NEWS

Republicans take control of US Congress

In a surprisingly strong showing in the US mid-term elections on Nov 5, the Republican Party took control of the US Congress, expanding its already solid majority in the House of Representatives and regaining control of the Senate with at least a 51-seat, and possibly a 52-seat, majority in the 100-member body.

With control of both the legislative branch and the White House, the Republicans now have a chance to advance several pieces of health-care legislation that the Democrats had been able to block in the Senate while it was under their control.

In general, as a matter of philosophy, the Republicans will push for non-governmental solutions to US health-care problems, says Robert Blendon, professor of health policy and political analysis at Harvard's Kennedy School of Government (Cambridge, MA). "The focus is going to be: let's find a way to let people buy into the private sector and use the marketplace and let's not have the government directly involved."

The Republican's ability to advance their agenda, however, will be limited, says Tom Miller, director of health policy studies at the Cato Institute, a Conservative think tank based in Washington, DC, because with 48 votes the Democrats will still be able to block legislation using procedural delays allowed under Senate rules that require 60 votes to overcome.

As a result, Miller does not expect the Republicans will be able to push dramatic reforms through Congress. "Normally, significant health-care changes require more than a one or two vote margin", Miller says. "You have to get a large head of steam to deal with the different interest groups who find they prefer the status quo over new alternatives."

The two greatest challenges to the health-care system are rising costs and a growing number of uninsured. US spending on health care reached US$1·3 trillion in 2000, or 13·2% of the US gross domestic product (GDP), and is predicted to reach US$2·6 trillion by 2010—16·8% of the GDP. Despite this spending, more than 41 million Americans—or one in seven—do not have health insurance.

While there is concern among most Americans about costs, there is not enough concern for them to consider accepting a cut in service, says Frank Sloan, director of the Center for Health Policy, Law, and Management (Duke University, Durham, NC). "There is no public constituency for cost containment," he says.

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PA Photos

A chance to advance health care reforms?

The attitude in the USA now seems to be to accept rather than fight cost increases. Sloan says: "We seemed to have survived with health care at 10% of GDP, and 12%, and 14%, so let's try 17%." Any cost-containment measures are likely to be limited to efforts by employers to shift costs to their employees by offering policies with higher deductibles and requiring large co-payments, he says.

"You have to get a large head of steam to deal with the different interest groups who find they prefer the status quo over new alternatives"

Blendon agrees that there seems to be little public support for the government to address the problem of rising costs. Moreover, the Republicans are philosophically opposed to such intervention, he says. "Republicans believe these issues have to be settled in the market place. I don't think one of them would think it's their job when they come to work in the morning to solve that problem."

Nor does Blendon believe the Republicans will undertake major initiatives to address the issue of the uninsured. In general, Democrats have favoured legislation that would expand the number of people eligible for Medicaid, the government-run health-insurance plan for the poor.

Republicans, however, are likely to propose legislation that would provide low-income individuals and families with tax credits that would allow them to buy their own insurance from private companies. Such initiatives, however, are likely to be limited because of budget restraints. The Republicans have passed large tax cuts and now with the recession the USA faces a growing budget deficit.

Most observers, however, feel that significant legislation will be passed in the area of prescription drug coverage. Currently, Medicare does not cover outpatient prescriptions. Democrats have favoured legislation that would expand Medicare benefits to cover outpatient drug costs. In general, the Democratic plans would provide more comprehensive coverage but would be more expensive.

The Republicans, on the other hand, have favoured providing Medicare enrolees with subsidies that would allow them to purchase supplemental prescription coverage from private insurance plans. The Republican plans also tend to offer less comprehensive coverage and limit the benefits to lower income enrolees.

It is likely that a compromise will be worked out, says Miller because the Democrats want some sort of prescription coverage and the Republicans want to give Bush some legislation that he can point to when he runs for re-election in 2004.

But, other than perhaps Medicare prescription drug coverage, it is likely that most health-care initiatives over the next 2 years will be "incremental, picking at the margins" says Miller. Policymakers in Washington "don't have enough ideas; they don't have enough money; they don't have enough votes—or any consensus about where to go."

Michael McCarthy

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How food is cooked may contribute to heart disease in diabetic patients

Diabetic patients may need to watch not only the types of food they eat, but also how those foods are prepared, report US researchers this week. Boiling, steaming, and stewing food—instead of frying or grilling—can limit exposure to advanced glycation end products (AGEs), potentially preventing the low-grade inflammatory state that may lead to accelerated vascular disease in diabetes, says lead researcher Helen Vlassara (Mount Sinai School of Medicine, New York, NY, USA). "Over and above the 'healthy food' part of the diet, there's another issue we've been completely blinded to", emphasises Vlassara. "Although some publicity has been given to the risks of charring food—cooking to excess—very little has been said about the processes that occur in the modest to high heat we normally use."

