Health in the Horn of Africa: a collective response needed

In 1984, the world said "never again" to famine in Ethiopia. But, 27 years later, famine has revisited the Horn of Africa. Between July 20 and August 3, the UN declared famine in five regions of Somalia. The disaster is expected to spread to all eight regions of the country in 4–6 weeks and is likely to persist until at least December this year.

A famine can be declared only when at least 20% of households in an area face extreme food shortages with a limited ability to cope; acute malnutrition rates exceed 30%; and the death rate exceeds two deaths per day per 10 000 people. Deemed the "worst humanitarian disaster" in the world by António Guterres, the UN High Commissioner for Refugees, it has threatened the lives of 12 million people, and more than 29 000 children younger than 5 years—nearly 4% of children in Somalia—are estimated to have died. Malnutrition was already prevalent in about half of all children younger than 5 years who arrived at UN camps in Somalia, which made them especially susceptible to the complications of diarrhoea and measles. According to WHO, the number of people becoming infected with measles and waterborne diseases is growing at an alarming rate, and cases of severe diarrhoea in Kenya and Ethiopia are a serious concern. Furthermore, hundreds of thousands of refugees from Somalia have fled to neighbouring countries, in particular Kenya and Ethiopia, and the ongoing refugee crisis has raised the risk of diseases associated with crowding such as measles, diphtheria, pertussis, acute respiratory infections, meningococcal disease, and tuberculosis. Additionally, humanitarian organisations reported that women in the refugee camps faced a drastic increase in sexual violence, which has put them at high risk of contracting HIV/AIDS.

The UN is stepping up deliveries of food aid in famine-affected areas, and WHO has led an emergency measles and poliomyelitis vaccination campaign, together with the provision of vitamin A and deworming tablets targeting children younger than 5 years on the Somali–Kenya border. However, in view of the extremely fragile health systems and poor sanitation in these countries, the vicious cycle of hunger, ill health, and poverty makes the situation even more intractable.

There are many factors underlying the famine. The drought, the worst in 60 years, is the initiator of the tragedy. More than 95% of Africa's agriculture is rain-fed, and is therefore susceptible to climate change. On top of that, Somalia faces a security crisis as a result of political conflicts, civil war, and anarchy, which has meant that most of its people have lived in an extremely precarious state since its last national government collapsed in 1991. As the economist William Easterly once commented on Ethiopia's struggles with famine over the past quarter-century: "It's not the rains; it's the rulers." The toxic politics should perhaps be regarded as the major culprit; the famine is more of a man-made disaster than a natural one.

The international community is also to blame for responding too slowly and neglecting its responsibilities in this preventable disaster. Despite the forecasting of the crisis from the Famine Early Warning Systems Network since November, 2010, the first aid flight did not arrive in Somalia until 8 months later. The UN issued its first appeal on July 20, and by August 3, the appeal was only 44% funded, with an additional US$1·4 billion still required to cover unmet needs. The USA, Europe, and other wealthy donors waited until pictures of starving children and desperate women made the evening news to hand over funds. China, Africa's second largest trading partner after the USA, merely said it would pay "close attention" to the disaster, and only pledged a modest $14 million of food aid on August 5, after US House minority leader, Nancy Pelosi, urged the country to do more.

In an era of advanced agricultural productivity and transportation networks, it is unacceptable that a famine has happened. It is even more unfortunate that Africa is still "a scar on the conscience of the world", as former UK Prime Minister Tony Blair said 10 years ago. More and longer-term investments in agriculture and health in Africa are needed alongside a collective global response. Notably, China, which experienced one of the largest famines of the 20th century and yet has harnessed 7% of the planet's arable land to feed 20% of the population, should be more of a leader here and show that it has an interest in the welfare of Africa's people. Such a humanitarian disaster must never be allowed to happen again. ■ *The Lancet*

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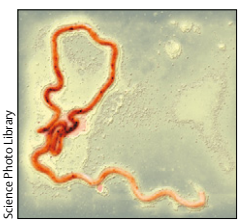
For more on **Horn of Africa famine** see http://www.un.org/apps/news/infocusRel.asp?infocusID=145&Body=Horn+of+Africa&Body1

Syphilis on the rise in the USA



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Most Americans will associate syphilis with prostitution, blindness, insanity, and the notorious US Government-run Tuskegee study done in the American South. Yet, most Americans are unlikely to know that the rate of syphilis has been on the rise in their country since 2001.

