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GPs will see little disruption in changes, Lansley tells MPs

Adrian O'Dowd LONDON

GPs will not suffer excessive disruption when they take control of most of the NHS budget as part of the government's shake up of the health service, England's health secretary has said.

Andrew Lansley, giving evidence to the parliamentary health select committee on 20 July in a one-off evidence session, said that doctors were looking forward to the changes as an "empowerment," not as an "upheaval."

MPs on the new health select committee—formed since the UK general election in May—quizzed Mr Lansley about the impact of the white paper published earlier this month (*BMJ* 2010;341:c3796, 14 Jul), which set out how GPs will be given more responsibility for spending as primary care trusts and strategic health authorities are phased out by 2013.

The committee's chairman, Stephen Dorrell, the Conservative MP for Charnwood, asked why the government had decided on such a major reorganisation of the NHS so soon after coming to power.

Mr Lansley replied, "I think it is absolutely clear from evidence in this country and beyond that professional empowerment in public services is a key ingredient of public service reform."

The white paper was intended to make it clear that ministers were there to set the level of resources and to hold the NHS accountable for its results and outcomes, he said, but not to prescribe the detail of how that should be done.

Mr Lansley said he had spoken to thousands of people in the NHS over the past six years, adding: "To clinicians who say we don't want another big upheaval, I say if you are working in a GP practice this is not going to lead to a big upheaval. It's about empowerment."

"My expectation is that many GPs do not see it impacting on them very much."

A committee member, Andrew George, the Liberal Democrat MP for St Ives, said that the government had torn up a prior agreement to resist imposing a top-down reorganisation.

Mr Lansley said that the government was looking to make substantial reductions in management costs in the NHS anyway, which meant that changes were inevitable.

Cite this as: *BMJ* 2010;341:c3953



Speakers at the conference called for donor countries to give \$20bn to the Global Fund in October

AIDS activists demand that funders meet their pledges

Richard Hurley BMJ

Access for all to preventive interventions and treatment for HIV and AIDS is possible—but only if countries increase their funding and respect universal human rights. This was the message from politicians, experts, and activists at the 18th international AIDS conference in Vienna this week, in response to worldwide cuts to aid.

An estimated 25 000 delegates watched protestors march across the convention centre, storm the stage, and delay the opening session, with shouts of "Broken promises kill. No retreat: fund AIDS!"

This year is the deadline for universal access set by the G8, the world's top eight industrialised countries. "We are nowhere near," said Julio Montaner, president of the International AIDS Society.

Although five million people in

poor countries are now receiving antiretrovirals, the situation is "very serious" for the 10 million people in developing countries who need the treatments, Dr Montaner said. "The G8 has, quite simply, failed us."

Speakers called for donor countries to replenish the Global Fund to Fight AIDS, Tuberculosis, and Malaria with at least \$20bn (£16bn; €19bn) this October.

Eastern Europe has some of the fastest growing HIV epidemics in the world, but politicians from Russia and Ukraine were absent from the conference.

Dr Montaner said, "[They] have shown total indifference. Not being here is irresponsible to the point of criminal negligence." He added that some G8 leaders were also missing, such as Stephen Harper, Canada's prime minister and the G8 group's chairman, who declined to

give a plenary speech.

Yves Souteyrand, of the World Health Organization, reported that the number of deaths from AIDS fell from 2.2 million in 2004 to two million in 2008. However, there are 2.7 million new infections a year, particularly among high risk groups such as injecting drug users, men who have sex with men, sex workers, and migrants. Women and girls are also disproportionately affected by HIV.

Dr Souteyrand explained the conference's theme "Rights here, right now": "Universal access cannot be achieved without human rights considerations taking centre stage."

Kgalema Motlanthe, deputy president of South Africa, said, "We cannot achieve a prevention revolution without [protecting] the rights of vulnerable groups."

See **NEWS**, p 172.

Cite this as: *BMJ* 2010;341:c3950

“Locked-in” patient asks for ruling on mercy killing



Tony Nicklinson: “Am I grateful that the Athens doctors saved my life? No, I am not”

Clare Dyer *BMJ*

A man with locked-in syndrome after a catastrophic stroke is taking legal action against the director of public prosecutions to clarify the law on mercy killing.

