

## Hope for health in Nigeria

Celebrations are afoot in Abuja. On May 19, the two Houses of the Nigerian National Assembly finally passed the National Health Bill into law, after 7 years of inaction and procrastination. The controversial bill, which promises to provide all Nigerians with a basic minimum package of health services, was originally proposed in 2004 and passed in May, 2009, before being withdrawn for bureaucratic reasons. It has effectively lain untouched since. The Nigerian Medical Association estimates that 7 million children and 385 000 mothers have died in the interim.

As the most populous country in Africa (one in four Africans live in Nigeria), providing universal health care is no easy task. But even allowing for the difficulties posed by providing health care to a large population, the country still underperforms. Life expectancy at birth averages just 54 years for both sexes. Maternal mortality is 608 per 100 000 livebirths, and the mortality rate for children younger than 5 years is more than double the global average at 157 per 1000 livebirths. Nigeria is the only country in the African continent to have never eradicated poliomyelitis, and only 3% of HIV-positive mothers receive antiretrovirals. Just 6% of the country's gross domestic product (GDP) is spent on health and there are enormous inequalities in its allocation between the rich and poor areas of the country.

The bill provides a framework for the regulation and provision of national health services, defines the rights of health workers and users, and stipulates guidelines for the formulation of a national health policy. Its promises will not change everything for Nigerians, but the bill does allow them to finally hold the government to account for their right to health, including equitable access to care. Never before has there been such momentum towards making a real commitment to improving health in this country.

The bill pledges to develop a national health policy that includes 60 billion naira (about US\$380 million) devoted to primary health care each year, commitments to the provision of essential drugs, and comprehensive vaccination programmes for pregnant women and children younger than 5 years of age. It rightly devotes a whole section to strategies to reduce the crippling effect of the brain drain on health care; there are as many Nigerian doctors working in the USA as there

are in the public health-care sector of Nigeria. The bill thus commits to providing adequate resources for ongoing education and training of doctors, including a continuing professional development programme. The health bill stipulates the need for measures of accountability, which are central to the bill's success. The country's performance and the state of citizens' health need to be assessed by an independent authority, and the government must be accountable for delivering on their promises.

On May 29, many Nigerians celebrated again as Dr Goodluck Jonathan was inaugurated as President for the next 4 years. The zoologist succeeded President Umaru Yar'Adua after his death last year, and in April, 2011, Jonathan was re-elected in what is widely considered the most transparent and legitimate election Nigeria has ever held. This is an exciting time for the country: it has a leader with a clear mandate, its economy is flourishing (it is predicted to have the highest average GDP growth of any country over the next 40 years), and efforts are being made to reduce its sporadic civic and religious tensions and endemic corruption.

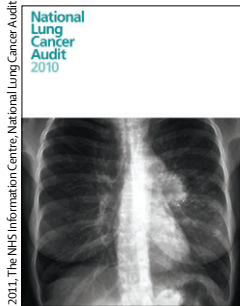
However, until now, health has been lamentably absent from Jonathan's declared priorities. Although progress has been made in poliomyelitis eradication and health-systems strengthening since he came to power in May, 2010, these are only two of hundreds of indicators in dire need of improvement. Many societal groups grew concerned over his neglect of a health agenda. On May 18, thousands of women protested about the delay in the passage of the health bill outside the National Assembly. Their efforts were rewarded with the passing of the bill the very next day. At the time of going to press, all that remains outstanding is presidential assent to make the National Health Bill a federal law.

This auspicious turn of events gives cause for hope. Perhaps President Jonathan is more devoted to rectifying the appalling state of health in Nigeria than has been apparent thus far. If he really is committed to providing equitable and affordable universal health care for all of his people, he should sign the National Health Bill immediately. There is no better way to say "thank you" for electing him. ■ *The Lancet*



President Goodluck Jonathan

## Specialist nurses and lung cancer



2011, The NHS Information Centre, National Lung Cancer Audit

For the **National Lung Cancer Audit 2010** see [http://www.ic.nhs.uk/webfiles/Services/NCASP/audits%20and%20reports/NHSIC\\_National\\_Lung\\_Cancer\\_Audit\\_2010\\_V1.0.pdf](http://www.ic.nhs.uk/webfiles/Services/NCASP/audits%20and%20reports/NHSIC_National_Lung_Cancer_Audit_2010_V1.0.pdf)