AGEs are toxic byproducts of spontaneous interactions among sugars, fats, and proteins. They occur naturally in the body—though in higher amounts in people with diabetes—and are well known irritants, stimulating cells to produce inflammatory markers. Since AGEs form quickly when food is cooked at high temperatures, Vlassara and colleagues speculated that AGEs in the diet might contribute to the inflammation in diabetes that accelerates heart disease.

In the study, 24 diabetic patients ate healthy diets (similar to that recommended by the American Heart Association) that were equal in all respects except for AGE concentrations. Those who ate meals with the usual AGE concentrations had high concentrations of serum AGEs and inflammatory markers; by contrast, those who ate foods with lower AGE concentrations had lower serum AGEs and "markedly improved" blood concentrations of inflammatory markers after 4 to 6 weeks (*Proc Natl Acad Sci*; published online Nov 11, 2002; http://www.pnas.org/cgi/doi/10.1073/pnas.242407999).

Vlassara adds that boiling or stewing food is a good way to reduce AGEs because AGE production is delayed in the presence of water. "The simple message is that we may need to rethink our concept of food preparation", she says. "The heating part on top of the fat and cholesterol that we know are bad makes for a highly catalytic mixture."

Judith Fradkin, director of diabetes, endocrinology, and metabolic diseases for the US National Institute of Diabetes and Digestive and Kidney Diseases, comments that although "it's really intriguing that when you give fewer AGEs in the diet, you also get changes in inflammatory markers that have been recently associated with cardiovascular disease, we can't yet make statements about clinical benefits. Clearly, the whole issue of inflammatory mediators is a 'hot' area, but there's still a lot of work to be done."

Marilynn Larkin

Syringe exchange programmes lower HIV risk

Despite research showing that syringe exchange programmes (SEPs) reduce HIV risk among injection drug users, the practice remains controversial in some countries. However, US researchers report this week that drug users with access to these programmes are up to six times less likely to put themselves at risk of HIV infection.

"Using a syringe exchange appeared to have a more than twofold protective effect against HIV risk behaviour for the members of our cohort who used it compared with those who didn't, and a sixfold protective effect for those who had no alternative sources of [sterile] syringes", explains David Gibson (University of California, Davis, CA, USA), who led the study. "The association between use of the exchange and reduced risk behaviour could have been an artifact of who sought out syringe exchange, but we believe we did a better job than previous studies had done in correcting for this form of selection bias."

Gibson and colleagues followed up a cohort of 259 untreated injecting drug users for 11 months, some of whom participated in a SEP operated by a private AIDS service organisation. Overall, injection frequency was similar between SEP users and non-users, but users were less likely to report borrowing either a sterilised or unsterilised syringe.

The researchers controlled for baseline risk behaviour and exchange use as markers of risk-taking tendency as well as other potential confounders. "We also corrected for another form of bias—called dilution bias—by adjusting in our analyses for access to syringes from sources other than syringe exchange", says Gibson.

Both univariate and multivariate analyses showed that HIV risk behaviour decreased more than twofold in individuals using the exchange. A second multivariate analysis revealed that the odds of HIV risk behaviour decreased more than sixfold for those without other sources of syringes (*J Acquir Immune Defic Syndr* 2002; **31:** 237–42).

"Although the authors use sensible statistical strategies, they cannot fully address the possibility of bias if more safety-conscious drug users choose to use the SEP", comments Harold Pollack (University of Michigan School of Public Health, Ann Arbor, MI, USA). "Notwithstanding these inherent limitations", he adds, "existing research amply justifies widespread provision of SEPs to men and women who inject heroin, cocaine, or other illicit drugs".

Mark Tyndall (British Columbia Centre for Excellence in HIV/AIDS, Vancouver, Canada) agrees on the importance of SEPs, but points that they did not prevent an outbreak of HIV and hepatitis C in Vancouver and Montreal. "Comprehensive strategies that include readily available drug treatment, long-term recovery programmes, and prevention are urgently required throughout north America", he says.