Tony Nicklinson is not physically capable of committing suicide even with assistance, but he wants the director of public prosecutions of England and Wales, Keir Starmer, to say whether it is always in the public

interest to prosecute someone who kills another person at the victim’s request.

He is calling on Mr Starmer to issue guidelines on when he would prosecute in a case of voluntary euthanasia, as he was forced to do on assisted suicide after the successful legal action brought by Debbie Purdy, who has multiple sclerosis (*BMJ* 2009;339:b3131). Under current English law mercy killing with

or without consent counts as murder, carrying a mandatory life sentence.

If the answer is that it is always in the public interest to prosecute for a consensual killing, Mr Nicklinson plans to press the Ministry of Justice to review the law on murder and decide whether voluntary euthanasia should be distinguished from killing without consent.

Mr Nicklinson, 56, who is

NICE approved 80% of drugs it evaluated in past decade

Jacqui Wise *LONDON*

More than four in five of the appraisal decisions on new drugs and technologies made by the UK National Institute for Health and Clinical Excellence (NICE) are positive, new data show.

Of the 367 decisions made by NICE between 1 March 2000 and 30 June 2010, 67% were categorised as recommended and 16% as “optimised,” which means the treatment is recommended in certain circumstances. In 6% of cases the treatment was categorised for use only in research, and in 11% of cases the treatment was not recommended.

Andrew Dillon, chief executive of NICE, told a media briefing that although the body tends to attract adverse publicity when it rules against a new cancer drug, such decisions are in the minority. He presented data showing that 74% of recommendations from cancer technology appraisals are positive.

Sir Andrew said that rulings against a new drug were made most often on grounds of cost effectiveness. He said that quality adjusted life years (QALYs) were still the best measure available to determine the cost effectiveness of a drug and that it would be too difficult to use a measure such as “willingness to pay” (*BMJ* 2010;341:c3899, 19 Jul), as it would mean commissioning individual studies.

“QALYs are not perfect, and they do have limitations,” said Sir Andrew. “However, they are practical, as the calculations can be carried out in a reasonable time frame, and they are a good way to make comparisons between treatments.”

Sir Andrew denied that there was a ceiling of £30 000 (€35 000; \$45 000) per QALY above which a drug would not be approved by NICE,



NICE chief executive Andrew Dillon denied that there was a limit of £30 000 per QALY for new drugs

although he said that above this threshold the advisory bodies would need to provide a lot more evidence to support a drug’s approval.

“We are not rigid in terms of a price point; there is considerable flexibility for the advisory bodies,” he said.

NICE has been increasing its output since it was established 11 years ago. As well as appraising new and existing treatments, it publishes clinical guidelines and information on public health. From 2011 it will produce information on medical devices and diagnostics.

NICE is also to publish 150 evidence based quality standards over the next five years. The first three quality standards on stroke, dementia, and prevention of venous thromboembolism were published a few weeks ago (*BMJ* 2010;341:c3536, 1 Jul). The next quality standard on specialised neonatal care is due to be published in September.

Sir Andrew said that the new quality standards were designed to be very accessible, with each one consisting of around 10 statements.

Cite this as: *BMJ* 2010;341:c3935

UK is ranked top out of 40 countries on quality of death

Susan Mayor *LONDON*

A new quality of death index has shown substantial variations in end of life care in different countries across the world, with the UK ranking top because of its hospice care network and statutory involvement in the care of people who are dying.

The Economist Intelligence Unit, the business information arm of the magazine the *Economist*, devised the quality of death index to rank countries according to the provision of end of life care services. It includes 24 indicators that evaluate quantitative measures such as life expectancy and healthcare spending as a percentage of gross domestic product, qualitative factors such as public awareness of end of life care, and status indicators, including

RANKING OF SOME OF THE 40 COUNTRIES USING THE ECONOMIST INTELLIGENCE UNIT'S QUALITY OF DEATH INDEX		
Rank		Overall score
1	UK	7.9
2	Australia	7.9
4	Ireland	6.8
8	Germany	6.2
9	Canada	6.2
9	US	6.2
11	Hungary	6.1
12	France	6.1
22	Denmark	5.1
24	Italy	4.4
26	Spain	4.2
28	Finland	4.1
30	South Africa	3.8
32	South Korea	3.7
35	Russia	2.8
37	China	2.3
38	Brazil	2.2
40	India	1.9

Source: Economist Intelligence Unit

married with two adult daughters, had a stroke five years ago while on business in Athens, which left him almost totally paralysed, unable to speak, and able to move only his eyes and head. His wife, Jane, said he would not ask her or anyone else to help him die if he thought that person would be prosecuted.