For more on **the role of specialist nurses** see [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0008/302489/003581.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0008/302489/003581.pdf)

For the **increasing role of specialist nurses** see [http://www.chks.co.uk/assets/files/Press\\_Releases/2011/Specialist\\_nurse\\_29\\_03\\_2011.pdf](http://www.chks.co.uk/assets/files/Press_Releases/2011/Specialist_nurse_29_03_2011.pdf)

Data reported in praise of specialist nurses in the UK's *National Lung Cancer Audit 2010* on May 23 showed that 64.8% of patients with lung cancer or mesothelioma who were seen by a lung cancer nurse specialist in 2009 were given cancer treatment compared with 30.4% of those who were not seen by such a specialist nurse. Data for the audit were gathered for more than 37 000 patients in Great Britain and Northern Ireland, representing about 95% of expected new cases.

Specialist nurses provide care for patients with long-term diseases—eg, multiple sclerosis, breast cancer, diabetes, epilepsy, Parkinson's disease, heart disease, and psychiatric illnesses. Their roles include provision of information and support for patients and their families, and coordination of patients' care. Multiple sclerosis nurse specialists save each National Health Service (NHS) trust £60 000 per year by comparison with inpatient care, by treating patients' relapse symptoms in their homes. The benefits associated with the care of specialist nurses include reduced referral times, improved dropout rates, shorter hospital stays, and

lower risks of complications after surgery. The number of NHS referrals to specialist nurses in 2005–06 was just over 115 000, and has been increasing by at least 100 000 per year to just over 650 000 in 2010–11.

*National Lung Cancer Audit 2010* recommended that "over 80 per cent" of patients are seen by a lung cancer specialist nurse, exceeding the present rate of 64% in England and Wales. Expansion of the system is hampered by underprovision; in a poll by the UK's Royal College of Nursing in 2008, one in four specialist nurses were at risk of redundancy, and 45% were asked to cover staff shortages by working outside their specialty. The college has asked for continued investment by NHS trusts in specialist nursing services. In its 2010 report, one of the recommendations of the Royal College of Nursing was that every patient with a chronic or long-term illness should have the right to care provided by a specialist nurse. NHS trusts should work to enhance, and not diminish, the role and numbers of specialist nurses in the delivery of patients' care. ■ *The Lancet*

## Ensuring HIV treatment for all in the USA



Corbis

If you are an HIV-positive person living in the USA with a low income and no or inadequate health insurance, then AIDS drug assistance programmes (ADAPs) are an important and vital safety net that pay for your treatment. That was until recently.

State-run ADAPs, which currently cover around 191 000 Americans, are facing financial difficulties and are struggling to accommodate all those requiring assistance. As of May 12, 8100 people with HIV in 13 states were on waiting lists to join an ADAP—a record number. This is a shockingly high figure for the world's richest nation but, worryingly, the true scale of the crisis could be much bigger. Several states have been forced to tighten financial eligibility criteria for their programmes. On July 1, in Illinois, for example, eligibility for the state's ADAP will change from a yearly income of US\$54 450 to \$32 670. And some ADAPs have even scrapped their waiting lists, effectively closing their programmes to new patients.

A mix of factors have led to this troubling situation, number one being the economic downturn, which has meant that more people with HIV are unemployed

and are in need of assistance. Between June, 2008, and June, 2009, alone, the number of new people who relied on ADAPs for their medication increased by 80%.

The federal government has increased funding for ADAPs by 13% to \$1.79 billion in the fiscal year 2010. State funding has also increased by 61% to \$346.2 million. And, thanks to negotiations led by the ADAP Crisis Taskforce, 12 drug companies have lowered or frozen the prices of their HIV drugs. Still, these individual measures have not been enough to meet the increasing demand for assistance.

When President Barack Obama's major health reform—the Patient Protection and Affordable Care Act—is fully implemented in 2014, pressure on ADAPs will decrease, but until then federal and state governments need to find more funding for these essential programmes. And drug companies that have not reduced their HIV drug prices, or have not guaranteed long-term lowering of prices, must do so without delay. A collective effort is required to solve the ADAP crisis and ensure that every American in need of HIV drugs receives them. ■ *The Lancet*

For more on **the situation with ADAPs** see [http://www.nastad.org/Docs/Public/InFocus/2011\\_516\\_ADAP%20Watch%20update%20-%205.13.11.pdf](http://www.nastad.org/Docs/Public/InFocus/2011_516_ADAP%20Watch%20update%20-%205.13.11.pdf)

