

LETTERS

Starvation of children in Syria – sanctions and the politics of revenge

As Syria completes two years of western sanctions (2011–13), their dramatic effects on health are being highlighted with first reports of starvation deaths among children in the suburbs of Damascus (1). Although heavy fighting has taken place in this area, experts had predicted for some time the unworkability of sanctions for regime change (2,3), arguing that only civilians would pay the price in a country (Syria in this case) which was once well on the way to meeting the Millennium Development Goals 4 targets on reducing child mortality (4). In this, as in the case of other “sanctioned” countries, it is not just “civilians” but the most vulnerable among them – children, who are experiencing the tragic consequences of sanctions.

Several infants have died of hunger in the suburbs of Damascus and also in Yarmouk and other pockets of the country at the epicentre of conflict.

Several children had died by mid-October (2013) and one doctor was quoted as saying to *Der Spiegel* (5) that dozens of infants are so weak that a mild infection will kill them. While the west remains obsessed with its own security and the need for Syria to destroy its chemical weapons so that they do not fall into the hands of the *jihadists*, International humanitarian law would be better served if they (the Western governments, notably the USA, UK and France) made some real effort to protect civilians by putting pressure on the Syrian government and on western-funded militias, not to continue to use civilians as a shield or a tool for vengeance.

Kasturi Sen, Wolfson College, University of Oxford, Oxford, OX2 6EU, UK, email: kas_sen2002@yahoo.com

References

1. Cihan. Starvation kills children in Damascus. *World Bulletin.net*. 2013 Sep 30 [cited 2013 Dec 11]. Available from: <http://www.worldbulletin.net/?aType=haber&ArticleID=119406>
2. Pape RA. Why economic sanctions do not work. *International Security* [Internet]. 1997 autumn; 22(2): 90–136. Available from: http://www.stanford.edu/class/ips216/Readings/pape_97%20%28jstor%29.pdf
3. Robbins CA. Why economic sanctions rarely work. *Bloomberg Businessweek* [Internet]. 2013 May 23 [cited 2013 Dec 11]. Available from: <http://www.businessweek.com/articles/2013-05-23/why-economic-sanctions-rarely-work>
4. Sen K, Al-Faisal W, AlSaleh Y. Syria: effects of conflict and sanctions on public health. *J Public Health (Oxf)*. 2013 Jun; 35(2):195–9. doi: 10.1093/pubmed/fds090
5. Reuter C. Cut off: starving Syrians hope to live through winter. *Spiegel Online International* [Internet]. 2013 Oct 31 [cited 2013 Dec 12]. Available from: <http://www.spiegel.de/international/world/starvation-threatens-isolated-towns-in-wartorn-syria-a-930757.html>

Practical issues in implementation of WMA’s draft Declaration of Helsinki

The working group of the World Medical Association (WMA) has published a revised draft of the Declaration of Helsinki for public consultation till June 15, 2013 (1). There are many positive changes in the document with respect to compensation, education of investigators, informed consent in the case of stored samples, etc. The changes represent a step forward for ethics. However, there may be certain points of concern regarding the implementation of the Declaration.

Point 20 of the document (1) states that medical research involving a disadvantaged or vulnerable population or community is justified only if it is responsive to the health needs and priorities of this population or community and *the research cannot be carried out among a non-vulnerable population*. Will this additional clause be harmful to vulnerable populations? Researchers may use it to conduct research among vulnerable people. This was prohibited earlier, the provision being that to begin with, many new markers had to be tried among the general population before conducting the study, depending on its merit, among a vulnerable population. With the addition of this clause, the same new markers can be tried simultaneously on the general and vulnerable populations. The same can be applied to drug trials. Point 20 also states that *consideration should be given to ensuring that the community receives a fair level of additional benefits*. How is it possible to measure this? Also, what is the meaning of “fair level”?

A component of point 22 states that the protocol must describe the arrangements for post-study access by the study subjects to interventions identified as beneficial in the study. Though this is very important ethically, there is a need to consider how far it is practicable. After a clinical trial has concluded, it takes from a few days to a few months to assess and reach conclusions about the beneficial effects, and it may take some time to obtain the Drugs Controller General’s approval for marketing the drug. Is it possible for a company/ institutional ethics committee (IEC)/investigator/study participant to give consent for a drug, for which the analysis of the efficacy is being worked out? The participants thus have to revert to the drugs or measures they were taking earlier till the Drug Controller General grants approval. The word “arrangement” may refer to subsidised drugs or free drugs. Would this assurance of free drugs act as an inducement to participate in trials, especially those involving cancer and end-stage disease? A component of point 32, on the subject of informed consent, states that an IEC should decide on the impracticability of obtaining informed consent in the case of stored samples. As all IECs are independent, there will be various opinions on the matter.