reviews

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Promoting Community Health: From Pholela to Jerusalem

Sydney Kark,
Emily Kark
Witwatersrand University
Press (available from Africa
Book Centre)
info@africabookcentre.com),
£14.95, pp 254
ISBN 1 86814 316 3

Rating: ★★★

Primary care groups and trusts have recently been set up in Britain to make health services more responsive to the needs of defined local communities. The Commission for Health Improvement challenges them and each primary care team to improve health as well as to deliver responsive care. Are there readily available models from which we might learn?

In South Africa in 1940 Sydney and Emily Kark, fresh out of medical school and

newly married, set up an experimental primary care service unit in a local community in the Drakensberg mountains of Natal (Kwazulu) in South Africa. The unit was backed by South Africa's secretary for health and chief medical officer, Eustace Cluver. It provided individual clinical and preventive care, combined with health promotion, to a defined community.

It also introduced community health activities and education for self help. The primary care team of doctor, nurse, and health educator included health workers recruited from the community, familiar with local beliefs and ways of living. This was the model for 400 proposed community health centres to be set up across South Africa, of which 40 were actually founded before the ideology of apartheid blocked further development. After leading this work for 20 years, along with the education of the professionals needed for it, the Karks (and many others involved in this enterprise) were forced to leave the country.

Promoting Community Health is the history of this prescient development, now known as community oriented health care.

Continued in a very different setting in Israel, this model offers one prototype by which the gap between care for individuals and care for the population has actually been bridged. Are there transferable lessons here, now that current policies pose a similar challenge for primary care trusts responsible for populations and their services in an English inner city? How, for instance, can we change mindsets towards concern for locality as well as for individuals, families, and practice populations? Is it not relevant to our multicultural cities to study ethnographic, sociological, and psychological as well as epidemiological dimensions?

These are all principles of community oriented health care. This book tells how they have been implemented in one country and pays generous tribute to those who have worked with the authors and helped to disseminate their ideas. It is also the story of a remarkable couple who have been influential in shaping international thinking about primary care in the community.

John Horder *president, UK Centre for the Advancement of Interprofessional Education, London*

Principles of Health Economics for Developing Countries

William Jack

World Bank Institute
Development Studies, £20,
pp 305
ISBN 0821345710

Rating: ★★

Health and economics have always been uneasy bedfellows, and both are currently in crisis. Britain's NHS, for example, is a poisoned chalice for politicians, whatever their affiliation. A recent article in the *Economist* suggested that economics as a discipline lacks pragmatism, with its obsessional search for general laws

and overreliance on human rationality and mathematics.

William Jack's book adopts the orthodox economics approach, and is not for the uninitiated. Jack is clearly most comfortable with theoretical arguments, such as those supporting public intervention in health markets and the introduction of user charges in public facilities. There is no mention of the abject failure of exemption mechanisms in most low income countries or that in certain circumstances equity has improved in rural areas after the introduction of user charges.

Jack's book is, however, a comprehensive and lucid account of existing economic theory as applied to the health sector. Sections on health outcomes and economic linkages; demand, supply, and insurance; and normative analysis for health policy cover the important theoretical issues that a health economist should master. Clear explanations of complex issues are mixed with detailed, calculus based explanations of issues such as moral hazard in insurance markets. The lack of examples from the real world and case studies, however, makes the book less accessible to non-economists, one of the groups that the book is aimed at.

Considerable space is given to the estimation of demand curves, a construct that some have suggested should be abolished, while other important issues are barely touched on—such as financial sustainability and policy trade-offs, like those of equity and quality in poor rural areas. Where they exist, considerations of developing countries are cleverly woven into the theory. For example, Jack discusses how high travel costs in rural areas deter use of services even when they are free at the point of delivery, how time costs are often highest for the rural poor, and how problems of corruption and moonlighting complicate supply theory. Each example provides a useful context for the economics, making the text original. It is not an easy job adapting economic principles to developing countries, and perhaps the book should be retitled.

If you have knowledge of economics and are interested in health in developing countries, then the book is a valuable read. If, however, you are more interested in using economics to assist you in the daily challenges of allocating limited budgets in developing countries, look elsewhere.

Matthew Jowett *research fellow, Centre for Health Economics, University of York*

Ratings are on a 4 star scale, 4=excellent

Safe Motherhood Initiatives: Critical Issues

Eds Marge Berer, T K Sundari Ravindran
Reproductive Health Matters,
£24, pp 244
ISBN 0 9531210 11

Rating: ★★★

Differences in maternal mortality constitute the greatest inequality in health between developed and developing countries. About 600 000 women in developing countries die each year from causes related to pregnancy and childbirth, of whom one in six die from an unsafe abortion. Whereas maternal deaths have become rare events in the developed world, pregnancy continues to be unnecessarily hazardous for most poor women in the South, even in countries that have achieved substantial health gains in other areas. The combination of high maternal mortality and high fertility means that one in 12 women in west Africa dies of maternal causes, compared with one in 4000 in northern Europe. Despite the initiatives of international and donor agen-

cies, averting maternal deaths in developing countries remains an elusive goal.

