

CORRESPONDENCE

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Important step for global security

Sir—In your May 17 Editorial (p 1665),¹ you list the ten steps that Sadako Ogata and Amartya Sen suggest could be taken to make our world more secure. All are laudable although some, such as providing universal basic education, could be difficult to achieve in the short term. Oddly, one point that is wanted, achievable, and would add greatly to global security is omitted: the need to meet the increasing demand for access to modern family planning.

There is a large unmet need for family planning in almost every developing country. Rapid population growth undermines economic progress² and exacerbates unemployment; 60 million young people aged 15–24 years are looking for work in developing countries. Furthermore, it increases competition for resources. In 1950, for example, the population of the Gaza Strip was 240 000, whereas today it is well over 1 million and, unless women are offered family planning choices, by 2050 it will be between 4 million and 5.7 million.

A high ratio of young men, especially if unemployed, creates an unstable society, and a correlation exists between communal violence and warfare and the ratio of young men to older men and to women in the population.³ Factors that bias the sex ratio in favour of males tend to increase conflict, and factors that create a surplus of women tend to be correlated with the liberation of women and social change.⁴

Women cannot be free, or have an equal role in society, unless they can choose when to have children. When women are offered family planning choices family size always falls.⁵ In Iran, which is a country ruled by religion, family size fell from five in 1990 to replacement level today—a more rapid fall than in China and without a one-child policy, but because women (and men) were given choices they had not previously enjoyed.

The Bush administration has withdrawn US\$34 million from the United Nations Population Fund—a policy that will undermine the war on terrorism. Family planning cannot guarantee a more peaceful world, but

without it, the search for security could prove futile.

**Martha M Campbell, Malcolm Potts*

*Center for Entrepreneurship in International Health and Development (MMC) and School of Public Health (MP), University of California, Berkeley, CA 94720, USA
(e-mail: mcbell@uclink.berkeley.edu)

- 1 Editorial. A new vision for human security. *Lancet* 2003; **361**: 1665.
- 2 Birdsall N, Kelley AC, Sinding SW. Population matters: demographic change, economic growth, and poverty in the developing world. Oxford: Oxford University Press, 2001.
- 3 Mesquite CG, Weiner NI. Male age composition and severity of conflicts. *Politics Life Sciences* 1996; **18**: 181–89.
- 4 Hudson VM, Boer AD. A surplus of men: a deficit of peace: Security and sex ratios in Asia's largest states. *Int Secur* 2000; **26**: 5–38.
- 5 Potts M. Sex and the birth rate: human biology, demographic change and access to fertility-regulation methods. *Popul Dev Rev* 1997; **23**: 1–39.

SARS infection control

Sir—The Research letter by W H Seto and colleagues (May 3, p 1519)¹ about infection control for severe acute respiratory syndrome (SARS) begs a few questions.

First, were any of the individuals with a cough among the 11 index patients? Cough was a symptom in eight of ten patients reported by Tsang and colleagues² and was a clinical feature in only 57% of the 156 patients reported by Lee and co-workers.³ Readers cannot and should not assume in a study with few patients that the sample is representative of the population. Patients who do not cough obviously do not generate aerosol. A small non-representative sample of patients with SARS who happen not to have a cough would give a false impression that wearing surgical masks alone offers adequate protection against aerosol when no aerosol exists. Whereas coughing produces large droplets that settle rapidly in the absence of air currents, it also generates particles less than 1 µm in diameter,⁴ suggesting that surgical masks are not an absolute means of protection against respiratory pathogens.

Second, were any of the 11 index patients intubated or admitted to the intensive care unit (ICU)? If none of the 11 patients were admitted to the ICU, then this group might not be representative of all patients with SARS, of whom up to 23% were admitted to an ICU in one report.³

Finally, none of the affected staff seem to be ICU staff, possibly because none of the index patients was admitted to the ICU. However, many of the health-care workers infected elsewhere have been ICU staff, suggesting that again the sample studied by Seto and colleagues is not representative. We would like a more thorough breakdown of the roles of the 241 non-infected staff.

The results of studies that involve limited numbers of participants should always be viewed as preliminary.

Tommy R Tong

Department of Pathology, Princess Margaret Hospital, Kowloon, Hong Kong, People's Republic of China
(e-mail: tommy.tong@graduate.hku.hk)

- 1 Seto WH, Tsang D, Yung RWH, et al. Effectiveness of precautions against droplets and contact in prevention of nosocomial transmission of severe acute respiratory syndrome (SARS). *Lancet* 2003; **361**: 1519–20.
- 2 Tsang KW, Ho PL, Ooi GC, et al. A cluster of cases of severe acute respiratory syndrome in Hong Kong. *N Engl J Med* 2003; **348**: 1977–85.
- 3 Lee N, Hui D, Wu A, et al. A major outbreak of severe acute respiratory syndrome in Hong Kong. *N Engl J Med* 2003; **348**: 1986–94.
- 4 Papineni RS, Rosenthal FS. The size distribution of droplets in the exhaled breath of healthy human subjects. *J Aerosol Med* 1997; **10**: 105–16.

Authors' reply

Sir—Tommy Tong has raised questions that can be addressed by the data we have collected.

We can confirm that nine of the 11 index cases of SARS were coughers, according to information obtained from the patients' medical records or from direct communication with the attending doctors. One of the index patients was transported from Hanoi, Vietnam, and was already intubated on admission, hence coughing was not observed. The other cases were