Roxanne Nelson

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Exchange programmes protect against HIV

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Inhaled nitric oxide could provide new therapy for sickle-cell crisis

New research may provide an explanation for the painful crisis episodes associated with sickle-cell disease and suggests a new treatment for them. "In patients with this genetic disorder there is a massive steady state haemolysis that intensifies during crisis", explains Mark Gladwin (National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, USA). "What we show is that cell-free haemoglobin released by haemolysis consumes nitric oxide [NO] in the blood. We suggest that the consequent NO destruction may explain the vascular complications of sickle-cell disease and that NO inhalation may therefore hasten crisis resolution."

In sickle-cell disease, haemoglobin S forms abnormal polymer rods, explains Gladwin. As a result, red blood cells take on a rigid, sickle shape and can block the microvasculature, causing tissue injury. Inflammation develops and adhesion molecule expression is upregulated, attracting more blood cells to the blockage. The end result is sickle-cell crisis—severe pain in the chest, abdomen, legs, and arms that can require hospitalisation. But, says Gladwin, "although we have known about this basic mechanism for more than 50 years, nobody really knows what precipitates crisis".

By drawing together two previously unlinked observations, Gladwin's team has taken a step towards solving this clinical mystery. "We have known for about three decades that haemoglobin rapidly reacts with and destroys NO", he explains, "and over

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Sickle-shaped cells cause vascular injury

the past 15 years, it has become clear that NO is the major regulator of vascular homeostasis. Could the haemoglobin released in sickle-cell disease react with NO and thus alter vascular homeostasis?"

In a series of chemical and physiological experiments, Christopher Reiter and other members of Gladwin's group show that the answer to this question is yes (*Nat Med*; published online Nov 11; DOI: 10.1038/nm799). "We then hypothesised", says Gladwin, "that if patients were to breathe high doses of NO, as the blood passed through the pulmonary vasculature, the NO would inactivate the cell-free haemoglobin, reducing its ability to consume NO in the periphery". The results of this experiment are so promising that Gladwin is planning a multicentre trial of inhaled high-dose NO versus placebo in patients presenting in acute crisis. "The primary endpoint will be speed of crisis resolution", he explains. Furthermore, he speculates, "NO scavenging by cell-free haemoglobin may be a common mechanism behind the vascular complications seen in other hereditary haemolytic diseases and these too might respond favourably to inhaled NO therapy".

"These results add another wrinkle to the NO story in sickle-cell disease", comments Dhananjay Kaul (Albert Einstein College of Medicine, Bronx, NY, USA). NO inhalation therapy, he says, "shows great promise for crisis management in sickle-cell disease although the beneficial effects may in part be because inhaled NO provides a counterbalance to the increased oxidative stress that occurs in the disease".

Jane Bradbury

Which diseases contribute to life-expectancy differences between races?

A new study published this week has shed light on the diseases that contribute to the discrepancy in life expectancy seen between different races and those with different educational levels.

The team, led by Mitchell Wong (University of California at Los Angeles, CA, USA), examined cross-referenced data from the National Health Interview Survey—which contains demographic and health data from a sample of US households—and the National Death Index for causes of mortality. The researchers then adjusted the mortality data to account for a recent decline in HIV-related deaths. In all, more than 600 000 individuals were included in the analysis (*N Engl J Med* 2002; **347:** 1585-92).

Wong says that the team expected to find that myocardial infarction and cancer accounted for most of the discrepancies in life expectancy between blacks and whites. However, "the results of the study show that we've really been looking in the wrong places", says Wong. "Hypertension, HIV, diabetes, and homicide are the major contributors to racial disparities."

Death rates between people of different educational levels were more in keeping with conventional wisdom, the researchers found. Wong says the top six contributors to early mortality among the less-educated subjects were all smoking-related illnesses: ischaemic heart disease, lung cancer, stroke, congestive heart failure, pneumonia, and chronic lung disease.

"From my perspective, the most important message of this analysis is that most of the influential diseases are ones in which the rates vary based on avoidable risks such as smoking, exposure to HIV, and obesity", says Peter Bach (Memorial Sloan-Kettering Cancer Center, New York, NY, USA). "This adds to the credibility of public-health interventions aimed at reducing the exposure to these risk factors."

Teri Manolio, director of the Epidemiology and Biometry Program, National Heart, Lung, and Blood Institute (Bethesda, MD, USA), agrees that the results offer hope for the elimination of racial disparities in health.

"The enormous contribution of low [socioeconomic status] to lower health status in blacks is often overlooked; this paper makes the point that many disparities attributed to racial differences are largely explained by differences in education", Manolio says. "Conventional wisdom attributes almost all racial differences either to unknown and unknowable 'biologic' or 'genetic' differences, and suggests that blacks and low [socioeconomic status] persons are at increased risk of almost everything. Teasing these two influences out and permitting some targeting of efforts is an extremely important step forward."

