and I sincerely hoped it would mean a life with them [in heaven]." Her eventual decision to have treatment stemmed from pleas from her family to think of her remaining son Zwelami, and some hard-won self-knowledge: "I saw how irresponsibly and selfishly I had been behaving: here I was with the opportunity to receive the best medical treatment in the country, and I was choosing to rather have the disease swallow me up from the inside because that decision was easier."

It is clear that Mandela's diagnosis with cancer, denial, and subsequent acceptance of the need for treatment, marked a turning-point in her life. The first part of her book is a tale of hedonism that ultimately harmed both herself and others. Cancer treatment, with an exacting timetable and debilitating side-effects, forced her into a routine that she would ultimately come to depend upon ("How can something I never wanted now be something I am attached to?"). This is not to imply that the treatment was pleasant; but enduring cancer therapies for the sake of others clearly forced her to re-evaluate her life, and by the end of the book she writes that she would like to raise awareness of breast cancer.

In that spirit, the latter half of the book provides clear and intimate detail about what a bilateral mastectomy means, both emotionally and physically for a woman, and exactly how gruelling chemotherapy can be. It could thus serve as a useful resource for anyone diagnosed with breast cancer who would like an honest account of what day-to-day therapy entails: in fact, the final chapters are each devoted to detailing the minutiae of each chemotherapy session. Mandela also raises awareness of what her treatments could mean for her life after cancer—eg, her chemotherapy affected her fertility, necessitating the discussion of fertility treatments and egg-harvesting regimens with her relatively new partner. She also grapples straight-forwardly with the knowledge that despite enduring treatment, it is no guarantee that the cancer will not return. The end of chemotherapy, for her, appears to mark a half-life: an interval of indeterminacy ended only by hearing that she has relapsed. Fortunately, at the time of writing, this is not the case, and Mandela continues to promote breast cancer awareness. The book is heavily marketed as a story of Mandela's survival, both through cancer and through the other episodes of her life. It is upon her own journey that she concentrates. Those hoping for an insider's view on life within the Mandela family, and insights into behind-the-scenes stories during the most turbulent episodes of South African history, will not find them here. At times this narrow focus can feel frustrating; knowledge of the wider backdrop against which her life played out can sometimes make the narrative feel sparse. But ultimately, through honest, clear writing, she provides an account of what cancer feels like for an every women, not just Nelson Mandela's granddaughter; it is here that the strength of the book lies.

Cassie Coburn



When Hope Whispers
Zoleka Mandela
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Web

International Cancer Control Partnership

Since the 2011 UN High Level Summit on non-communicable diseases, cancer has been increasingly recognised as a major global health issue by the broader international health community. With a smattering of partners the Union for International Cancer Control has now launched its own International Cancer Control Partnership web portal. This portal has an extensive selection of links and downloads covering topics as diverse

For the **ICCP web portal** see http://www.iccp-portal.org/

as advocacy, education, and training through to surveillance and statistics. It's easy to navigate and, so far, has no broken links. Likewise the drop-down menu and map linking through to national cancer plans has been well designed and implemented. There are also some other buried gems. I'd recommend people look at the Pan American Health Organization (PAHO) country profiles that provide a nice up-to-date snapshot of cancer control in Latin America. This information is excellent, and reflects the fact that PAHO has always been many steps ahead of other WHO regions in addressing health and cancer control.

But what's missing? In addition to national cancer control plans, some thought should be given to resurrecting cancer-relevant health legislation that was originally obtained by the WHO International Digest of Health Legislation, but has since been, bizarrely, abandoned. Plans are all well and good, but it's not until functional national institutions subject to legislation begin to put them into action that the benefits are actually felt by people.

Overall the web offering and meta-catalogue is good and will be a huge help to students and policy scientists wishing to do comparative research. But herein lies the issue. Does this all really help "ensure that all countries have and are implementing a quality cancer control plan linked to non-communicable disease (NCD) control efforts", and is it really delivering a "unique initiative that brings the experience and best practice knowledge of leading cancer organisations and experts...all in one place"?

Global cancer control is awash with plans, documents, more plans, and more documents. Most middle-income countries know exactly what their problems are with cancer control and are trying, with variable success, to address this. As we march further down the human development index, the health systems of these countries become less and less functional. Against this backdrop any discussion of national cancer planning is quixotic. While the global health community has been articulating the importance of good health at low cost since 1985, there has been no movement beyond the policy rhetoric as to how this, practically, can be achieved in cancer. Global health has embraced non-communicable diseases but focused instead on financing, health systems strengthening, and generic risk factors. But people are dying through lack of care, and dying badly through lack of palliation. Web sites of plans address none of this. Indeed the more one studies the political spectrum of cancer control today, the more apparent it becomes that the financing for global cancer is disastrously low. The community has yet to deliver a Global Cancer Fund. Cancer is by far the most complex and complicated care to deliver in a health system, and pathways and models from other diseases actually have little applicability in the cancer setting. Indeed, as the Institute of Medicine has recognised, cancer care is the one area of medicine that exposes all the strengths and weakness of health-care systems. Although broader generic global health initiatives such as surgery will help cancer care, the breadth and complexity of even the most minimum treatment system for cancer requires exceptional focus and effort that will not just trickle down from efforts in either communicable diseases or other areas of non-communicable disease strengthening. We need new ways for developing capability and capacity in cancer care. Of all the models that have been put forward by the global health community, twinning partnerships have been demonstrated to have the most impact, resilience, and flexibility required to deliver the complexities of cancer care and control. In paediatric oncology, organisations such as St Jude's and World Child Cancer have demonstrated significant progress using the international twinning partnership model for childhood cancers, and the Academic Model Providing Access to Healthcare (AMPATH)-Oncology—a partnership between North American, European, and Kenyan teams to develop a comprehensive cancer care in western Kenya—has been a remarkable success. Furthermore, the training and education partnerships between Cuba and a variety of countries of low to middle income have also benefited cancer care in tangible ways. And many radiation oncologists from Africa are now trained in India, which has also made superb progress in developing next-generation cobalt machines for low-resource settings. Partnerships between low-to-middle-income countries make far more sense when one appreciates the commonality in shared resource constraints, spectrum of pathology (more advanced), and social issues that they face compared with what we see in high-income countries. Global cancer is not short of initiatives, global task forces, high-level summits, and the like. But standing back it's difficult to see how all these jigsaw pieces fit into anything approximating a coherent global strategy. Even where we have seen years of on-the-ground engagement (eg, International Atomic Energy Agency's ImPACT programme around radiotherapy provision) the evidence for actually changing cancer outcomes or delivering an affordable modality of care is limited. A few organisations have actually started to fund global cancer research (eg, NCI Centre for Global Health), but compared with the billions we pour into fundamental biology and cancer drug development that benefits the lucky few in high-income countries, what we actually invest in research to address the real global cancer challenge is shameful. To address global cancer we need to dramatically shift our thinking, and funding.

Richard Sullivan