His lawyers argue that refusing him the opportunity to end his life through an absolute prohibition on euthanasia is a disproportionate interference with his right to personal

autonomy and a breach of article 8 of the European Convention on Human Rights, which guarantees the right to a private life.

In a statement for the court he said: "I need help in almost every aspect of my life. I cannot scratch if I itch. I cannot pick my nose if it is blocked. I have no privacy or dignity left. I am washed, dressed, and put to bed by carers who are, after all, still strangers.

"I am fed up with my life and don't want to spend the next 20 years or so like this. Am I grateful that the Athens doctors saved my

life? No, I am not. If I had my time again, and knew then what I know now, I would not have called the ambulance but let nature take its course."

His solicitor, Saimo Chahal of the law firm Bindmans, said it would be "wrong" to charge Mrs Nicklinson with murder if she gave in to her husband's demand to end his life "when you consider that this places her in the same category as a bomber who intends to maim or kill as many people as possible."

Cite this as: *BMJ* 2010;341:c3943

the existence of a government led national palliative care strategy.

Analysis of the quality of death index for 40 different countries found that the UK had the top score. Despite achieving a low ranking (28th) on the quality of its healthcare system as a whole, it scored very highly on the quality of end of life care, which included good availability of training, access to pain control, and doctor-patient transparency.

Many rich nations lag a long way behind, including Denmark (22nd), Italy (24th), Finland (28th), and South Korea (32nd), largely because of poor quality and availability of care and a lack of policy coordination. The US and Canada ranked equal ninth.

"Quality of life is a common phrase. The majority of human endeavours are ostensibly aimed at improving quality of life, whether for the individual or the community," the report authors suggest. "But quality of death is another matter." It found that fewer than 8% of the estimated 100 million people around the

world who would benefit from hospice and palliative care annually have access to it.

A key factor influencing a country's quality of death score was state funding of end of life care. The researchers found that this was limited in many countries, where curative treatment is prioritised. Even where palliative care treatment is available through national healthcare systems or insurance, the research found that organisations providing end of life care often have to rely on charitable donations and philanthropic bodies to support them.

"Few nations, including rich ones with cutting-edge healthcare systems, incorporate palliative care strategies into their overall health policy—despite the fact that in many of these countries, increasing longevity and ageing populations mean demand for end of life care is likely to rise sharply," the report warned.

Access to effective pain relief emerged as a key factor in determining quality of death scores.

The report is available at www.eiu.com.

Cite this as: *BMJ* 2010;341:c3836



Access to opioids and training in how to use them are fundamental to good quality end of life care

Too few people in UK at high risk of stroke get endarterectomies

Zosia Kmietowicz LONDON

Fewer than half the people in the United Kingdom who are at high risk of having a stroke are benefiting from carotid endarterectomy to improve blood flow in the veins in their neck, an audit has shown.

Surgeons carry out only 4500 carotid endarterectomies a year in the UK, even though an estimated 10 000 patients could benefit from the operation. The number of carotid endarterectomies per head of UK population is the lowest in the developed world and a 10th of that in the United States (99 per 100 000 in California). In England the rate is 8.7 per 100 000.

Surgeons who carried out the second audit of vascular surgical services and carotid endarterectomy in the UK are calling for an urgent review of services, so that patients having a stroke or who are at risk of a stroke are fast tracked to hospital in the same way as heart attack patients. And the public needs to be made more aware that the symptoms of stroke should be treated with the same urgency as those of a heart attack, they say.