David Lawrence

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Brushing up on doctors' communication skills

Of all the pressing concerns facing doctors today, taking lessons in talking to patients is way down the list. "I would query whether people who spend their working lives communicating need classes run by psychologists", former consultant Evan Harris, now a member of parliament for the Liberal Democrat Party, was reported as saying when asked to comment on a recent National Health Service proposal to include communication skills in British junior doctors' training.

He added: "I hope that the lessons will not be an exercise in teaching doctors to spin bad news"—a decent enough dig for an opposition politician to make, the joke being that medical doctors have to give bad news at least as often as the British Government's spin doctors.

What's not so funny is that problematic communication with patients—whether it's giving bad news or simply the daily routine of dealing with less than cooperative patients who may be delirious, anxious, mentally impaired, or simply not listening—is known to contribute to emotional burn-out and low personal accomplishment in doctors as well as high psychological morbidity.

Certain specialties are particularly demanding in testing doctors' ability to communicate, says Lucille Ong, a medical psychologist at the Academic Medical Centre (Amsterdam, Netherlands). "Paediatricians have to communicate effectively and empathetically with children—from babies to 18 year olds—as well as with very worried and demanding parents. A gynaecologist's consultation may well cover sexuality, sexual abuse, pregnancy, childbirth, menopause, or cancer. And in a single consultation, oncologists, surgeons, and intensive care doctors have, on a regular basis, to tell families that the patient has died and discuss a post-mortem and donor donation", she says.

Yet given the option to attend a communication skills course, many doctors decline. "Every doctor thinks that since they started communicating as an infant and have been doing it all their life, all they have to do is learn the medical science and, bingo, they are an adequately communicating doctor", says William Clark (Midcoast Hospital, Brunswick, ME, USA), a director of courses at the American Academy on Physician and Patient (AAPP).

Surgeons, among those most resistant to acknowledging the need to brush up their talking skills, are a cause of concern for the Royal College of Surgeons in the UK. "We tend to go into training because we like the technical aspects", says the chair of its Patient Liaison Group, Charles Collins. "Yet only around 25 per cent of the surgeon's job requires technical expertise, even less in many specialities. The rest is about communicating with patients."

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Communicating with patients can be difficult

As a result, says Lesley Fallowfield, professor of psycho-oncology at Sussex University (Brighton, UK) and a leader in communication skills training, her team is continually astounded by "the basic neediness of senior doctors, including heads of professional units, over fundamental aspects of communication such as dealing with angry relatives".

The training programme that Fallowfield helped to devise is now successfully used—in Australia, but not in the UK, where "we have been left behind". About a quarter of clinicians dealing with breast cancer in Australia have already taken part in communication skills training. And, says, Sally Redman, director of the National Breast Cancer Centre in Sydney, Australia, "eight out of ten surgeons now acknowledge that they need formal training and assessment in the areas of breaking bad news to patients and preparing patients for surgical procedures".

But it's not just the UK that's been left behind. Although communication skills courses are now part of the undergraduate curriculum in the USA, additional training for practising doctors is not widely available. "Those who get more have to look hard to find it", says Clark. "The fascination of science and the business of money are too big and strong to both patients and doctors; the 'work' of interviewing will have always have a back seat", he says.

Similar attitudes have undermined an initiative launched in the mid-90s by the European-based Balint Foundation to go international, according to Raffaele Renella, a paediatrician at Centre Hospitalier Universitaire Vaudois (Lausanne, Switzerland). It failed, she says, because of the medical obsession with becoming efficient and cost-effective. "At the professorial level and in the faculties there is a low interest for an activity that takes time and has no direct and measurable return on investment", she says.

A new package of training, due to be unveiled in January aims to take Balint a stage further. Entitled *Values in Health Care, a Spiritual Approach*, the package encourages meditation, reflective practice, and compassionate listening. It aims to help doctors in a consultation to "be themselves in that space with someone else", says Craig Brown, a general practitioner from Rustington, UK. "We are taught in medical school that getting involved with patients will be emotionally exhausting, but the opposite is true. By learning the skills to be openly caring, doctors can protect themselves against burn-out and regain their role as an integral part of the healing process."

The AAPP is planning to unveil a web-based, multimedia teaching programme using experts in core competencies to "stimulate doctors' thinking about how their attitudes and biases influence their communication in sensitive situations".

