outcomes may be observed to change over time in the absence of any intervention.[9] Observed changes therefore may not be due to the intervention itself but to an independent secular trend. Additionally, the effects of other ongoing local, regional, or national initiatives may confound the results of evaluations. Without a matched community control, attributing any independent effect of the intervention itself is difficult. Study designs with community comparisons must adequately control for potential confounding factors.

Overall, retail interventions may have either a small but important effect or no effect on diet and health. Although these studies had similar aims and results, uncertainty over the efficacy of retail led interventions stems from problems of interpretation owing to differences in study design. However, the implications for the future development of dietary interventions are similar. Changes in fruit and vegetable consumption, although small, are consistent with other evidence. Two recent reviews of dietary interventions for cancer risk found an average increase of 0.6 portions of fruit and vegetables per day,[10 11] and relatively small increases in fruit and vegetable consumption may have encouraging prospects for the prevention of disease.[12] The potential negative impacts of large scale retail interventions need to be understood and accounted for—improved retail provision may also increase the availability of foods associated with poor diet. Activities such as advertising and price promotion that surround store opening may be important mediators of impact and effect. If new retail provision is to have an impact on diet and health, we need a multidimensional approach that also tackles food awareness, affordability, and acceptability in addition to retail change.

Changing access through improving retail provision alone may not have a substantial impact on diet and health. Changing knowledge without ensuring access seems problematic intuitively. An approach that changes knowledge and access simultaneously may have a better chance of securing improvements in diet and health and a reduction in health inequalities.

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A theme issue "by, for, and about" Africa

Call for papers

2005, it seems, is the year of Africa.[1 2] As world leaders gathered in Davos to discuss debt relief and pop stars re-released their poverty anthem, the world's attention is drawn to magnificent Africa—a continent of vast cultural and regional diversity and potential but plagued by extreme poverty and disease.

The Roll Back Malaria campaign reports that of the 300 million acute cases of malaria each year around the world (which result in 1 million deaths), over 90% occur in Africa. These mostly affect children under the age of 5.[3] A new UN report estimates that more than 80 million Africans will die of AIDS by 2025, and another 90 million—more than one in 10 people on the continent—will become infected.[4] Tuberculosis, maternal mortality, domestic violence, and undernutrition pose further health challenges.

Undoubtedly, these are problems of poverty. Despite substantial growth in the global economy over the past half century, most of Africa remains poor, with living conditions not conducive to good health and without access to cheap and effective medicines. Seventy five million more Africans are in poverty than a decade ago, and the depth of that poverty is brutal and widespread. Thirty four of the world's 49 least developed countries are in Africa. Nearly half the region's population lives on $1 a day or less. Women are disproportionately affected.[5]

Africa's health challenges and solutions are complex, deeply rooted in political, socioeconomic, and cultural issues. Unfortunately, this complexity is rarely reflected in the current discourse on health. Instead, Africa is often inadequately portrayed in the broader world as a "basket case": run by corrupt leaders, vulnerable to terrorist extremes, lacking infrastructure, unable to look after itself. Recently, efforts to help countries in the region to achieve the millennium

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development goals have taken centre stage, propelled by Tony Blair's call to arms that Africa "remains a scar on the conscience of the world."[6 7]

But the millennium development goals have their problems. The gains of the specific goals for health will not necessarily flow to the poor and in fact may exacerbate inequalities between the rich and poor.[8] Few countries are anywhere near honouring their financial commitment to the goals—a paltry 0.7% of their national income. Moreover, conservatism, including America's reluctance to support the importance of women's sexual and reproductive rights—a long acknowledged essential component of development—will threaten advances. And some Africans have already rejected Blair's international commission for Africa as a public relations gimmick.

Still, new and innovative leadership within Africa and among countries around the world is emerging, and there's perhaps no better time than now to harness and inspire global responsibility, accountability, and strategy for change in Africa.

The *BMJ* plans a theme issue for September 2005 "by, for, and about" Africa, to deal exclusively with the region's problems and, more importantly, offer solutions. Following the model of our South Asian issue last year,[9] we will discuss a wide range of health challenges such as HIV/AIDS, tuberculosis, malaria, violence against women, and maternal and child health, as well as emerging challenges such as cardiovascular disease and diabetes. We will consider the political economy of health, including progress toward achieving the millennium development goals; health systems issues such as human resources development and retention; and the contributions made by traditional health systems and approaches.

We hope the theme issue will be a diverse mix of papers, debate pieces, editorials, and reviews (these might include art, literature, and popular media). We are particularly interested in original research conducted in Africa. The deadline for submissions of original research is 30 April 2005.

Our aim is to bring together health professionals in the region to discuss issues that are common to all. But we want to encourage submissions that tackle the historical, political, social, economic, and cultural dimensions of health. We need stories of Africa's problems, but also of its potential: "Stories are important because we read a lot about how Africa is dying and despairing but not about how Africa is living and developing."[10]

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New standards for cardiopulmonary resuscitation

Represent a milestone in resuscitation practice and training

A joint statement, Cardiopulmonary Resuscitation—Standards for Clinical Practice and Training, has been issued by the Royal College of Anaesthetists, Royal College of Physicians of London, the Intensive Care Society, and the Resuscitation Council (UK).[1] This was endorsed by a further nine healthcare organisations including the National Patient Safety Agency and defines minimum standards for the delivery of resuscitation related services in healthcare institutions. Perhaps the only major omissions from this list are the Royal College of General Practitioners and the Royal College of Obstetricians. This is surprising given that most cardiac arrests occur out of hospital and that cardiac arrest of mothers has a potentially catastrophic outcome. However, the endorsement of these guidelines by so many national professional organisations is a milestone, and their implementation marks an advance in resuscitation practice and patient safety.

Since the first major report from the United Kingdom on resuscitation was introduced in 1987, considerable changes have taken place in the science and practice of resuscitation.[2] These include founding of the United Kingdom and European resuscitation councils, development of evidence based clinical guidelines, the introduction of resuscitation related courses, and the establishment of resuscitation officers as an independent discipline. The new statement integrates these advances to produce patient focused guidance for those responsible for planning and delivering resuscitation services. Although the document focuses primarily on resuscitation in hospitals admitting acutely ill patients, its recommendations are relevant to other healthcare institutions that may be involved with resuscitation such as general practice surgeries, minor injury units, maternity hospitals, ambulance trusts, mental health units, and the military.

The main recommendations of the document form the basis for integrated resuscitation related practice (box). A local resuscitation committee should be responsible for the delivery of an effective audited response to a cardiac arrest. The committee should

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