Although a link between prescribing antibiotics and resistance has been established at the level of the individual,[7] this relation is unclear at practice level or even group level.[8] Generally, higher prescription rates seem to be associated with higher resistance rates. Moreover, prolonged use of an antibiotic in chronic conditions seems to be an important factor in the promotion of resistance.[9 10] This means that a short antibiotic course of one to two weeks for acute primary impetigo should be relatively harmless, but impetiginised eczema or atopic dermatitis should not be treated with topical antibiotics.

The effectiveness of any antibiotic is dependent on the susceptibility of the causative bacteria. In impetigo this is usually *S aureus*. Resistance rates in staphylococci against fusidic acid vary considerably between regions and in time.[6 10] Therefore, treatment of impetigo should be guided by susceptibility testing of a *S aureus* isolate obtained from the patient. However, this time consuming procedure is hardly feasible in general practice and therefore is seldom done.

The final choice of treatment can be determined best by regional or national guideline developing bodies. Knowledge of local resistance patterns on the basis of surveillance of specimens derived from general practice should be incorporated in these documents. Furthermore, they may contain policies to reserve certain antibiotics for the treatment of other, more serious infections. For example, systemic fusidic acid is considered vital in the treatment of severe bone infections, and mupirocin is a cornerstone in eradication of methicillin resistant *S aureus* carriage. Frequently updated guidelines of this kind are not available yet in most parts of the world.

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Making sense of rising caesarean section rates

Time to change our goals

In Canada and the United States the appropriate role of caesarean section was an important women's issue, a topic for research on patterns of use, and a target of professionally endorsed guidelines in the early 1980s. Two decades later women, researchers, and the medical establishment are once again debating the use of this procedure.

Rather than being a case of history repeating itself, the current debate is different in content and tone. Historically, as caesarean section rates rose and crossed the 15% mark that the World Health Organization had suggested as an upper limit, research focused on determining the extent to which the increase was driven by medical indications.[1] The medical profession defined approaches to care that would reduce or limit the rise in caesarean section, and systematic efforts were made to implement these strategies.[2] Currently, caesarean section rates in Canada and the United States are close to 25% and over 20% in England, Wales, and Northern Ireland.[3]

Recent articles in leading journals support offering women, in whom an accepted medical indication for the procedure does not exist, the right to choose a caesarean section as the mode of delivery (that is, a primary elective caesarean section or caesarean section on demand).[4 5] Offering elective caesarean sections can only put further upward pressure on rates of caesarean sections. Offering elective caesarean sections has been endorsed by professional associations in Canada and the United States despite concerns raised by women's groups[6] and is being debated by the International Federation of Gynecology and Obstetrics.[7] (Rising rates of caesarean sections and renewed debate over the appropriate role of the procedure are not limited to Canada and the United States, but also are occurring in Europe and South America .[3 6 7–9] What is behind this apparent shift in thinking?

The appropriate use of caesarean section, like the appropriate use of any medical intervention, should be based on evidence on risks and benefits. One reason for the shift in thinking could therefore be new evidence supporting a larger role for caesarean section. In terms of recent randomised trials, a search of the *Cochrane Library* shows that, other than a recent trial of planned vaginal delivery versus planned caesarean section for term breech presentation, no new large trials exist that compare the risks and benefits of caesarean section with vaginal delivery for common indications. Moreover, the search shows that there is very little evidence for any period of time from randomised controlled trials that compare caesarean section with vaginal delivery.

The articles supporting elective caesareans cite primarily observational studies, rather than randomised

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controlled trials, to make two main points. Caesarean sections are increasingly safe for women and children, and the rate of pelvic floor problems (particularly urinary incontinence) is substantially higher in women who had vaginal deliveries than in women who had caesarean sections.[4 5] Although this evidence is discussed in the context of elective caesareans, it can be seen as challenging the professional perspective on the risk-benefit trade off for caesarean sections compared with vaginal delivery for specific indications.

Other potential reasons for the shift in how caesarean sections are perceived include changes in patients' preferences and in the part that doctors play in decision making. How women view the care they want to receive in labour and delivery may have changed, moving from the notion of demedicalisation that was common in the early 1980s to the increased demand for the use of medical technology found in today's world. The way in which the relationship between doctors and patients is viewed by patients and doctors may have changed. The historical role of the doctor acting as the informed agent for the patient may be changing, thanks to the increasing reliance on a model where the patient is seen as the consumer and the doctor as supplier of services. Suppliers may find it difficult to ignore consumers' demands. Patients' preferences have an important role in informed decisions, but these preferences can be expressed fairly only in the context of the best evidence on risks and benefits, and doctors should not be expected to provide services that are of no clinical benefit or potentially harmful.

Without solid evidence on the risks and benefits of caesarean section versus vaginal delivery, making informed decisions with individual patients is difficult. This lack of evidence on risks and benefits, combined with the changing preferences of patients and roles for doctors, makes setting national goals for rates of caesarean sections virtually impossible. The term breech trial has shown that it is possible to conduct a large international trial that provides the needed evidence.[10]

Three specific indications—fetal distress, dystocia, and previous caesarean section—account for most caesarean sections.[1] We have little evidence from controlled trials on the risks and benefits of caesarean section for these indications. One obvious goal is to support large, well designed, randomised trials that could help define appropriate care for these common indications. However, trials take time, and in the short term decisions for individual patients and for health systems will have to be made in the face of uncertainty about the risks and benefits of caesarean section compared with vaginal delivery. Another goal should therefore be to have a more comprehensive and frank debate about the ethical issues related to the role of doctors, preferences of patients, and informed consent with respect to caesarean sections.

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HIV in injecting drug users in Asian countries

Available effective interventions need to be implemented

Discussions of HIV control in developing countries usually pay insufficient attention to injecting drug use. Yet half the population of the world now lives in developing countries within a few hours' flight from Bangkok, in a region where HIV infection is dominated by the sharing of injecting equipment. The number of people infected with HIV in India and China alone is estimated to increase from 6-10 million at present to 30-40 million by 2010.[1] By 2010 The Joint United Nations Programme on HIV/AIDS (UNAIDS) expects that Asia will outstrip sub-Saharan Africa in absolute numbers of HIV carriers.[1] In seven of the 10 UNAIDS regions—accounting for 90% of the global population—injecting drug users are considered among the most important risk groups for HIV.[2]

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Fortunately, strategies to prevent the spread of HIV infection among and from injecting drug users can be effective and cost effective interventions. In addition, the effectiveness and safety of these prevention strategies have been known for almost two decades. Moreover, we now have extensive international experience to draw on, as these measures have long been put to good effect in many countries of the European Union and Australasia.[3 4]

How can national authorities be persuaded effectively to adopt these prevention strategies early enough in the development of an HIV epidemic? How can such authorities quickly scale up the size of the response in order to slow the rate of HIV spread among injecting drug users? The major obstacle remains an entrenched commitment to an unbal-