## Can India achieve a balance of sexes at birth?



The masculine nature of the Indian population, as indicated by the lower than normal sex ratio (defined as female-to-male ratio in India), has been a matter of concern since the first Indian census in 1871.<sup>1</sup> Almost a century and a half later, the sex ratio in children aged 0–6 years in India—of 915 girls to 1000 boys—is the lowest ratio recorded since data became available in 1961.<sup>2</sup> The steady decline in the ratio is surprising, and counterintuitive, in view of India's progress in recent decades in improving the levels of female literacy and increases in income per person. In *The Lancet*, Prabhat Jha and colleagues<sup>3</sup> present a timely analysis of trends in sex ratio at birth in India, and show that the ratio for second-order births, conditional on the first born being a girl, fell from 906 girls per 1000 boys in 1990, to 836 girls per 1000 boys in 2005. On the basis of this finding, the investigators estimate that there have been between 3.1 and 6 million abortions of female fetuses in the past decade.

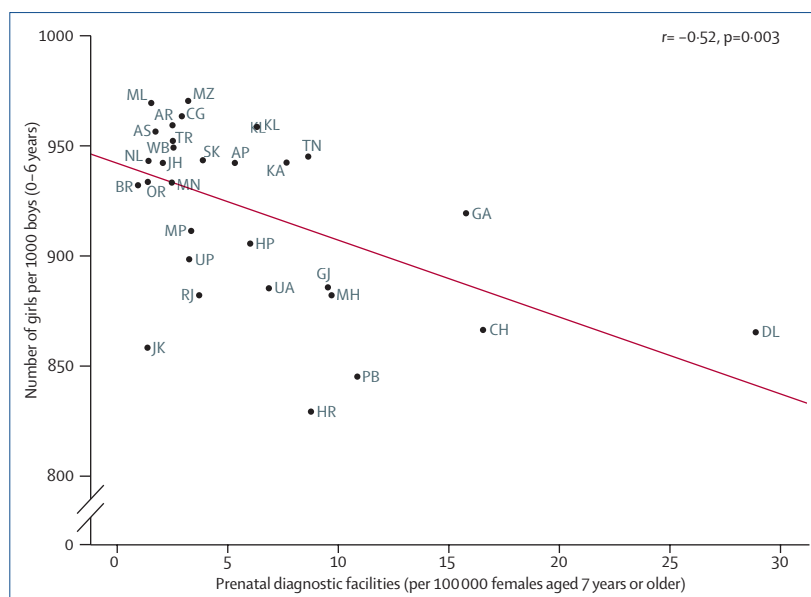
In view of the unverifiable assumptions that are needed to derive statistical estimates of sex-selective abortions, the value of the analysis by Jha and colleagues is mainly independent confirmation of two important aspects of the sex ratio in India that have been reported previously with different data.<sup>4,5</sup> The first is that sex imbalance at birth seems to be particularly concentrated in households with high education and wealth. This pattern suggests that dominance of the son-preference norm is unlikely to be offset, at least in the short term, by socioeconomic development. Second is that the overall problem of sex imbalance seems to arise throughout India, including in Kerala,<sup>4,5</sup> which has often been characterised as a model state for social development and gender equality.<sup>6</sup> The problem of sex imbalance seems to be a function of socioeconomic status, not geography.

The abnormal sex ratio in children was initially attributed to gender discrimination in the allocation of health-related resources within households—indicative of the strong societal norm of son preference—leading to excess mortality in girls.<sup>7</sup> Recent declines in the child sex ratio, however, are thought to be driven largely by medical technologies to determine the sex of fetuses, followed by selective abortion of girls.<sup>8</sup> Although the implementation of the Pre-Natal Diagnostic Techniques Act<sup>9</sup> makes it illegal to identify the sex of a fetus, there

is little evidence that the law is accomplishing its goal.<sup>4</sup> Rather, it seems that states with increased availability, per person, of registered prenatal diagnostic facilities have lower child sex ratios than states where this equipment is less available. This finding suggests either increased demand for such services in states with populations with a high son preference, or that the presence of these facilities is actively contributing to the lowering of sex ratios through sex determination and sex-selective abortion (figure).