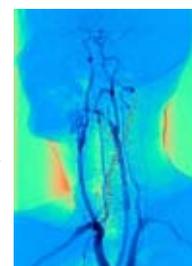
Guidelines from the National Institute for Health and Clinical Excellence (NICE) say that patients with symptoms of stroke or transient ischaemic attack should have surgery within two weeks, while the government's national stroke strategy gives a deadline of 48 hours.

However, the audit shows that only 3% of these patients had surgery within 48 hours and that only about a third of patients made the NICE guideline of 14 days. The average wait from symptoms to surgery is 28 days.

Most delays related to presentation and referral, with 18% of patients failing to present to a GP or hospital and 40% not being referred on from primary care. But the audit also found that 18% of patients missed the deadline because staff or theatres were not available, and 9% were delayed because of a lack of imaging equipment.

Ross Naylor, consultant vascular surgeon and a member of the audit steering group, said that surgery within 48 hours of symptoms starting "must be our ultimate goal, and multidisciplinary team working is key to achieving this." The audit is at www.vascularsociety.org.uk.

Cite this as: *BMJ* 2010;341:c3879



Only 3% of patients had surgery within 48 hours

SOVEREIGN, ISM/SPL

IN BRIEF

Spina bifida prevalence falls in US:

A study covering about 14% of US children from birth to age 11 years found that the prevalence of spina bifida fell by a consistent rate of 1.4% a year between 1991 and 2002. The researchers have attributed the fall to fortification of food with folic acid in the United States. The prevalence of spina bifida in 2002 was 3.1 cases per 10000 children and adolescents aged 0 to 19 years (*Pediatrics* doi:10.1542/peds.2009-2084). The rate in 1991 varied regionally from about 3.4 to 3.9 per 10000 children.

Paul Nurse is to head world leading centre for biomedical research:

The Nobel prize winning biologist Paul Nurse is to become the first director and chief executive of the UK Centre for Medical Research and Innovation planned for central London. The centre has been founded by four of the UK's largest and most successful scientific and academic institutions: the Medical Research Council, Cancer Research UK, the Wellcome Trust, and University College London. It will carry out research to advance understanding of human health and disease.

BMJ is honoured with awards: The *BMJ's* editor in chief, Fiona Godlee, won editor of the year in the UK Medical Journalists' Association 2010 awards, announced on 15 July. Zosia Kmiotowicz and Susan Mayor won medical journalist of the year and freelance journalist of the year, respectively.

New levels set for melamine in food:

The United Nations Food and Agriculture Organization and the World Health Organization have set new maximum limits for the amount of melamine allowed in powdered infant formula at 1 mg/kg and the amount of the chemical allowed in other foods at 2.5 mg/kg. High levels of melamine are toxic and were found recently in infant formula in China, which left six infants dead and 300000 seriously ill.

Germany launches study of lifestyle and health:

German scientists from the Helmholtz Centre's German Research Centre for Environmental Health in Munich and the German Cancer Research Centre in Heidelberg have announced the nation's largest biomedical study, an investigation of the health, lifestyle, and genetics of 200000 people. Funding has not yet been officially announced, but one press report put the cost at €210m (£180m; \$270m) over 10 years.

Cite this as: *BMJ* 2010;341:c3858



Dr Jerome Ikwueke was the first professional to identify the possibility of abuse of Baby P

Baby P's GP is suspended despite "unblemished record"

Clare Dyer *BMJ*

The GP who failed to take urgent action to protect the battered toddler Peter Connolly has been suspended from practising for 12 months but is allowed to stay on the medical register.

A General Medical Council fitness to practise panel held that Jerome Ikwueke's failures were not wilful and that there was no risk that he would repeat them in the future. He had an

Requests for freedom of information could suffer in cutbacks

Clare Dyer *BMJ*

The UK Information Commissioner's Office is to launch a new enforcement policy to get tough on public bodies that consistently fail to meet deadlines for answering freedom of information and data access requests.

Deputy commissioner Graham Smith, who announced the initiative at a seminar on 15 July held by the Westminster Legal Policy Forum, a cross government forum aimed at raising debate on legal policy, said that some public authorities were consistently failing to meet deadlines. "We are saying we will work with you, but if there is no improvement we will issue an enforcement notice," he said.