A new report, by John Su and colleagues from the US Centers for Disease Control and Prevention (CDC), in the August 2 issue of *Annals of Internal Medicine*, shows that syphilis disproportionately affects minority populations in the USA. The report states that two-thirds of recently acquired syphilis infections in the USA between 2005 and 2008 affected men who have sex with men (MSM). Compared with white Americans, the rate of syphilis infections in black MSM has increased eight-times faster between 2005 and 2008. Alarmingly, the biggest relative change in recently acquired syphilis infections occurred among young black and Hispanic MSM (aged 15–19 years).

Since the US minority populations are also those with low socioeconomic status, poor access to health care, and low awareness of risks to health and health literacy, the existence of syphilis infection among them comes as no surprise. What is worrying within the newly reported syphilis rates is the magnitude of the disease burden affecting the MSM population.

High prevalence of sexually transmitted diseases usually occurs in tandem and syphilis infection, for example, is a highly accurate predictor of subsequent HIV infection. Joseph Prejean and colleagues from the CDC, in *PLoS ONE* on August 3, report that current HIV infection rates in the USA are primarily driven by MSM, accounting for 61% of all new infections in 2009, and the highest nationwide increment in HIV rates is found in young black MSM (aged 13–29 years).

High-risk sexual behaviours (including unprotected intercourse and multiple partners) seem to be on the rise and contributing to a high incidence of sexually transmitted diseases in young American MSM. There is an urgent need for implementation of culturally customised public health messaging focused on safe sexual practices, syphilis awareness, and screening, in conjunction with HIV counselling. ■ *The Lancet*

For more on **syphilis in the USA** see http://www.annals.org/content/155/3/145.abstract

For more on **HIV in the USA** see http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0017502

The NHS IT nightmare

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If there were an award for the world's most mismanaged national health project, England's National Programme for IT in the NHS would be a strong contender, if not outright winner. Started in 2002, Tony Blair's brainchild has, like the computer in *2001: A Space Odyssey*, gone badly wrong.

The main aim of the project was to create a fully integrated centralised electronic care records system to improve services and patient care by 2007. The budget for the undertaking was a substantial £11·4 billion. 9 years on, the Department of Health has spent £6·4 billion on the project so far, failed to meet its initial deadline, and has had to abandon the central goal of the project because it is unable to deliver a universal system.

Given the ineptitude that has characterised this project, disaster was almost certain. According to a new report by the Public Accounts Committee (PAC), the Department has failed to get value for the vast sums of money that it has paid contractors. Of the two companies that are still involved in the project, one has yet to deliver the bulk of the systems that it was contracted to supply despite being paid £1·8 billion since 2002, and the other is being paid £9 million to implement systems at each NHS site that have cost other organisations outside the programme £2 million. The Department seems to have been foolishly duped by commercial companies that promised the sun, cost the earth, and delivered not much more than hot air. Damningly, PAC's report states: "The Department could have avoided some of the pitfalls and waste if they had consulted at the start of the process with health professionals."

Health Secretary Andrew Lansley has blamed Labour for the mess, but, more than a year into the coalition government, buck-passing is pointless. The Department is now relying on individual NHS Trusts to develop systems compatible with those in the central programme, which means a patchwork of incompatible systems is likely to emerge. As the NHS heads into the biggest reform in its recent history, the project needs to gain what it has been sorely lacking: leadership, oversight, and accountability. ■ *The Lancet*

For the **PAC report** see http://www.publications.parliament.uk/pa/cm201012/cmselect/cmpubacc/1070/107002.htm

Hepatitis in drug users: time for attention, time for action

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In place of saints' days or public holidays, public health practitioners celebrate disease days: World Cancer Day in February,[1] Stroke Day in October,[2] and World AIDS Day on Dec 1.[3] The main reason for these days is to raise awareness, a key part of which is the presentation of descriptive statistics: without intervention, 84 million people will die of cancer between 2005 and 2015;[1] every 6 s someone will die from stroke;[2] and 33 million people are living with HIV.[3]

In *The Lancet*, Paul Nelson and colleagues[4] review 4386 peer-reviewed sources and 1019 grey literature sources to estimate—at national, regional, and global scales—prevalence and population estimates for hepatitis B and C in injecting drug users (IDUs). The investigators provide the requisite bold statistics: 10 million IDUs might be positive for hepatitis C antibodies and more than 80% of IDUs in 12 countries are estimated to be infected. More than 6 million IDUs might be positive for hepatitis B core antibodies. The investigators do not estimate the burden of death and disease from these infections, but it is likely to be substantial: more than 1·5 million deaths occur every year from acute hepatitis B and C infections, hepatocellular carcinoma, and cirrhosis.[5]

July 28 is World Hepatitis Day, and the article by Nelson and colleagues[4] forms part of the efforts to raise awareness about this disease. While focusing attention on hepatitis is a challenge generally, mobilisation of action to address the disease in drug users is even more difficult.

