Letters

Preventing cardiovascular disease. A despondent view

Editor – Both the question raised by Claude Lenfant (*1*) and the discussion of it made stimulating reading. The crucial issue is whether populations really make serious attempts to change their lifestyle. Undoubtedly, there is a fair appreciation of the risk factors involved. We know we should not overeat; we should eat less fat and more plant foods, especially vegetables and fruit. People should also stop smoking, restrict their alcohol consumption, and considerably increase their level of physical activity. Yet the fact must be faced that there have been very few meaningful responses to the appeals made. Thus, in European populations, there has been generally no fall in fat consumption, which still supplies about 40% of the total energy intake. Moreover, rises in vegetable and fruit consumption have been barely significant.

On the one hand, in many industrialized countries, life expectancy has increased to roughly 75 years for men and 83 years for women. The number of centenarians is increasing considerably. In the African population in South Africa, in 1985 — before the onslaught of HIV/AIDS — the mean survival time was 62 years, closely approaching that of many populations in far richer countries.

On the other hand, in industrialized countries and in measure in urban areas of developing countries, some major risk factors for cardiovascular diseases are rapidly increasing. For example, in the USA, the proportion of obese adults rose from 12% in 1991 to 17.9% in 1998 (*2*). The proportion of people worldwide with type 2 diabetes is "exploding" and is likely to double in the next 10 years (*3*). In 1992, diabetes accounted for 15% of the total health care expenditure in the USA (*4*), and 27% of Medicare costs (*5*). As for coronary heart disease, while there has been elation over major falls in the mortality rate from the disease in industrialized countries, its incidence has scarcely changed, and it remains the leading cause of death and disability (*6*).

In summary, the present day challenge is to increase, not so much survival time, but far more importantly, healthy life expectancy or years of "wellness" (*7*). To bring about meaningful beneficial improvements will require truly heroic efforts, such as those described in a *Lancet* editorial in 1998 (*8*). While there is understandable despondency over the continued lack of response, there must be greater publicity concerning the benefits of the various health promotion measures. ■

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Proper HIV/AIDS care not possible without basic safety in health set-up

Editor – The observation by Feachem that health systems of poor countries are dysfunctional (*1*) is a sad truth. Due to fear and discrimination by health care workers, it is still difficult for people with HIV to be admitted to hospitals for the treatment of common ailments like injury, fever, pneumonia, diarrhoea, delivery, etc., even after nearly two decades of the HIV epidemic. That is not to say that health workers are neglecting people with HIV. It is ironic that health workers, afraid to take care of the relatively few known HIV-positive people, are in fact taking care of many more undiagnosed HIV sufferers without taking even basic safety precautions. Nurses, laboratory technicians and phlebotomists, who are exposed daily to hollow needle injections, as well as staff who clean the used instruments, are at greater risk of occupational HIV infection than other health care workers. But safety precautions, including the proper disposal and incineration of needles and the decontamination of used instruments, are not routinely taken to protect the vulnerable "lower staff".

Similarly, the recommended practice of using only sterilized or high-level disinfected gloves and instruments, during procedures with the potential for transmission of blood-borne infections, is not routinely followed in minor medical and dental procedures. These minor procedures are more common than major ones, but instead of collectively trying to make them safe and reduce unnecessary ones, surgeons perceive themselves to be at undue risk. They advise indiscriminate preoperative HIV testing without counselling or confidentiality. They also deny necessary surgery to those who test positive. In a central hospital of Nepal during the last 3 years, the proportion of HIV tests on admitted patients performed by the surgical department was almost two-thirds of the total performed. Examples of such behaviour do little for the declining morale among health workers and it is no wonder that discrimination against people with HIV continues amongst the public. Defeating HIV-related discrimination requires that health and social services be sensitive to discrimination and act against it (*2*).

The modes of HIV transmission have been well defined and precautions to prevent bloodborne infections can easily be taken without compromising care of HIV sufferers. Making arrangements for these simple precautions is surprisingly difficult in developing countries. One of the major hurdles in implementing the precautions is difficulty in communication, explanation and reinforcement of these issues to health workers and managers. I have focused on displaying posters outlining safety issues at the workplace as a continuous reminder to all workers concerned, but this may achieve only limited local impact. Regular implementation of basic safety procedures would allay fears of the health care workers and, in turn, accelerate health care access to people with HIV, a key priority of UNAIDS as highlighted by Piot & Seck (*2*). These two issues are interlinked. Unless international experts and organizations, especially WHO, come up with clear recommendations, the situation will not change in most developing countries. With increasing concern over the possible significant role of minor health procedures in the spread of HIV (*3*), the need of such international recommendations has become imperative. ■

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