Other speakers at the seminar warned that freedom of information could be one of the early victims of the colder economic climate, because teams dealing with requests under freedom of information legislation were not likely to be seen as frontline staff.

Mr Smith said that personal issues were behind nearly all freedom of information requests—for example, requests concerning the treatment a relative had received in a hospital or care home. The failure to satisfy requests for access to information by the subject of data held was the main reason for complaining to the information commissioner.

The Information Commissioner's Office oversees compliance by public bodies with freedom of information requests and their protection of personal data. The commissioner's annual report for 2009-10 this week showed that of 57 undertakings to improve practice given during the past year 21 were from NHS trusts.

The latest undertaking, given this week, was a promise by Birmingham Children's Hospital

NHS Foundation Trust to take remedial steps after three laptops with unencrypted, sensitive information on patients were stolen.

The commissioner, Christopher Graham, is pressing for his role to become fully independent from government, accountable only to parliament. At present his office is funded and overseen by the Ministry of Justice.

Jane Sigley, head of freedom of information policy and strategy at the ministry, pointed to pledges by the new coalition government to "throw open the doors of public bodies," "extend the scope of the Freedom of Information Act to provide greater transparency," and "create a new 'right to data,' so that government held datasets can be requested and used by the public, and then published on a regular basis."

She said that the current context was one of an increasing volume of requests and a new government that placed emphasis on transparency but also one of considerable impending financial restraints.

"Our ministers are very interested in freedom of information," she added. "What we've also got is a government which is acutely aware of cost. Ministers are very conscious that all of this comes at a cost."

Robert Hazell, director of the constitution unit at University College London, warned that the cold economic climate would be "highly likely" to affect freedom of information. "FOI teams, relatively recent in most Whitehall departments, are not likely to be regarded as frontline services." When staffing cuts had been introduced in other countries such staff had often been the first to go, he said.

Increasing fees was one possible option, he said. The UK's fees policy was relatively liberal, and government departments almost never charged. When fees were increased in Ireland the volume of requests halved, he added.

The information commissioner's annual report is available at www.ico.gov.uk.

Cite this as: *BMJ* 2010;341:c3877

“unblemished record,” testimonials described him as a “conscientious, hardworking, and caring doctor often going beyond the call of duty,” and he had undertaken child protection courses and had revised his practices at his surgery.

But his “limited insight” into his failings and their serious nature justified imposing a 12 month suspension, the panel ruled.

The 17 month old toddler was found dead in his cot with multiple injuries in August 2007, eight days after Dr Ikwueke last saw him. His mother, her boyfriend, and his brother are in prison for causing or allowing his death.

The GP noted that Peter seemed withdrawn, was “not his usual happy self,” and pulled away

from him when he saw him on 26 July 2007 but failed to refer him urgently to hospital. Instead, said the panel’s chairwoman, Judith Worthington, he took “false reassurance” from the fact that the boy was due to attend the child development centre on 1 August and merely arranged a follow-up appointment seven days later.

She said that Dr Ikwueke had been the first professional to identify the possibility of child abuse and had referred Peter to a paediatrician in December 2006. He saw his role as “lighting the fuse,” but his responsibility did not end there.

“You as a GP were at the centre of a network and, by virtue of your role, in a position to . . . share information,” she told him. He had been

guilty of a series of failures over a period of 10 months, culminating in a “grave error of judgment at the consultation on 26 July.”

She said that these included failure to share information with the health visitor, social workers, and the hospital, a failure to consider the possibility of child abuse and urgently refer at a consultation in October 2006, and failure to urgently refer him on 26 July 2007.

He had also failed to take steps to see Peter as soon as practicable after Tracey Connolly told him during a consultation on 30 July that Peter had “grab marks,” and that she kept being accused of harming him, Ms Worthington added.

Cite this as: *BMJ* 2010;341:c3887

German doctors and politicians disagree on reimbursement for homoeopathy

Annette Tuffs HEIDELBERG

A recent spate of demands in the United Kingdom that homoeopathic treatments no longer be provided on the NHS has prompted a debate in Germany about the place of homoeopathy in its health service.

Despite the fact that some German pharmacology experts would like to see public health insurers cease paying for it, the German Medical Association (Bundesärztekammer) has come out in favour of keeping its reimbursement.

