What response is needed? The global scale and molecular epidemiology of extensively drug resistant tuberculosis require urgent assessment, and laboratory capacity needs to be greatly increased within a network of sentinel sites. Control practices must be rigorously and effectively implemented. Increasing cure rates for tuberculosis through directly observed treatment short course (DOTS) is crucial. Detection rates for cases of tuberculosis need to be improved, highlighting the need for a new diagnostic test. Technologies that can determine the presence of drug resistance at the point of care are needed, as are new drug treatments. The DOTS-Plus strategy[10] for treatment of multidrug resistant tuberculosis needs to be further developed for areas where the disease is established. Nosocomial transmission of tuberculosis is probably commonplace in the developing world, and simple, effective strategies to reduce such transmission need to be urgently implemented. More fundamentally, the emergence of extensively drug resistant tuberculosis is a reminder that tuberculosis needs massive broader commitment: the incompletely funded Global Plan to Stop TB[11] demands political will and financial action.

Stephen D Lawn *senior lecturer in infectious and tropical diseases*

(stevelawn@yahoo.co.uk)

Desmond Tutu HIV Centre, Institute of Infectious Disease and Molecular Medicine, Faculty of Health Sciences, University of Cape Town, Anzio Road, Observatory 7925, Cape Town, South Africa

Robert Wilkinson *Wellcome Trust senior fellow in clinical tropical medicine*

Institute of Infectious Disease and Molecular Medicine, University of Cape Town

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Emergency contraception

Is it worth all the fuss?

Emergency contraception can prevent pregnancy after unprotected sex, but it can also cost you your job. In 2005 an assistant commissioner resigned from the Food and Drug Administration (FDA) in the United States after a decision to make emergency contraception available off prescription was postponed indefinitely, despite two committees recommending it (after three years' delay the FDA has recently approved over the counter sales, with restrictions, of the emergency contraceptive Plan B).[1] In 2006 two editors of the *Canadian Medical Association Journal* (*CMAJ*) were fired, partly because they published an article about access to emergency contraception in Canadian pharmacies.[2] Emergency contraception has been described as "the latest battleground in an ideologically divided America."[3] It has always been a battleground, but is it worth all the fuss?

First used in the early 1970s, emergency contraception was a well kept secret until the late 1990s. At this time interest in this form of contraception exploded and considerable efforts were made to promote it. Dedicated products are now available in many countries, increasingly off prescription. Its use in most countries is low, however. A minor proportion of women undergoing abortion claim to have used emergency contraception in the past to try to prevent pregnancy (1.3% in the US,[4] 2.9% in Sweden, and 9.2% in France). In the United Kingdom its use has grown from 1% among women requesting an abortion in 1984, to 6% in 1996,[5] and 12% in 2002.[6]

Emergency contraception has been heralded as the solution to rising abortion rates. Some authors have suggested that almost a million abortions could be prevented in the US annually if every woman used emergency contraception every time she needed it.[7] Proponents claim that 43% of the reported fall in abortions in the US (110 000 between 1994 and 2000) was due to use of emergency contraception, and that around 51 000 pregnancies were prevented by its use in 2000-1.[4] Similar calculations would lead us to conclude that emergency contraception prevented more than 66 500 abortions in England and Wales in 2004.

Yet, despite the clear increase in the use of emergency contraception, abortion rates have not fallen in the UK. They have risen from 11 per 1000 women aged 15-44 in 1984 (136 388 abortions) to 17.8 per 1000 in 2004 (185 400 abortions). Similarly, increased use of emergency contraception in Sweden has not been associated with a reduction in abortion rates.[8] A multitude of social and economic factors influence pregnancy rates, and it is hard to show the effect of a single factor. For example, the fall in the

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abortion rate in the US could be due to reduced access to abortion clinics—another ideological battleground.

Three key questions should be asked about a healthcare intervention: "Can it work?" (denoting efficacy), "Does it work?" (denoting effectiveness), and "Is it worth it?" (denoting efficiency).[9] For emergency contraception the first question has not been answered for obvious ethical reasons—a placebo controlled trial has never been performed. Estimates of efficacy are based on calculating the day of ovulation for individual women using emergency contraception and calculating the chance that pregnancy would have occurred by using data obtained from a cohort of women trying to conceive, who kept diaries of menses and intercourse and who had the day of ovulation determined biochemically. Many women using emergency contraception have recently had unprotected intercourse more than once, many are vague about the date of their last period, and a few were too drunk to be sure they had even had sex.

Even if emergency contraception can work (is efficacious), the experimental evidence that it does work (is effective) is disappointing. Ten studies in different countries have shown that giving women a supply of emergency contraception to keep at home, so that they have it when they need it, increases use by twofold to threefold.[10] In three studies that measured subsequent pregnancy rates, advance provision of emergency contraception increased its use but had no measurable effect on rates of pregnancy or abortion.[10–12] When reasons for not using emergency contraception, despite having a supply at home, were documented three out of every four women said they did not realise they had put themselves at risk of pregnancy.

So is emergency contraception worth the fuss? If you are a woman who has had unprotected sex then of course it is, because emergency contraception will prevent pregnancy in some women some of the time—and if you don't want to get pregnant anything is better than nothing. If you are the *CMAJ*'s editor or FDA commissioner then yes, because scientific freedom is worth the fight. If you are looking for an intervention that will reduce abortion rates, emergency contraception may not be the solution, and perhaps you should concentrate most on encouraging people to use contraception before or during sex, not after it.

Anna Glasier *director*

(anna.glasier@lpct.scot.nhs.uk)

Lothian Primary Care NHS Trust, Edinburgh EH4 1NL

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Salt reduction in the United States

Halve salt in processed and restaurant food, says American Medical Association

In June 2006, the American Medical Association catapulted its salt policy into the headlines. In a bold step the association's membership voted to implement several strategies to reduce salt intake. The members voted *(a)* to urge the Food and Drug Administration (FDA) to revoke the "generally recognized as safe" (GRAS) status of salt and develop regulatory measures limiting the amount of salt in processed and restaurant foods; *(b)* to establish quantifiable milestones, specifically a 50% reduction over the next decade, in the salt content of processed foods, fastfood products, and restaurant meals; *(c)* to join in partnership with organisations to educate consumers about the benefits of long term salt reduction; and *(d)* to work with the FDA to improve food labelling and develop warning labels for foods high in salt. The association's decision to advocate salt reduction follows a recent series of reports in the United States recommending sharp reductions in salt consumption, largely because of its adverse effects on blood pressure.[1–5]

The response from industry was swift and predictable. Leading the charge against the proposal is the Salt Institute, an international trade organisation of salt producers. In a news release, the Salt Institute claimed that "the American Medical Association has misread the science, confusing blood pressure effects with health outcomes." The Salt Institute, now allied with the US Chamber of Commerce, argues that policy making should rely only on evidence from clinical trials that use clinical outcomes such as stroke and mortality rather than intermediary outcomes such as blood pressure. However, blood pressure is an important, aetiologically relevant risk factor for cardiovascular and renal diseases and is widely accepted as a valid marker for policy making.[6] In addition, a large scale, long term, lifestyle modification trial with clinical outcomes is unrealistic. It would not be worth the considerable time and expense because of the overwhelming evidence for salt's adverse effects on blood pressure.[7]

Reducing salt intake is similar to achieving other lifestyle modifications in that a substantial public health approach will be required in addition to changes in individual behaviour. The need for a public health

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