Drug users around the world face stigma, discrimination, mistreatment, and the systematic violation of their human rights.[6] Harm-reduction strategies that, in addition to prevention of HIV infection, could help to reduce hepatitis B and C transmission are widely underfunded or blocked by local or national governments altogether. In June, 2011, the United Nations General Assembly feebly called on nations to give "consideration, as appropriate" to implementation and expansion of harm-reduction programmes.[7] Not surprisingly, countries that do not find drug users worthy of consideration often find harm reduction inappropriate.[8]

Through country-by-country estimates, Nelson and colleagues provide an opportunity to examine striking disparities in rates of hepatitis B and C. Why is the prevalence of hepatitis C antibodies in IDUs in Hungary 23%, whereas it is about 90% in Estonia or Lithuania and 73% in Russia? Why do 85% of IDUs in Mexico have hepatitis B core antibodies compared with 20% of IDUs in Uruguay? These differences could be due to the limitations of the data: despite thousands of studies reviewed, grade A reports (ie, a multisite seroprevalence study with several sample types for at least one hepatitis marker) were only available for 20 of the 77 countries for which any data were available, and few studies provided truly national estimates.[4] However, the differences may also show trends and patterns of drug use, or important differences in state policies and investment in harm reduction. Large between-country variations emphasise how high rates of hepatitis B, hepatitis C, or HIV infection in drug users are not inevitable.[9] Moreover, the estimates provide a powerful means for health and human rights advocates to question government officials in countries with high prevalences, and to caution governments in countries with low prevalences about the potential costs (human and economic) of failing to put in place, or sustain, effective, rights-based policies.

Nelson and colleagues[4] conclude that improved recognition of hepatitis in IDUs and development of comprehensive and effective strategies are needed. No doubt this is true, to some extent. However, the history of HIV in IDUs shows that much more than awareness and evidence-based approaches are needed to bring about change.[10] A lesson to recall is the importance of looking to those most affected (ie, people who use drugs) for guidance

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and leadership in development of effective responses and identification of barriers to their implementation.

Until governments abandon the failed so-called war on drugs[11] and their reliance on repression in response to drug use, we will continue to need days to recognise and raise awareness of hepatitis in drug users. At the same time, we should remember the harm that arbitrary detention, forced labour, physical abuse, and torture causes to IDUs.[12] Health is often proclaimed to be at the centre of drug policy, but support for the protection and promotion of the right to health, and other human rights, of drug users is often wholly absent.[13]

Nelson and colleagues[4] provide us with a first step and powerful data to draw attention to the problem of viral hepatitis in people who use drugs. The next step is to challenge governments to act, and hold them accountable for implementation of rights-respecting and evidence-based programmes.

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I declare that I have no conflicts of interest.

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Folate and cardiovascular disease: one size does not fit all

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Hundreds of studies have investigated the association between homocysteine and cardiovascular disease during the past several decades; results from randomised trials and observational studies have been discrepant, and the issue is not fully resolved. The common *MTHFR* 677C→T polymorphism increases homocysteine concentration, and mendelian randomisation studies of this polymorphism show a link with risk of stroke, supporting a causal relation. However, these studies have also been inconsistent. In *The Lancet*, Michael Holmes and colleagues[1] summarise results from randomised trials of homocysteine reduction with folic acid supplementation (with or without additional B vitamins) to reduce stroke incidence. Adequate folate abrogates the effect of the polymorphism and, as hypothesised, the investigators found that trials tended to be positive in regions with low folate and null in high folate regions (either naturally in the diet or because of folate fortification). Thus, many of the folate supplementation trials for stroke prevention might have been destined to fail because they were not undertaken in a low folate setting. This result, perhaps obvious in retrospect, illustrates an important difference between drug trials, in which the placebo group has no intervention, and trials of nutritional supplements, in which everyone has variable intake that can be substantially greater than the amount of the intervention and can vary widely during the course of the trial. Some trialists (including ourselves[2]) might have underestimated the baseline level of folate beyond which supplementation has no discernible effect.

A secondary conclusion is that meta-analyses are fraught with the potential for oversimplification. Summary estimates can mask true causal effects in susceptible subgroups. In their summary, Holmes and colleagues conclude that the benefit of high folate intake and low homocysteine concentration is probably limited

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