The association’s president, Jörg-Dietrich Hoppe, has defended homoeopathic treatment in an official statement. He said that despite the lack of scientific evidence for its effectiveness homoeopathy was an important part of medicine. It was especially effective in treating travel sickness and general malaise, he said.

He was backed by the federal health minister, Philipp Rösler, who wants to keep the status quo in Germany, where homoeopathy is reimbursed by the public health insurance companies.

Professor Hoppe’s and Dr Rösler’s statements

come amid a public debate after last week’s publication in the magazine *Der Spiegel* of a lead article questioning the value of homoeopathic treatment (www.spiegel.de/wirtschaft/soziales/0,1518,706336,00.html). It referred to the current debate in the UK, where doctors and the parliamentary health select committee have called on the NHS to stop paying for homoeopathy (*BMJ* 2010;340:c3513; 2010;340:c1091).

This view is supported by German medical experts and a few politicians who claim that in cases where homoeopathy seems to work it is as a result of a placebo effect. They want to see it withdrawn from the funding budget of the public health insurance companies, which together are currently spending an estimated €100m (£85m; \$130m) on homoeopathic preparations.

A recent study by the Allensbach Institute, a public opinion research firm in southern Germany, stated that use of homoeopathy is on the rise. In 1970 only one in four West Germans had ever used homoeopathic remedies, a figure that has since risen to 57%.



Karl Lauterbach, chairman of the German parliamentary health committee, has called for health insurance companies to stop funding homoeopathic remedies. In an interview with *Der Spiegel* he said that many patients believe that insurance only covers treatments that have proved to help and therefore it is in the public interest to stop the practice. “Health insurers are dignifying homoeopaths through their actions,” he said.

Cite this as: *BMJ* 2010;341:c3902

FDA committee urges tight restrictions on rosiglitazone

Bob Roehr WASHINGTON, DC

An advisory committee to the US Food and Drug Administration has recommended further restrictions on the drug rosiglitazone (Avandia), used to control type 2 diabetes. The decision came after two days of intense hearings on 13-14 July, outside Washington, DC.

There was no question about the effectiveness of the widely prescribed drug, but a trail of evidence indicated that long term use increased the risk of cardiovascular disease. The meeting

focused on the quality of that evidence and the comparative merits of randomised controlled trials, observational studies, and a meta-analysis.

A consensus emerged that the data probably did indicate that rosiglitazone increased the risk of cardiovascular disease, possibly more so than did use of pioglitazone, a drug in the same class, the thiazolidinediones. But others at the meeting expressed concern that they might be seeing a long term class effect that showed up with rosiglitazone because it was first to come on the

market and that there are several more years of data on pioglitazone that are not yet available.

Roughly a third of the committee (12 of 33 voting members) did find the data compelling enough to recommend withdrawal of rosiglitazone from the market; three members would make no changes; while 17 sought increased black box warnings and education of doctors.

Clinicians in particular were reluctant to remove the drug from their treatment options.

Cite this as: *BMJ* 2010;341:c3862

Ugandan hospitals ration AIDS treatment as drugs run out



Patients currently receiving antiretrovirals continue to be treated—but for how long?

Henry Wasswa KAMPALA

Doctors in Uganda have warned that the country is facing an acute shortage of antiretroviral drugs. New patients with HIV or AIDS are being turned away from clinics, and those lucky enough to be getting treatment are being given just one month's worth instead of the usual three months' supply.

Zainab Akol, manager of the health ministry's AIDS control programme, said, "All the 228 000 patients currently on ARV [antiretroviral] treatment are receiving the drugs. But because we do not have adequate quantities of ARVs, we have first to maintain those already on treatment. We do not recruit new patients at the cost of those we already have."

Uganda has about a million people with HIV. Of the total 2.5 million people estimated to have been infected by the virus since the early 1980s, about half have died, the health ministry says.

Although Uganda has one of the world's most aggressive HIV and AIDS control programmes,

the rate of HIV infection has been rising in recent years. The health ministry estimates that there are now 130 000 new infections each year, including 20 000 among babies.

