mon good, which could not be further from the truth. They believe that the doctor is their advocate and will act in their interest. But often there is not even a potential benefit to the patients, and sometimes there is considerable risk. They frequently have their normal drug treatment changed, and the treatment is often withdrawn at the end of the trial even if benefit was evident. That they do consent is testimony to the strength of the relationship and trust they have in the doctor and their desire to enhance this relationship. In these circumstances the ethics of informed consent are clearly compromised.

If it is unethical to offer patients financial incentives to participate in trials then the same should apply to doctors. I would suggest that the doctor's remuneration must be part of the information required for consent to be valid. Local ethics committees should consider whether excessive financial incentives invalidate the informed consent process when they consider study applications.

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1 Dyer C. Consultant struck off over research fraud. *BMJ* 1997;315:205. (26 July.)

Humanitarian issues

Young people affected by HIV must be supported year in, year out

EDITOR—The increase in cases of HIV infection worldwide is reported to have included 600 000 new cases in children in 1997¹; the theme of the most recent World AIDS Day was children. The danger with this theme, and the day, is that we may isolate both—as if HIV matters on only one day a year and children with HIV infection are separate from the rest of the population.

The truth is that HIV infection is with us all year round, across the world. The UN report shows that, worldwide, over 30 million people have HIV infection. Most do not have access to clean water, adequate housing, or the basic health care that might be taken for granted in developed countries. Children live in households where whole generations are being wiped out by starvation and war. People fleeing from such situations may find themselves ostracised and penniless on the streets of richer countries such as our own, seeking asylum while benefits are removed.

In Britain, children and young people living in households in which somebody is infected with HIV are not immune to all the other pressures. Such households may, for example, experience poverty, unemployment, injecting drug use, and poor housing and are then subject to the pressures on community care budgets and unequal access to new treatments for HIV infection. We have to overcome the inequalities in the provision of health and social care, in Britain and worldwide, if people with HIV infection are to receive equal care to that received by everyone else.

At the same time, the messages given to children and young people by politicians and the press need to encourage equality and a positive outlook on life. In Britain we need to see positive moves: the introduction of an equal age of consent at age 16, repeal of section 28 of the Local Government Act (which forbids the portrayal of homosexuality as "normal"), and withdrawal of the proposal to make the transmission of HIV a criminal offence (which would discourage young people from coming forward for HIV testing, advice, or treatment).

If we want to support children and young people affected by HIV we have to make sure that we don't make them a separate issue, special just for one day. We must end the discrimination associated with HIV; a good start would be to remove the barriers, such as those related to gay sexuality and represented by the cuts in benefit brought in by the Asylum and Immigration Act 1996.

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1 UNAIDS/World Health Organisation. *Report on the global HIV/AIDS epidemic*. Geneva: UNAIDS, 1997.

WMA wants medicines and foods to be excluded from economic sanctions

EDITOR—Delamothe rightly points out that economic embargoes, some of which are based on United Nations policies, are having a devastating effect on the health of many people in affected countries.¹ Children are particularly vulnerable to the shortage of medical supplies—including vaccines—and food. Starvation is life threatening; long term food deprivation affects physical development, including that of the brain. The young people in Iraq, Cuba, and other countries clearly show the devastation that sanctions can cause. It was for this reason that the World Medical Association, at its assembly last November, passed the following resolution, which had been prepared by the BMA:

"Recognising that all people have the right to preservation of health and that the Geneva convention (article 23, number IV, 1949) requires the free passage of medical supplies intended for civilians, the World Medical Association urges national medical associations to ensure that governments employing economic sanctions against other states respect the agreed exemptions for medicines, medical supplies, and basic food items."

The BMA has already written to the secretaries of state for international development and for foreign affairs over this matter. We shall be asking colleagues from other national medical associations what responses they have had from their governments.

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1 Delamothe T. Embargoes that endanger health. *BMJ* 1997;315:1393-4. (29 November.)

Paediatrician needed in Kabul

EDITOR—Following Vivienne Nathanson's editorial calling for doctors to become more involved in humanitarian issues,¹ we write in the hope of finding a paediatrician to address a tragic consequence of war on children.

Extreme poverty induced by 18 years of conflict in Afghanistan has led some families to place children in the state orphanage in Kabul. This institution contains 396 boys and 52 girls aged 3-15 years; 78% of the children have at least one living parent, 14% have close relatives, and 8% are without a family. They exist in a partially destroyed building with one outside hand pump for water and no sewerage system; faeces litter the floors. The children wear little more than rags and few have shoes (usually the plastic kind worn by our children when on the beach). Hygiene is poor, with five children sharing one towel. Serious and recurrent infection is common and results in children being admitted to the Indira Ghandi Children's Hospital, where similar conditions prevail. There is no heating and during the winter the temperature inside the building reaches -20°C. Access of girls to the open air is restricted to the roof (which has a 1 m ledge around it and is their open toilet). Eighteen girls have recently "fallen" 20 m to the ground below. In bedrooms 6 m by 7 m there are 23 beds.

Maliha, aged 13, has written: "When I was eight my father was on his way to work when a rocket hit him and he died. We cried a lot, but no hope. Three years after his death my mother was also martyred by a rocket. We were with our uncle; he is a very kind man. He is taking care of us much. After one year of the death of our mother he put all four of us (two brothers, one sister, and me) in the orphanage. We suffer a lot, but what to do. Our uncle is coming on the weekend and taking us home for two days."

The Department for International Development² has provided funds to Children in Crisis and Child Advocacy International to return as many as possible of these children to their families or to foster homes. A paediatrician is needed (see paediatrics section, classified supplement) to examine the children, treat illnesses, monitor growth and development, and educate local nurses and social workers to sustain the programme.

This is an opportunity not only to address an issue of human rights but also, if it succeeds, to highlight a way of helping the many thousands of other children within similar institutions around the world.

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1 Nathanson V. Humanitarian action: the duty of all doctors. *BMJ* 1997;315:1389-90. (29 November.)

2 Secretary of State for International Development. *Eliminating world poverty. A challenge for the 21st century*. London: Stationery Office, 1997.