Such initiatives, though, may well fail without establishment backing. Engaging clinicians who are not interested requires "support from the professional colleges", says Redman. Mandatory training, as practised in the Netherlands' Academic Medical Centre, is another option. It's one of the few hospitals to require all new doctors—and since this year, every junior member of staff—to attend communication skills courses that hinge on videotaped role play.

This approach works, says Ong. "Doctors become enthusiastic when confronted with their own consultation style and receiving feedback from a professional, encouraging them to practise 'difficult consultations' in role play." Such an example is unlikely to be widely copied as long as communication skills are confused with "spinning" the truth.

Jane Feinmann

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BOLIVIA

Bolivia and USA wage war on the coca leaf farmers

Although most people's attention is on the "war on terrorism" there is another war taking place in a small South American country. Bolivia is fighting a "war on drugs" as part of the US government's campaign against cocaine abuse.

Bolivia is the world's third largest producer of coca leaf, the raw ingredient of cocaine. While tackling the root problems of drug abuse at home, the US government is putting pressure on Bolivia and its neighbours—Peru and Colombia—to totally eradicate coca farming.

Bolivia is one of the poorest countries in Latin America with a per capita income of around US$1000 a year. Coca has brought in millions of dollars to the country and is the only provider of work for thousands of people. More than that, use of the coca leaf among indigenous people dates back 12 000 years.

A coca leaf contains 0·1-0·8% cocaine. A 5000 hectare coca plantation could produce 35 tonnes of cocaine, which would have a multi million dollar street value. Supporters of the coca leaf note that the plant has many nutritional ingredients including high concentrations of calcium, iron, vitamin A, and vitamin B complex. However, once coca leaves are processed into cocaine none of these beneficial properties remains.

Bolivians maintain that the plant is an essential part of traditional rituals, therapies, and the tough daily life that some have to endure. For example, in the silver mines of Potosi, in the central highlands of Bolivia, 4090 m above sea level, working conditions are appalling. Children as young as 12 years old work here, and coca-leaf chewing is considered essential for survival. As one miner explained: "When we chew coca we can work from day until night without resting. Coca stops us feeling tired and hungry."

In 1987, US Drug Enforcement Agency (DEA) agents were sent into the Chapare region, which once provided much of the world's cocaine supply, with limited success. In the early 1990s, coca farmers were offered US$2000 per hectare cleared of coca and replaced with another crop, but farmers simply uprooted coca and planted it elsewhere. In December, 1997, the Bolivian government stepped up the fight against the coca farmers and launched the US-financed "dignity plan", to eradicate coca by the end of 2002.

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AP

Coca farmers protest against the eradication campaign

Whether coca eradication has been successful or not depends on who you ask. According to the Bolivian government, the number of acres used for growing coca has decreased from 127 000 hectares in 1997 to about 5000 hecatres today. However, some people argue that these figures are inaccurate and that coca farming is increasing again.

> **"the Pentagon announced last week that it was scaling back its role in the "war on drugs "**

What has been the cost of this "dignity plan" to Bolivia? The eradication of coca was supposed to be a gradual, voluntary process in exchange for compensation and substitution of coca for pineapple or banana farming. Instead, the US government has funded, trained, and equipped Bolivian antinarcotics police, who have taken a far more heavy-handed approach to wiping out coca farming in the Chapare region.

Since the eradication campaign began in 1997, at least 39 Bolivian farmers, police, and soldiers have been killed. According to Human Rights Watch: "the Bolivian government has engaged in serious human rights abuses such as excessive use of force, arbitrary detention, and the suppression of peaceful demonstrations . . . Unfortunately, the United States has failed to ensure that effective protection of human rights is a condition of US counternarcotics support."

The US government invested US$80 million in alternative development programmes in Bolivia. However, banana trees, passion fruit vines, and palm trees are not as profitable as coca. Coca growing needs very little attention and produces four harvests a year. According to US and Bolivian government estimates, in 1998 Chapare farmers who grew coca earned about US$2700 a year. They now earn less than US$900.

The USA has spent US$75 billion fighting the war on drugs in the past 5 years, but seems to have made little progress. According to the United Nations Office for Drug Control and Crime Prevention's (UNDCP) World Drug Report 2000, the USA has among the highest levels of cocaine abuse in the world. UNDCP suggests that drug traffickers have switched their efforts to Colombia where the government has little control over its territory.

In fact, in what is seen as an admission of failure, the Pentagon announced last week that it was scaling back its role in the "war on drugs" to concentrate on anti-terrorism activities. However, the US government has pointed out that terrorism and the drug trade are linked.