As one of the contributors to *Safe Motherhood Initiatives* asks, why, at the end of the 20th century, should it make sense to devote a book to maternal mortality when it has become a forgotten chapter in the medical history of the Western world? This collection of articles, by professionals from medical and social science disciplines involved in the "safe motherhood" advocacy, provides an overview of the problem, an analysis of the causes, and guidance on ways forward. The book takes a public health and social justice perspective. Case studies from various countries illustrate the approaches tried across the developing world and the lessons learned.

Countries as diverse as Bangladesh, Indonesia, and Kenya show remarkable similarities in the medical and social factors contributing to maternal deaths, such as poverty, distance from health facilities, weak referral systems, and delays in care. Underlying these is the low status of women in these countries, who lack education, resources, autonomy, decision making power, and control over their own fertility.

Although the major causes of maternal death—haemorrhage, sepsis, and eclampsia—are not dissimilar between rich and poor countries, the scale of their impact is very different. The vast majority of complications and deaths occur during or shortly after delivery, or from unsafe abortions, but most

cannot be predicted. Therefore, survival depends on prompt access to emergency obstetric care—the reason for the fall in maternal mortality in England from 441 per 100 000 in the mid-1930s to 40 by 1960.

The difference that access to good maternal care can make is illustrated graphically by the example of South Africa, where maternal mortality in white women is 3-8 per 100 000 births compared with 150-250 in black women. In many developing countries, however, initiatives for improving maternal health have focused largely on antenatal care rather than on obstetric and postpartum care. Consequently, even substantial investments in health infrastructure and the abolition of user charges have had little impact on maternal mortality.

As several contributors to the book note, strategies for reducing maternal mortality are undergoing a paradigm shift as a consensus emerges that the key ingredients are family planning and abortion services and quality emergency obstetric care to deal with complications. However, while anaemia, malaria, tuberculosis, and HIV infection add to the maternal health burden of poor, undernourished women, antenatal care will continue to play an important role.

Veena S Raleigh senior lecturer in epidemiology and public health, Postgraduate Medical School, University of Surrey, Guildford

Nothing About Us Without Us: Developing Innovative Technologies for, by and with Disabled Persons

David Werner

Health Wrights, pp 360
ISBN 0 9655585 3 3

Rating: ★★★★★

A recurrent theme from disabled people over the past 20 years is "nothing about us without us." This aptly titled book gives many practical reasons for including disabled people in technological and rehabilitation programmes. Written by the author of *Disabled Village Children* and *Where There Is No Doctor*, this book is a clear development of his previous work. The focus of this book is on developing appropriate and innovative technologies in developing countries. Yet the approach has applicability to all situations,

given the focus on putting the person and the resultant process before the technological product.

This innovative book is meant to be an "ideas book" about problem solving rather than a "cook book" with precise instructions and measurements. It is about thinking problems through and finding appropriate solutions for people with a variety of disabilities.

The technological solutions and case studies explored in the book arise from PROJIMO (The Program of Rehabilitation Organised by Disabled Youth of Western Mexico). The approach taken by this world renowned project, which started in 1981, is compelling. Werner's book clearly documents in words, pictures, and case studies the ways in which community empowerment can emerge from such a cooperative approach.

David Werner says of this book, and of his project, that "our objective is not to catalogue a set of aids and equipment to be copied, but to share an empowering problem-solving approach." Not only has he done this well, but he has shown how this approach may be taken and applied to a variety of circumstances. Perhaps most inspiring of all, *Nothing About Us Without Us* moves us from doing rehabilitation to disabled people to involving them in culturally appropriate rehabilitation. Many of the

rehabilitation workers and technicians responsible for the innovations in this book actually have a disability themselves.

Most importantly, the community development, partnership, and person focused approach adopted to rehabilitation taken by Werner is not just appropriate to so called developing countries, where Western technological aids may either be inappropriate or unavailable. The book's theme has important lessons for all rehabilitation programmes, especially in fostering partnerships and community development.

The book is an excellent and well illustrated resource which moves well beyond ideology to showing concrete and practical reasons for involving disabled people and living out its title.

Christopher Newell senior lecturer, School of Medicine, University of Tasmania

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Innocents

Director Peter Kosminsky, written by Neil McKay
Channel 4, Sunday 1 October, 9 pm

The events that took place in the operating theatres and intensive care units of Bristol Royal Infirmary between 1984 and 1995 are likely to have far reaching implications for medical practice in Britain for the foreseeable future. The "Bristol heart babies," as they have become known, are the innocents referred to in the title of this "factual drama," screened this weekend as part of a short season called *Doctors on Trial*.

