

- 1 Ralston ME, Day LT, Slusher TM, Musa NL, Doss HS. Global paediatric advanced life support: improving child survival in limited-resource settings. *Lancet* 2013; **381**: 256–65.
- 2 Cole-Ceesay R, Cherian M, Sonko A, et al. Strengthening the emergency healthcare system for mothers and children in The Gambia: a pilot programme description and interim evaluation. *Reprod Health* 2010; **7**: 21.
- 3 Bin Nisar Y, Hafeez A, Zafar S, Southall DP. Impact of essential surgical skills with an emphasis on emergency maternal, neonatal and child health training on the practice of doctors: a cluster randomised controlled trial in Pakistan. *Resuscitation* 2011; **82**: 1047–52.

Authors' reply

We thank Louisa Pollock and colleagues and David Southall and colleagues for their thoughtful comments, and particularly for highlighting current efforts to improve paediatric emergency and critical care in limited-resource settings.

Pollock and colleagues are in agreement with us that the evidence base for existing guidelines should be improved and that additional research is needed to address gaps in management and implementation. They also agree that these guidelines should include the entire continuum from Integrated Management of Childhood Illness to hospital care. We have proposed strengthening paediatric advanced life-support guidelines at varying levels of available resources with suggestions for appropriate resource substitutions.¹ This includes integration of guidelines into existing primary care programmes in community settings, where early recognition of critical conditions and initiation of time-sensitive treatment has improved clinical outcomes, including reduced mortality in children younger than 5 years.^{2–4}

Pollock and colleagues also agree with the importance of a systematic approach to critically ill or injured children. We have characterised this systematic approach specifically in terms of patient assessment and categorisation of illness (by type and severity), which then drives appropriate triage and further management. We take the position that training in this systematic approach should

be more widely disseminated if possible in the prehospital setting. We have acknowledged the efficacy of Emergency Triage Assessment and Treatment in reducing paediatric inpatient mortality where implementation has been feasible and are interested to learn about plans to regularly update these resources on the basis of current evidence, such as occurs in paediatric advanced life-support courses in high-income settings.⁵

Finally, we agree with Pollock and colleagues about the priority of addressing barriers to guideline implementation and the caveats expressed by Southall and colleagues with respect to the implementation of paediatric emergency care training in limited-resource settings.

To achieve desired improvements in global paediatric advanced life-support training, management, and implementation, strong international collaboration is paramount. We believe such collaboration between like-minded groups can lead to regular evidence updates which can then guide us to our common goal—a significant reduction in global under-5 mortality.

The views expressed herein are those of the authors, and do not necessarily reflect the official policy or position of the Department of Defense, or the US Government. We declare that we have no conflicts of interest.

**Mark E Ralston, Louise T Day, Tina M Slusher, Ndiamaka L Musa, Helen S Doss*
mark.ralston@med.navy.mil

Naval Hospital Oak Harbor, Oak Harbor, WA 98277, USA (MER); Department of Pediatrics, Uniformed Services University of the Health Sciences, Bethesda, MD, USA (MER); Department of Pediatrics, LAMB Hospital, Parbatipur, Dinajpur, Bangladesh (LTD); Center for Global Pediatrics, University of Minnesota, Pediatric Intensive Care Unit, Hennepin County Medical Center, Minneapolis, MN, USA (TMS); Division of Critical Care, Department of Pediatrics, Medical College of Wisconsin, Milwaukee, WI, USA (NLM); and SIL Clinic, Ukarumpa, Papua New Guinea (HSD)

- 1 Ralston ME, Day LT, Slusher TM, Musa NL, Doss HS. Global paediatric advanced life support: improving child survival in limited-resource settings. *Lancet* 2013; **381**: 256–65.
- 2 Guiscafré H, Martínez H, Palafox M, et al. The impact of a clinical training unit on integrated child health care in Mexico. *Bull World Health Organ* 2001; **79**: 434–41.

