Primary health care must go beyond WHO

We were pleased to hear Margaret Chan’s strong commitment to primary health care 30 years after the Alma-Ata Declaration. In your Editorial on her statement (May 31, p 1811),1 you mention that the challenge in revitalising primary health care lies in tying together the ever-increasing number of global initiatives.

However, there is more to it than this. To reappraise primary health care, we should go back to the basics, or the three pillars of primary health care: participation, intersectoral collaboration, and equity.2 We have seen great progress in participation and equity. Participation has been strengthened in many communities and countries, as exemplified by the growth of the civil society movement. In terms of equity, “health for all” used to be the slogan for primary health care, and access has been the key to achieving it. The Global Fund and other initiatives have indeed improved access to bednets, antiretrovirals, and tuberculosis treatment, which has resulted in visible outcomes.

By contrast, we have seen little progress in intersectoral collaboration. When the UN set up the Millennium Development Goals, each goal was expected to have synergistic effects. However, in trying to achieve each goal more rapidly and more effectively, the leading health initiatives have instead taken selective approaches. Now the Global Fund and GAVI Alliance are trying to spend more funding on health systems. A diagonal approach is also recommended.3

However, intersectoral collaboration must go beyond health, it must go beyond WHO. To make a breakthrough in primary health care, we need more progress in intersectoral collaboration and in synchronising all three pillars of primary health care at a global level.

We declare that we have no conflict of interest.

Iodine nutritional status in Tibet

The Comment by Sumei Li and colleagues (June 14, p 1980)4 on iodine status in Tibet is alarming. More than 30 years after the Tibet Autonomous Region launched an ambitious programme to prevent iodine deficiency, the situation seems to have hardly changed, since today two-thirds of the Tibetan population reportedly have no access to iodised salt. Li and colleagues correctly describe Tibet as having “among the most severe iodine deficiency in the world”, so one might wonder why so little has been achieved so far. The data presented by Li do not even mention the existence of endemic cretinism in Tibet, which, unlike goitre, is the hallmark of severe iodine deficiency. 10 years ago, we reported neurological cretinism in Tibet.5

Apparently, some Tibetan school-children are fortunate enough to receive iodised salt while at school. However, we do not know what happens with children who do not attend school or with children born of severely iodine-deficient pregnant women. In fact, few data on iodine deficiency in Tibet have been published in peer-reviewed publications, and none of the studies published on iodine intake in China was done in Tibet.3

Elimination of severe iodine deficiency has been achieved in most developing countries because strong and long-term political commitment has prevailed over economic difficulties. Consequently, there seems no reason why an emergent economy like China cannot take the appropriate steps to eliminate severe iodine deficiency in Tibet.

We declare that we have no conflict of interest.

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Sumei Li and colleagues’ provide an informative insight into the enormous challenge of eliminating iodine deficiency disorders in Tibet. Although their comments on the poor coverage with iodised salt in remote communities are accurate, we believe they portray a rather pessimistic view of the successful iodised oil supplementation programme.

From 2000 to 2004, working collaboratively with the Tibet Department of Health at the operational level, and with financial support from AusAID and WHO, we developed a Tibet region-wide supplementation programme aimed at providing sufficient iodine by administering one capsule of iodised oil annually to all women of child-bearing age and children younger than 2 years. Implemented as an interim strategy, in the absence of an effective programme of iodised salt production and distribution, the iodised oil reached about 95% of the target population.2 Urinary iodine excretion in these women increased on average from 39 μg/L to 96 μg/L.

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We estimate that 170 000 children born in Tibet since the programme commenced have been protected from brain damage. We are aware, however, that iodised oil coverage has declined recently because of lack of resources and we are attempting to find funding to restore the programme to the 2004 level.

We declare that we have no conflict of interest.

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Iodine deficiency in the UK and Ireland

Your timely Editorial (July 12, p 88) indicates that salt iodisation ensures adequate iodine intake and that, reassuringly, household use of iodised salt has increased from 20% to 70% in developing countries. We are concerned that in two developed countries, the UK and Ireland, the consumption of iodised salt is probably less than 5%.

Although the Editorial states that "the number of households in the developing world that use iodised salt has risen", Europe still lags behind and the UK and Ireland languish at the bottom of the international league table in terms of iodised salt availability. We measured the iodine content in 36 different salt preparations obtained from nine major national supermarkets in Cardiff, Wales. The number of samples ranged from one to seven per retail outlet. Iodine concentrations varied from undetectable in 32 samples to trace quantities (0-005 mg/kg) in two. Another two samples, which were labelled as iodised salt, contained about 20 mg/kg iodine (one of these was German in origin, the other English). Thus only four of the 36 retail salt samples contained measurable concentrations of iodine, and only two of these contained meaningful concentrations related to the prevention of iodine deficiency.

Should this lack of iodised salt cause concern? Data from northeast England,2 Wales,1 and Scotland3 suggest that not only is this intake not being achieved but that up to 50% of pregnant women could be significantly iodine deficient during gestation. A similar pattern of iodine deficiency has been seen in Ireland, with iodine intake being particularly low in the summer months.3

In view of the neurocognitive defects of gestational iodine deficiency noted in your leader, we suggest that the situation relating to iodine consumption, particularly in pregnancy, be systematically examined in both countries.

We are, respectively, the UK and Ireland representatives of the International Council for Control of Iodine Deficiency Disorders (ICCIDD). We declare that we have no conflict of interest.

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Voclosporin (ISA247) for plaque psoriasis

We have concerns with the trial of voclosporin (ISA247) for plaque psoriasis by K Papp and colleagues (April 19, p 1337).1

The use of placebo despite the existence of proven treatments is unethical and cannot be justified by the US Food and Drug Administration requirement of placebo-controlled studies.2 Also, the rate of adverse effects in the placebo group (79%) requires discussion.

Lipid concentrations at the start of the trial are not stated. Did patients with high triglyceride concentrations receive the treatment required for an at-risk population? Were patients screened for changes in other lipid and non-lipid risk factors, considering that high serum triglycerides are associated with an increased risk of ischaemic heart disease and other risk factors?3

What proportion of patients received previous topical or no therapy for psoriasis? How were patients switched from previous oral therapy to voclosporin? The inclusion of patients who had previous oral or topical therapy for plaque psoriasis complicates the study.

47% of patients in the 0-4 mg/kg group responded to treatment compared with 4% of the placebo group. Chaidemenos and colleagues4 showed that intermittent versus continuous 1-year cicalcitol use in chronic plaque psoriasis was associated with 92% versus 62%, respectively, of patients achieving a 75% improvement in psoriasis area and severity index score (p=0.008). One wonders how the efficacy of voclosporin would have compared to cicalcitol.

Finally, with a follow-up of only 24 weeks, the study was too short to determine effect and relapse rates.

We declare that we have no conflict of interest.

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