In the mid-1990s the health ministry began antiretroviral treatment programmes for people with AIDS, but these have been hampered by the misuse of funds by government bureaucrats and the global financial crisis, which has resulted in massive reductions and delays in donations.

Uganda's HIV and AIDS control programme is mostly funded by the World Health Organization, UNAIDS (the joint United Nations programme on HIV and AIDS), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the US President's Fund for Aids Relief (PEPFAR).

Two weeks ago hundreds of women with AIDS staged peaceful street marches in the capital, Kampala, in protest at the scarcity of drugs.

A doctor working for a Catholic mission hospital in central Uganda said that its AIDS clinic had begun rationing drugs, stopped CD4 count tests, doubled outpatient fees, and reduced the number of doses that patients can take away. The health centre has more than 5000 patients with AIDS.

He said, "PEPFAR has stopped funding for AIDS programmes here. We have introduced a system of rationing the drugs. The cost for the drugs for each patient per month is 35 000 shillings [€10; €12; \$15], and a CD4 count costs 20 000 shillings. In the future the patients may have to pay for the drugs."

An estimated 500 000 Ugandans are eligible for antiretroviral treatment. The government planned that 350 000 would be given the drugs by June 2011. But a shortage of funds means not enough antiretrovirals have been procured to meet this target, said Dr Akol.

Cite this as: *BMJ* 2010;341:c3900

US announces its domestic strategy for tackling AIDS

Bob Roehr WASHINGTON, DC

The US government unveiled its strategy for tackling HIV/AIDS within its own borders last week after an arduous process of community consultations that lasted more than a year.

The aim of the plan is to reduce the annual toll of new HIV infections by 25% after five years. New infections have numbered about 56 000 a year for more than a decade. A 2001 plan by the Centers for Disease Control and Prevention (CDC) to halve the rate of infections failed to reach its target, the failure being attributed by commentators to a lack of funding for the job.

Last year Johns Hopkins University HIV prevention researcher David Holtgrave told Congress that prevention funding would have to nearly double, to about \$1.3bn (£0.86bn; €1.03bn) a year, "to make a big difference in the epidemic in the US."

But health and human services secretary Kathleen Sebelius seems not inclined to do so. She told the audience at the event, "All of us are being asked to do more with less... We can't



Health secretary Kathleen Sebelius has promised \$30m

expect this to be solved by a huge infusion of new resources." She offered \$30m spread over several years.

The second major element of the strategy is to increase access to care and optimise health outcomes. Ms Sebelius hopes that this might

ALAN DIAZ/AP/PA

North Korea's healthcare system is in dire straits

John Zarocostas GENEVA

North Korea's state healthcare system is in a crisis, with hospitals and clinics lacking essential drugs and supplies and doctors forced to reuse hypodermic needles and to carry out operations, including amputations, without anaesthesia, says a report by Amnesty International.

Many facilities are run down and often have power cuts and no heat. At night staff members sometimes have to work by candlelight, says the report.

Because of the shortages health workers "recycled medical supplies

until worn, sometimes with little regard to hygiene and safety," it says.

The report draws on interviews with more than 40 North Koreans who left the country and with aid organisations and health professionals who work there. They say that medical personnel often do not receive salaries and have little or no access to drugs.

The report says, "Even if patients receive a medical diagnosis, they must first buy the recommended medicine at a market or a private home. If it is an injection, then the drug is brought back to the hospital

for the doctor to administer."

It is "common knowledge" that health workers sell hospital drugs privately or to market vendors as a means to earn an income, it says.

"As doctors have begun charging for their services, which is illegal under North Korea's universal health care system, the poor cannot access full medical care, especially medicines and surgery," says the report.

"During operations, patients, if lucky, are given anaesthetic but sometimes not enough to completely control the pain."

Contrary to claims by the government that its healthcare system is free for all, North Koreans have had to pay either in kind or in cash for medical care since the 1990s, says Amnesty. It's common for doctors to be paid in cigarettes, alcohol, or cash.

Catherine Baber, Amnesty's deputy director for the Asia-Pacific region, said, "North Korea has failed to provide for the most basic health and survival needs of its people."

The Crumbling State of Health Care in North Korea is at www.amnesty.org.