Meanwhile the coca farmers and their supporters maintain that US intervention is a violation of Bolivian sovereignty. Evo Morales, leader of the pro-coca movement and runner up in Bolivia's August presidential elections, has promised to end coca eradication and remove the US Drug Enforcement Agency from Bolivian soil.

The US and Bolivian governments' eradication programme will continue, and US President George Bush met the Bolivian President, Gonzalo Sanchez de Lozada, on Nov 14. The Bolivian government is pinning its hopes on persuading farmers that there is an alternative to growing the coca plant.

Minal Chande

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United Nations calls for tighter control on pesticide use in poor nations

The United Nations Food and Agriculture Organization (FAO) published a new code of conduct for the distribution and use of pesticides on Nov 4, which "should significantly reduce agrochemical threats in the developing world".

Governments must "regulate the availability, distribution, and use of pesticides . . . and should ensure the allocation of adequate resources for this mandate", said the revised code. Governments must monitor occupational pesticide exposure and document all cases of pesticides poisoning, according to the new rules.

According to WHO, there are about 25 million cases of pesticide poisoning and 20 000 pesticide-related deaths every year worldwide-mostly in developing countries.

"The new code stresses the responsibility of all stakeholders in reducing pesticide-related health and environmental risks. If applied, it would save many lives, help avoid environmental damage, and make agricultural production more sustainable", Gero Vaagt, FAO senior officer for pesticide management told *The Lancet*.

The code calls for measures to prevent the dumping of obsolete pesticides and used containers in developing countries. For example, FAO estimates that world's rich countries have dumped more than 500 000 tonnes of unuseable pesticides in developing countries.

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Still Pictures

Poor nations need education on pesticide risks

Barbara Dinham of Pesticide Action Network, London, UK, said, "for the first time, the code recognises the importance of addressing environmental risks, protecting biodiversity, and monitoring of pesticide residues in food. Many deaths are caused by reuse of empty pesticide containers to store food and water, and the collection systems proposed would remove this temptation."

Carl Smith from the Foundation for Advancements in Science and Education (FASE), a US-based non-governmental organisation, said "the new version of the code expands industry's responsibility in the whole life cycle of pesticide products, from use and storage to disposal".

Jørgen Schlundt from WHO considered the adoption of the code to be "an extremely important step" because "its rigorous observance clearly will result in considerable reductions in human health risks and environmental damage associated with the improper use of pesticides".

According to Schlundt, the code "properly focuses" on the key issues such as pesticide residues in food and water. However, he cautioned that "while such guidelines and codes are important prerequisites for prevention, they should be complemented by more specific measures to lower risks, such as improving health care and education programmes for farm workers".

Khabir Ahmad

United Nations debates human cloning ban

Spain and the USA headed a 36-nation bloc that derailed French and German efforts on Nov 7 to reduce the human cloning ban to cover only reproductive and not therapeutic cloning.

The move took place during the UN 57th General Assembly, in New York, after the US and Spanish delegations persuaded the Assembly's Sixth Committee to postpone a vote on a global ban on human cloning for 1 year, while warning that the French-German proposal did not cover therapeutic cloning.

France and Germany had urged the Committee to act to halt reproductive cloning immediately and discuss therapeutic cloning later. The Assembly decided that the UN working group on cloning, which meets again next autumn, should make a final decision on the scope of the ban by the end of 2003.

The push for a worldwide ban on human reproductive cloning began in August, 2001, after Italian embryologist Severino Antinori and his US colleague Panos Zavos announced plans to clone human beings. The German and French foreign office ministers reacted by asking UN president Kofi Annan to put the issue of reproductive cloning on the UN's agenda.

The UN set up the Ad Hoc Committee on an "International Convention Against the Reproductive Cloning of Human Beings" in December, 2001. At its first meeting in March, the USA delivered a position paper supporting "a global and comprehensive ban on human cloning, regardless of the purpose for which the human clone is produced". Therapeutic cloning "which involves the creation and destruction of human embryos must be part of this global ban", said the USA.

The report called France and Germany's decision to prohibit only reproductive cloning "unsound". Since the Ad Hoc Committee did not reach a consensus last March the UN recommended that it continue discussions in September, 2002, when it could provide an update to Sixth Committee, which deals with international legal matters.

At the Sixth Committee meeting on Oct 17, representative for the German delegation, Christian Much, who also spoke on behalf of France, said their proposal "allows us to move fast where consensus exists . . . [offering] a chance to win the race against Antinori and Zavos" while the US approach "is benefiting the wrong side". In a statement on Nov 7, just after the French–German initiative was turned down, both countries said the failure to move fast "leaves the field open to those working towards giving birth to a cloned human being".