- 3 Sazawal S, Black RE. Effect of pneumonia case management on mortality in neonates, infants, and preschool children: a meta-analysis of community-based trials. *Lancet Infect Dis* 2003; **3**: 547–56.
- 4 Bari A, Sadruddin S, Khan A, et al. Community case management of severe pneumonia with oral amoxicillin in children aged 2–59 months in Haripur district, Pakistan: a cluster randomised trial. *Lancet* 2011; **378**: 1796–803.
- 5 American Heart Association. Pediatric advanced life support provider manual. Dallas: American Heart Association, 2011.

High-risk drug practices in men who have sex with men

Tony Kirby and Michelle Thornber-Dunwell (Jan 12, p 101)¹ highlight a “perfect storm”² for HIV and hepatitis C transmission in high-risk drug practices in men who have sex with men (MSM). As part of an ongoing investigation of the continuing shigellosis epidemic in MSM in the UK,³ we did in-depth interviews that explored the lifestyle and sexual behaviour of 12 MSM diagnosed with *Shigella flexneri* serotype 3a.

Mephedrone, ketamine, crystal metamphetamine, and γ -butyrolactone had been used by most MSM (nine of 12) during sexual encounters. “Slamming”—a term probably used to reduce the social stigma of injecting recreational drugs—occurred at sex parties and was reported by two.

Drug use seemed linked to disinhibiting behaviour and pushing boundaries to seek new sexual experiences, including fisting and scat play. Condom use was rare, and most encounters were anonymous and arranged through internet sites. Most men (nine) were HIV positive (two who were negative are retesting), reported high numbers of sexual partners in the past year (median 60), and had had gonorrhoea (nine) and chlamydia (seven). A small number of infections of syphilis, lymphogranuloma venereum, and hepatitis C were also identified.

Lymphogranuloma venereum and syphilis outbreaks have been reported

in recent years in MSM with similar patterns in sexual behaviour, and the potential for further infectious disease outbreaks and HIV transmission is clear.^{4,5} Both HIV-positive and HIV-negative MSM need to be aware of the adverse effect of certain recreational drugs on their sexual health. HIV and sexual health clinicians should discuss recreational drug use with their patients and refer them to appropriate treatment services when indicated.

We declare that we have no conflicts of interest.

*Victoria L Gilbert, Ian Simms, Maya Gobin, Isabel Oliver, Gwenda Hughes
vicky.gilbert@phe.gov.uk

Public Health England, London NW9 5EQ, UK

- 1 Kirby T, Thornber-Dunwell M. High-risk drug practices tighten grip on London gay scene. *Lancet* 2013; **381**: 101–02.
- 2 Daskalakis DC, Blaser MJ. Another perfect storm: *Shigella*, men who have sex with men and HIV. *Clin Infect Dis* 2007; **44**: 335–37.
- 3 Borg ML, Modi A, Tostmann A, et al. Ongoing outbreak of *Shigella flexneri* serotype 3a in men who have sex with men in England and Wales, data from 2009–2011. *Euro Surveill* 2012; **17**: pii=20137.
- 4 Jebbari H, Simms I, Conti S, et al. Variations in the epidemiology of primary, secondary and early latent syphilis, England and Wales: 1999 to 2008. *Sex Transm Infect* 2011; **87**: 191–98.
- 5 Ward H, Martin I, Macdonald N, et al. Lymphogranuloma venereum in the United Kingdom. *Clin Infect Dis* 2007; **44**: 26–32.

In their report on the consequences of high-risk drug practices on the London gay scene, Tony Kirby and Michelle Thornber-Dunwell¹ quote UK Health Protection Agency (HPA) data for incidence of HIV and hepatitis C virus (HCV) co-infection in men who have sex with men (MSM), which show a decrease from 7.38 per 1000 person-years in 2008 to 1.46 per 1000 person-years in 2011. However, as Kirby and Thornber-Dunwell also note, these figures could be a substantial underestimate and might even be increasing.