Cite this as: *BMJ* 2010;341:c3903

be achieved through elements of healthcare reform passed earlier this year, such as reforms of health insurance and the beefing up of community health centres.

The third focus is to reduce health disparities related to HIV. Again, the reliance is on overall health reforms such as standardising state eligibility requirements for Medicaid, the government health insurance programme for people on low incomes, rather than HIV specific programmes.

Director of the Office of National AIDS Policy (ONAP) Jeffrey Crowley will issue an annual report on progress towards meeting those goals.

The HIV Medicine Association applauded the plan but cautioned that success “will depend on an effective implementation plan supported by the resources necessary for monitoring and evaluation to meet the strategy’s stated targets.” It was a view shared by most HIV advocates.

Charles King, of the New York charity Housing Works, however, blasted the strategy as “insufficiently ambitious” in aiming to reduce new infections by only 25%. “We have the prevention tools to dramatically reduce the spread of HIV if only we would dedicate the resources to doing so . . . Would President Obama suggest that we only clean up 25% of the Gulf oil spill?”

AIDS Healthcare Foundation president Michael Weinstein noted that the plan does not “even really prioritise” the CDC’s 2006 guidelines to make testing for HIV part of routine medical care. “All around, this is a real disappointment.”

The foundation operates HIV clinics serving 139 000 patients.

The National HIV/AIDS Strategy and the accompanying implementation plan are available at www.whitehouse.gov/administration/eop/onap/.

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Norma Kang Muico, who presented the report, said the health system was failing the people

LEE JIN-MAN/AP/PA



STR-NEWREUTERS

Charities in Haiti face difficulties retrieving their goods from customs and are then charged storage for the period they have been held. Meanwhile residents suffer (above)

Goods are stuck in Haitian ports as NGOs deal with paperwork

Sophie Arie LONDON

Medical supplies sent to Haiti since the January earthquake are remaining trapped in customs for months, disrupting aid efforts and costing non-governmental organisations (NGOs) large sums in storage costs.

Some 15 000 pairs of spectacles and 12 000 eye drops donated by medical organisations in the United States and transported with funds from the Bill Clinton Foundation are sitting in a container at the port in the capital, Port-au-Prince, where they arrived in early April.

The Haitian Society of Ophthalmology, which intended to use the supplies to treat people living in camps around the capital, was told its paperwork was incomplete. Having provided additional documents and met ministry officials, the society says it has been told repeatedly the goods would be released. But at the time this article went to press they were still being held.

“I have had no choice but to stop the mobile clinics we have been running in the camps,” said Franz Large, the society’s president. At least 1.3 million people are still homeless and NGOs are attempting to meet their health needs with mobile clinics regularly visiting the camps. Some 20% of Haitians have glaucoma, said Dr Large.

Substantial amounts of supplies have reached their destination in the past six months, and some large organisations, such as the US based Partners in Health, say they have had no problems at customs.

But many NGOs in Haiti are struggling with delays. Sources say some organisations have as

many as 60 containers stuck at the port. Before the 12 January earthquake there were often similar delays and disappearances of supplies. One US organisation is still trying to locate two ambulances it sent in 2005. With supplies now arriving in unprecedented quantities at a port that was destroyed by the quake and later repaired by the US military, the authorities are struggling to cope but are determined to control the influx.

“There has been dumping on a huge scale here,” said Ariel Henry, principal private secretary at the health ministry. “All sorts of people have sent things that are totally unsuitable or out of date.”

NGOs are normally exempt from import taxes on humanitarian supplies. But—with a myriad small new organisations now working in Haiti—the health ministry says many have failed to prove their tax free status.

Organisations are charged a fee—reportedly \$45 (£30; €36) a day—for the time their supplies are held in storage before paperwork is accepted and goods released.

“It’s possible for goods to clear customs in a day,” said Dr Henry. “If they don’t, it’s because NGOs are failing to comply with the rules. If that means they are wasting money that could be spent on . . . people in need, whose fault is that?”

Sources say that smaller, inexperienced NGOs have resorted to paying bribes to speed up the release of supplies. Dr Henry says he is unaware of cases of extortion among customs officials.

For some months there has been concern that aid supplies are ending up on the black market.

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