Xavier Bosch

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Southern Africa famine crisis complicated by HIV/AIDS epidemic

The devastation wreaked by the combined effects of famine and HIV/AIDS in southern Africa topped the agenda at a 2-day United Nations meeting in Johannesburg on Nov 6–7.

Without food aid, 14·4 million people in the six south African countries are facing starvation in the next few months. At least 5·9 million of these people have HIV/AIDS and there are more than two million AIDS orphans, according to UNAIDS. Famine and HIV/AIDS have become inseparable and the conference of more than 50 delegates called for a new approach to this unprecedented humanitarian crisis.

According to UNAIDS, people infected with HIV/AIDS should increase their food intake and eat about 50% more protein and foods rich in micronutrients. Richard Lee of the World Food Programme told *The Lancet* that the fortification of maize meal to combat HIV/AIDS and the food crisis was discussed at the meeting.

The meeting brought together the six countries—Lesotho, Malawi, Mozambique, Swaziland, Zambia, and Zimbabwe—as well as UN agencies, the 14-member Southern Africa Development Community, and various non-governmental organisations.

A draft consensus statement by delegates noted that among other issues: international partners must pool expertise and financial resources; the HIV/AIDS epidemic must be integral to all responses to the food crisis; the international community should promote fully integrated responses to the AIDS crisis in the key political fora of governments at national and regional levels; and further resources must be leveraged through all instruments such as the Global Fund.

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Panos Pictures

Healthy workers needed to harvest crops

Sandra Anderson, from the UNAIDS Intercountry team for east and southern Africa told *The Lancet*: "In 1992 there was famine but the rains finally came and people went back to work. Now because of HIV/AIDS people are too sick to return to the fields to farm the land and there is no food."

Press reports from Zambia note that desperate parents are being forced to take drastic measures. It's a vicious cycle that begins with parents selling their children for labour, prostitution, or early marriage, and then ends with the parents selling themselves to earn money for food. The high-risk behaviour leads to HIV/AIDS, which in turn leads to decreased productivity and famine. Families are also forced to use precious resources to care for sick relatives and to pay for funeral costs.

A recent report by the UN Special Envoy for Humanitarian Needs in southern Africa said that HIV/AIDS was the single greatest threat to the region. Agricultural production has fallen significantly because people are too sick to work. The UN has estimated that HIV/AIDS is responsible for 9·6% depletion in Zimbabwe's agricultural labour force in 2000. Malawi lost 5·8% of its farmers in 2000 while Mozambique lost 2·3% and is expected to lose 20% by 2020.

Adele Baleta

European Commission proposes Europe-wide nuclear safety rules

The European Commission (EC) has proposed "an unprecedented package of measures" to improve nuclear safety and the handling of nuclear waste that would apply both to the current members of the European Union (EU) and the ten countries that are part of the EU's enlargement plans.

Between them, the new countries have 22 nuclear power plants, 20 of which are Soviet-designed nuclear reactors. The EC wants to introduce EU-wide safety standards and independent monitoring of nuclear plants, along with a timetable to bury nuclear waste.

"It is our responsibility to ensure a common approach to nuclear safety and waste management: European citizens would never forgive us for inaction by the EU in this field", said Loyola de Palcio, the commissioner responsible for energy and transport, announcing the proposals on Nov 6.

The new rules will come under the Euratom Treaty, originally signed in 1957. The EC said that although the primary task of the Euratom Treaty is to provide safeguards for the operation of nuclear installations, no standards were set on nuclear safety. Instead, countries follow the guidelines set by the International Atomic Energy Agency (IAEA). Both France and the UK say the IAEA guidelines are enough to protect the public.

The EC says that since Chernobyl in 1986, Europeans have become concerned about nuclear safety issues. Eight EU countries currently have nuclear installations but five have introduced or proposed a nuclear power moratorium. France, the UK, and Finland have not taken any decision but it is unlikely that any new plants will be built in the near future.

The EC's proposals identify burial of nuclear waste as the safest method now known. Each country will have to decide on the location of burial sites by 2008 and to have the sites operational by 2018. For low-activity, short-life waste, disposal arrangements must be ready by 2013.

Each country will have to set up an independent nuclear safety authority responsible. There are no plans to do on-the-spot safety inspections at nuclear installations and the EC says "there is no intention, under any circumstances, of setting up a corps of European inspectors" opting instead to depend on a peer-review system to inspect the national inspectors.