The subject is the fate of those babies affected by congenital heart abnormalities who were operated on by two cardiac surgeons working in Bristol at that time. The Channel 4 drama is based on interviews with the parents of these babies and contains extracts from an eight month inquiry held by the General Medical Council, from 1997 through 1998. The GMC ruled that one surgeon be erased from the medical register and the other prevented from operating on children. The medical chief executive of the hospital trust was also struck from the register.

At the time of writing, a public inquiry is ongoing, and its findings are imminent. But

an expert review of a randomised sample of case notes "deliberately weighted towards younger children who had open heart surgery, and towards children who died" has already been published. Its conclusions are on the Bristol Royal Infirmary Inquiry website (www.bristol-inquiry.org.uk), and they implicate not only the surgical procedure but also preoperative and postoperative care, service organisation, and communication between professionals.

Innocents focuses on a few of the people at the heart of what became a tragedy. It shows parents discovering that something awful is wrong with their children. It also describes their oscillation between extremes of despair and apparent salvation, and the fragile peace of mind that reassurance brings—especially reassurance by a doctor. There is a hard school of psychodynamic thought that questions whether "reassurance" is ever justified. It may be well meant, but it is ultimately a form of infantilisation, since there is always uncertainty in life. All doctors might ponder the scenes of reassurance in this programme.

There are familiar faces here. The characters are played by actors recognisable from many previous television series, and this is important to keep in mind when watching the programme because this is not a documentary—it is drama. We are witnessing a compelling, but necessarily incomplete, account of what went on.

The production is clean and elegant. Preoperatively, the babies do not look ill, the surgeons do not look tired, and the wards are neither too busy nor too untidy. There is little music, and what there is sounds remarkably like that of *Silent Witness*, a Brit-

"The grieving parent and the guilty heart surgeon"

ish television drama about a pathologist. Whether intended or not, this musical reference acquires significance.

The narrative is carefully paced, and the denouement, a feeding frenzy of media intrusion, feels almost visceral. The viewer has been so immersed in the feelings of a few characters that the sudden presence of many more comes as something of a jolt.

Although *Innocents* gives viewers a sense of what the parents experienced in the course of this protracted torment, it doesn't give us any understanding of the doctors' experience—there is little information about the surgeons involved or the anaesthetist who blew the whistle. But most of what I saw seemed familiar enough to have been feasible, with one exception. In one scene a mother petitions a hospital manager to see her dead child's "retained heart," which has been kept by the hospital. She is told by a condescending manager, "Here it is," as he unveils a heart in a kidney dish that has been sitting on the desk between them all along. I can't believe that this actually happened as portrayed, but if it did then we are all diminished by this episode.

The dilemmas facing the doctors in this dramatic reconstruction are not unique. How does a "good" doctor remain "good"? What does a "good" doctor do if the service is not "good enough"? How long is it reasonable to wait for the good enough service to evolve? An individual is relatively unlikely to change a service on his or her own, yet an individual who does not try is necessarily complicit. And individuals who leave the service have merely averted their gaze; they have not changed anything. Individuals who will not talk to other individuals have little hope of change—and hope of change is the little to be salvaged from the death of innocents.

Sean A Spence senior lecturer in psychiatry,
University of Sheffield

WEBSITE OF THE WEEK

Health care in developing countries The International Network for the Availability of Scientific Publications (INASP) wants there to be "universal access to reliable information for health care workers in developing and transitional countries." Its website (www.inasp.org.uk) helps to make this goal realistic, providing useful links to information resources, mainly in Africa and Latin America, including local library links. The Links and Resources section is constantly being updated, the sign of a thriving site, and INASP is open to suggestions for further links.

The Wellcome Trust is a registered charity, and, although it still has a 4.7% stake in the pharmaceutical giant GlaxoWellcome, it claims that the two organisations are entirely independent. The trust supports global research in biomedicine and population studies and also offers research development awards and funding initiatives. These are explained in detail at www.wellcome.ac.uk/international.

Visiting the mighty World Health Organization site (www.who.int/) requires a little advance planning. It is comprehensive and has a myriad of possible tangents, so a quick browse can easily become a few hours of surfing. There is a search option, but it is often "not connected to server," a real disappointment. The site is a good starting point for thinking about research in tropical regions—it has up to date reports, surveillance data, and useful information on tropical diseases. In contrast, the Malaria Network (www.malariainetwork.org), a joint WHO and World Bank project, gives worryingly outdated advice (see News article).