In its annual report on hepatitis C in the UK,² the HPA makes only a brief reference to sexual transmission of HCV in HIV-positive MSM and instead focuses extensively on hepatitis C in intravenous drug users (IDUs). There is

a danger of the HPA being complacent by ignoring issues relating to infection prevention in MSM in this key report. Although the prevalence of HCV among HIV-positive IDUs is higher than in HIV-positive MSM (83.7% vs 7.2%), in absolute numbers there are more MSM than IDUs known to be co-infected in the UK.³

Rates of HCV reinfection are particularly high in HIV-positive MSM in London compared with Hamburg (Germany) and Amsterdam (Netherlands).⁴ The National AIDS Trust⁵ considered it striking that there is no agreed strategic approach to the epidemic of sexually transmitted hepatitis C in HIV-positive gay men in the UK, given the increasing importance of morbidity and mortality from liver disease in co-infected patients. The increase in high-risk drug practices described by Kirby and Thornber-Dunwell makes the need for a national strategy even more urgent.

We declare that we have no conflicts of interest.

*Marcus Griffin, Darren Shickle
m.griffin@leeds.ac.uk

Academic Unit of Public Health, University of Leeds, Leeds LS2 9JL, UK

- 1 Kirby T, Thornber-Dunwell M. High-risk drug practices tighten grip on London gay scene. *Lancet* 2013; **381**: 101–02.
- 2 Health Protection Agency. Hepatitis C in the UK: 2012 report. <http://www.hpa.org.uk/Publications/InfectiousDiseases/BloodBorneInfections/HepatitisCinTheUK/1207HepCintheUK2012/> (accessed April 2, 2013).
- 3 Turner J, Bansi L, Gilson R, et al. The prevalence of hepatitis C virus (HCV) infection in HIV-positive individuals in the UK—trends in HCV testing and the impact of HCV on HIV treatment outcomes. *J Viral Hepatitis* 2010; **17**: 569–77.
- 4 National AIDS Trust. Hepatitis C and HIV co-infection. London: National AIDS Trust, 2012. <http://www.nat.org.uk/media/Files/Publications/Jan-2012-Hepatitis-C-and-HIV-co-infection.pdf> (accessed Feb 3, 2013).

Polio eradication: getting the basics right

Your Jan 5 Editorial (p 1)¹ argues for bringing polio eradication back on track in Pakistan through ensuring security for immunisation workers, going beyond the “polio only” agenda,

and integration of polio vaccination into routine health and immunisation programmes. This viewpoint and other analyses² have rightly highlighted the worsening security conditions and increasing inaccessibility to vaccination in Pakistan as the root cause of failure in polio eradication. Recent efforts by WHO also focused on significantly boosting the number of polio eradication officers at national, provincial, and district levels.

Yet this overall focus on polio, security, and winning hearts and minds has taken focus away from the role of the crumbling routine immunisation programme itself. Poor governance, staff absenteeism, and corruption have all weakened the public infrastructure through which polio eradication initiatives are delivered.³ Routine immunisation services fail to vaccinate nearly a third of children, and, in recent months, more than 200 infants have died in Sindh province from measles alone.⁴

Strengthening of the routine immunisation programme is crucial because: (1) it is not possible to provide security to 90 000 lady health workers during country-wide vaccination campaigns—they are an obvious soft target for terrorism; (2) in the run-up to the forthcoming parliamentary elections, polio does not have a big role; and (3) high-risk population groups (mainly of Pashtun ethnicity) resist polio vaccination campaigns owing to their religious and cultural beliefs.⁵

If the world does not want to miss another public health deadline, it is imperative to address the systemic problems that have plagued the routine immunisation programme in Pakistan. This will require accurate, context-specific communication, and perhaps integration with vaccination against other diseases the communities consider more important than polio.

We declare that we have no conflicts of interest.

*Asmat Ullah Malik, Peter Stewart Hill, Anar Ulikpan, Saima Hamid
asmat.malik@uqconnect.edu.au



Corbis