Karen Birchard

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US charity donation for HIV/AIDS in India sparks government row

The chairman of Microsoft, Bill Gates, announced during a visit to India this week that his charity, the Bill and Melinda Gates Foundation, will give the Indian government US$100 million to tackle HIV/ AIDS.

Gates's high-profile visit and the generous aid package were sidelined by a US government report stating that the number of people with HIV/AIDS in India will increase five-fold in the next 10 years.

The Indian Health Minister said the report exaggerated the levels of HIV/AIDS and accused Gates and the US Ambassador in New Delhi, Robert Blackwill, of "spreading panic".

"HIV-AIDS is at a relatively low level in India and experience shows that countries that act at an early stage can prevent the disease from becoming widespread", said Gates.

But the Indian Health Minister Shatrugan Sinha described the US projections as "completely inaccurate. However Sinha will chair the board that manages the Gates Foundation's programme in India. And after a meeting with Indian Prime Minister Atal Behari Vajpayee, Gates said "Mr Vajpayee appreciated the foundation's work and was very supportive of our activities".

Meanwhile the Delhi government continued its efforts to promote safe and rational use of drugs in government-run healthcare system. The WHO-India Programme on Essential Drugs in partnership with the Delhi Society for Promotion of Rational Use of Drugs (DSPRUD) published standard treatment guidelines (STG) on Nov 7.

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Reuters/Popperfoto

Bill Gates visits an AIDS patients centre in New Delhi

The guidelines are "a tool for providing most appropriate treatment with a list of essential drugs. The idea is to avoid using scarce resources of hospitals or patients on unnecessary drugs or inappropriate combinations", said the President of DSPRUD, Ranjit Roy.

The guidelines were prepared after extensive consultation with 70 clinicians and external peer review by 15 clinicians from leading Indian medical institutes. Standard treatment for 285 priority diseases commonly encountered in ten specialties including paediatrics, ENT, and psychiatry have been recommended based on comprehensive literature review and evaluation of available evidence.

"Although drug supply is based on an essential drugs list, ample opportunity exists for ineffective, unsafe or wasteful prescribing. STGs will help in arresting inappropriate drug use, which is almost endemic to users and prescribers", warns Sangeeta Sharma, one of the editors of the STG.

However the medical community is split over the value of such guidelines to reign in untrained practitioners. "One section feels that since we can't effectively check informal prescribers like pharmacists or untrained practitioners in rural areas, these guidelines can help them in better prescribing . . . But bodies of professional doctors are against this and feel it will encourage quacks in continuing their business unchecked", points out Sharma.

Dinesh C Sharma

Netherlands introduces child-proof cigarette vending machines

Cigarette vending machines in The Netherlands will be locked from Jan 1, 2003, and will only be accessible by smart card to smokers older than 16 years old.

Cigarette machines have been restricted because Dutch tobacco law will forbid the sale of cigarettes to children younger than 16 years next year.

The 4·2 million smokers older than 16 years will be able to buy cigarettes by using a credit card style "AgeKey"—an electronic chip implanted on a plastic card, which will be provided by the post office, who will be responsible for age verification.

Having verified their age using the card, a smoker will complete the vending machine sale by using either coins or a bank card. Foreigners will not be able to use vending machines from next year and will have to buy their cigarettes from tobacco shops or supermarkets.

The AgeKey system has been developed by British American Tobacco Netherlands (BAT), the national association of tobacco distributors (LBT) and the banking organisation Interpay.

BAT, producer of brands such as Barclay, Lucky Strike, and Peter Stuyvesant, owns 69% of Dutch vending machines, most of them located in places frequented by young people. The company has invested E20 million in the AgeKey project, but believes it can earn this money back, says Coert van Hasselt, chief of Corporate and Regulatory Affairs of BAT Netherlands. "The Netherlands is the first European country that will use this kind of lock, but we expect other European Union countries will also introduce national regulations for age verification, because WHO has advised so. Germany, which has 900 000 cigarette vending machines, has already shown interest for instance. Other countries that come to mind are Belgium, Spain, and Portugal. The AgeKey system can also be used for the selling of other age-related products, like beverages or videos".

Defacto, an organisation that informs the public about the dangers of smoking to health, thinks it would have been better to ban all vending machines in The Netherlands. "The AgeKey system is not fraud-proof. It's too easy to borrow a bank card from a friend over 16 years', says Defacto director Trudy Prins.

Frank van Kolfschooten

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