Non-governmental organisations often produce the most insightful reports, and www.netaid.org gives an A to Z of all the organisations you can possibly think of, with links to their sites. But, beware, you could end up linking to a video of Bono, lead singer of the rock group U2, opining on Third World debt.

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PERSONAL VIEW

My part in the “brain drain”

I am a Colombian family doctor and a clinical epidemiologist. Four months ago I left my country and migrated to the United Kingdom. This is my experience of what it is like to be part of the so called “brain drain” of doctors from developing countries to rich countries in the north.

As a researcher in Colombia I was based in a private university and supported by one of the international clinical epidemiology network's units. My work was well valued and as a group we were able to sort out many of the difficulties that researchers have to solve, such as finding funding while the American government imposed sanctions as part of its drug fighting policies. We were able to get grants and produced good quality research. We were encouraged to develop evidence based medicine, research, and clinical epidemiology training in the medical school. My memories of those six years are happy ones. Until last year I never thought of leaving Colombia, because I felt that trained people should remain in our country to help solve its complex problems.

But things changed for me. While we were expecting our first child, violence was

We are sure we made the right decision every time we look at the news

bursting out in the country between different guerrilla factions and paramilitary groups. Civilians were being caught up in this violence and the peace process initiated two years ago was not taken seriously by the guerrilla groups. Over the past decade justice and peace turned into an illusion for many ordinary people. Corruption was everywhere and affected daily activities to a great extent. Extortion and kidnappings became common. There was a feeling that living was much harder for those who obeyed the law and that impunity favoured criminals. Most of our uncorrupt political leaders were murdered and for many Colombians the word politician is now a synonym for corruption and abuse.

We were not happy at the prospect of bringing up our baby in such an environment. The final factor that determined us leaving was the incapacity of the university, probably because of the economic crisis, to keep me on a full time basis in research. Although I had been successful in getting involved in trials and finding grants I was asked to do another job for which I was overqualified. Finally, I was being employed to do research but only on a half time basis, which was not enough to keep my family. So I had to find two other jobs and was working 13 hours a day.

The toll for leaving the country has been high. Our family is now splitting up as other relatives are migrating to other countries. Ten of my 24 cousins have emigrated and within my group of close friends, some of whom are also doctors, 25 have already left. Many are overqualified for the jobs they find abroad. All of us have left with a feeling of frustration and all have suffered directly or indirectly the consequences of violence. A friend was kidnapped, a relative was shot while being burgled, others were attacked in the streets. Four of my cousins, who remained in Colombia, all highly trained professionals, have now been unemployed for more than six months.

Although our exile is voluntary, it is painful. We miss so much about our warm and colourful country and culture, but we are sure we made the right decision every time we look at the news on the internet. We hope that things will change and that we will be able to return one day.

Luis Gabriel Cuervo Amore clinical editor,
Clinical Evidence, London

Students protesting against increasing violence

SOUNDINGS

What not to do

In 1968 Dr Richard Armour wrote an essay in *JAMA* in which he pretended to have found an old book, “being a study of certain curious categories of physicians.” There were four types. Firstly, the Ebullient, outgoing, exuding optimism and good cheer, backslapping, always encouraging and minimising his patients’ illnesses. Next, the Lugubrious, entering the sickroom with a pained look like an undertaker coming to remove a body, speaking in a low sepulchral tone and always guarded about the outlook. Then the Fussbudget, meticulous to the extreme, even checking his stethoscope before using it, ordering every possible test and keeping elaborate notes on every detail, his files overflowing, his waiting patients growing weak while he completes his first physical examination of the day. Finally, Dr Speedy, always looking at his watch, notes in shorthand, counting the pulse while looking at the tongue, never sitting down, always on the move.

During my medical school days I also had an old book. It was a real one, bought on an impulse, written in French by no doubt a distinguished member of the academy. I never read much of it, but after graduation I took it on a Pacific cruise and in an expansive mood after an all-night party threw it overboard. It rests at the bottom of the ocean somewhere between Suva and Noumea, where generations of Francophone fish have come to appreciate the interesting approach of starting each chapter with brief introductory vignettes on “what to do” and on “what not to do.”

In former days the warnings of “what not to do” were against such things as administering creosote to consumptives or arsenic for gonorrhea. Now they might be against giving intravenous calcium to patients being given digitalis, morphine to patients with asthma, pethidine to patients receiving dialysis, or amiloride to patients with renal insufficiency.

More on the domestic side, you might add a warning against not heating water in a microwave unless you put in the cup something non-metallic such as a wooden stir stick or a tea bag. Otherwise there could be a build-up of energy, such as happened recently to a young man who sustained severe facial burns and was blinded in one eye as hot water blew up in his face. The doctors at the hospital said that they had seen several such cases, and accordingly emphasised this important “what not to do” warning.

George Dunea attending physician,
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