Can India balance its distribution of sexes at birth? The prospects seem grim. The demand for sons among wealthy parents is being satisfied by the medical community through the provision of illegal services of fetal sex-determination and sex-selective abortion. The financial incentive for physicians to undertake this illegal activity seems to be far greater than the penalties associated with breaking the law. The market for sex determination and selective abortion has been

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**Figure:** Number of girls per 1000 boys (2011) by per-person availability of prenatal diagnostic facilities (2006) across states in India  
Child female-to-male ratio at ages 0–6 years from 2011 Census of India.<sup>2</sup> Prenatal diagnostic facilities calculated as per 100 000 women (age 7 years and older), based on number of facilities registered by state through 2006.<sup>9</sup> Facilities include genetic counselling centres, genetic laboratories, genetic clinics, ultrasound clinics and imaging centres, mobile clinics (vehicles), and in-vitro fertilisation and infertility centres. State names: Andhra Pradesh (AP), Arunachal Pradesh (AR), Assam (AS), Bihar (BR), Chandigarh (CH), Chhattisgarh (CG), Delhi (DL), Goa (GA), Gujarat (GJ), Haryana (HR), Himachal Pradesh (HP), Jammu and Kashmir (JK), Jharkhand (JH), Karnataka (KA), Kerala (KL), Madhya Pradesh (MP), Maharashtra (MH), Manipur (MN), Meghalaya (ML), Mizoram (MZ), Nagaland (NL), Orissa (OR), Punjab (PB), Rajasthan (RJ), Sikkim (SK), Tamil Nadu (TN), Tripura (TR), Uttar Pradesh (UP), Uttarakhand (UA), and West Bengal (WB).

estimated to be worth at least US\$100 million per year,<sup>8</sup> and the pervasive nature of the low sex ratio at birth suggests that this is not a consequence of a minority of errant physicians in a few states. Therefore the medical establishment must be held accountable on moral, social, and legal grounds. Although there have been efforts to increase the penalty for non-compliance on the part of technicians and physicians, the sluggishness of the Indian judicial system, and the absence of systematic record-keeping of births, will remain a major hurdle for effective implementation of the Pre-Natal Diagnostic Techniques Act. For example, 800 court cases against doctors in 17 states have resulted in only 55 convictions.<sup>10</sup>

India does not record how many children are born every day. Immense challenges exist to register every birth, but sample survey data based on a mother's recall of her entire birth history, as used by Jha and colleagues, are far from ideal. The decadal frequency of the census limits its usefulness for frequent monitoring and surveillance of the proportion of sexes at birth. Any meaningful progress towards achieving a balance of sexes at birth, therefore, has to start by enumerating every child at birth.

Public policy efforts thought to have helped normalise sex ratios at birth in South Korea,<sup>11</sup> together with calls for effective implementation of the Pre-Natal Diagnostic Techniques Act, raise hope for a possible turnaround in India. However, son-biased sex ratios were found for second and higher births in Indians living in the USA, with no such biases found in the ratios for whites at all birth orders.<sup>12</sup> In this natural experiment of sorts, whereby the social norms that facilitate son preference are removed, son-biased sex ratios persist. This finding raises a difficult and provocative question for public policy: if no male biases are noticeable for the first born,

as is the case in India,<sup>3</sup> should medical technology and services be allowed to play a part in letting a family plan their desired composition, especially when there is an active public policy effort to voluntarily limit family size to replacement level?

\*SV Subramanian, Daniel J Corsi

Department of Society, Human Development and Health, Harvard School of Public Health, Boston, MA 02115, USA (SVS); and Population Health Research Institute, McMaster University, Hamilton, ON, Canada (DJC)  
svsubram@hsph.harvard.edu

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## Gene therapy for critical limb ischaemia: the TAMARIS trial

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Atherosclerosis in leg arteries disrupts blood flow in one in ten adults older than 50 years in high-income countries.<sup>1</sup> Fortunately, the severe clinical symptoms of critical limb ischaemia, such as rest pain, ulceration, and gangrene, are uncommon, with an annual incidence of 500–1000 per million population.<sup>2</sup> However, the prognosis for patients with critical limb ischaemia

is bleak: 1 year after initial treatment, a quarter are dead, a third have had an amputation, and a fifth have continuing symptoms.<sup>2</sup>

The mainstay of treatment is surgical revascularisation, but this procedure is major, invasive, and costly (>US\$20 000) and 20% of patients end up with an amputation within 3–5 years.<sup>2</sup> Furthermore, many

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