Key messages

- The standard of health care in prisons in England and Wales varies widely—a few provide a quality of care close to that in the NHS, but many provide low quality care
- The commissioning of health care and the monitoring of services in prisons are inadequate
- More exacting standards for appointing doctors, a mandatory system for continuing professional development, and better support for healthcare staff are needed
- A better ethical framework is essential
- The NHS should be more involved in both the commissioning and the provision of health care in prisons

reviewed means that an opportunity now exists to resolve this longstanding problem.

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Household survey of locomotor disability caused by poliomyelitis and landmines in Afghanistan

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After 19 years of civil war and the total collapse of health services, disabled people are numerous in Afghanistan. Injuries caused by landmines are a major cause of disability,¹ but data on other causes of disability are lacking. We assessed locomotor disability, rehabilitation needs, and coverage of oral polio vaccine in Kandahar province, a heavily mined area in south west Afghanistan.²

Methods and results

A multistage random cluster sampling was performed in four districts of Kandahar province (population 428 390). A disabled person was defined as someone unable to walk normally without help or unable to move their hands or arms properly for a reason other than age. Poliomyelitis was defined as recommended by the World Health Organisation for lameness surveys.³ Coverage of oral polio vaccine was measured by standard WHO methods for children aged 12-59 months.⁴ Data were collected in June 1996 and analysed by EpiInfo 6 software; design effect was accounted for in the analysis.⁵

Overall 12 065 people were surveyed. The global prevalence of locomotor disability was 23 per 1000, but some populations at higher risk of disability were not included (nomads, soldiers, and the residents of a few mined villages). War related injuries were the leading cause of disability, but they affected men almost exclusively. Other causes of disability were medical problems and other traumas. More people had been disabled by poliomyelitis than by landmines (table). Among those <15 years old the leading cause of disability was poliomyelitis (4.8 per 1000). Of the 275 disabled people, 204 (74%) had a disability that required an orthopaedic device. Though the rehabilitation needs of people who had had a limb amputated were adequately covered, the rehabilitation needs of those with other disabilities were not.

Of the 327 children surveyed for vaccination coverage, 11 (3%; 95% confidence interval 1% to 6%) had received three doses of the vaccine according to their immunisation cards and 43 (13%; 7% to 20%) had according to their carer.

Numbers (percentages) of people with disabilities by age and sex, with prevalence of disability per 1000 population

Cause of disability	Children <15 years		Women ≥15 years		Men ≥15 years		Total	
	No (%)	Prevalence per 1000 (95% CI)	No (%)	Prevalence per 1000 (95% CI)	No (%)	Prevalence per 1000 (95% CI)	No (%)	Prevalence per 1000 (95% CI)
Related to war:								
Landmines	1 (1)	0.2 (0 to 0.5)	0	NA	27 (19)	9.5 (4.7 to 14.2)	28 (10)	2.3 (1.2 to 3.4)
Other*	2 (2)	0.3 (0 to 0.7)	3 (7)	1.0 (0.0 to 2.5)	42 (29)	14.7 (9.9 to 19.5)	47 (17)	3.9 (2.7 to 5.0)
Other trauma	21 (23)	3.3 (1.8 to 4.9)	15 (36)	5.1 (3.0 to 7.3)	35 (24)	12.3 (7.9 to 16.6)	71 (26)	5.9 (4.3 to 7.3)
Poliomyelitis	30 (33)†	4.8 (3.0 to 6.5)	2 (5)	0.7 (0.0 to 1.6)	6 (4)	2.1 (0.5 to 3.7)	38 (14)	3.1 (2.1 to 4.2)
Medical	16 (18)	2.5 (1.0 to 4.1)	19 (45)	6.5 (3.9 to 9.1)	25 (17)	8.8 (5.1 to 12.4)	60 (22)	5.0 (3.7 to 6.2)
Congenital	17 (19)	2.7 (1.2 to 4.2)	1 (2)	0.3 (0.0 to 1.0)	3 (2)	1.0 (0.0 to 2.2)	21 (8)	1.7 (0.7 to 2.8)
Unknown	3 (3)	NA	2 (5)	NA	5 (3)	NA	10 (4)	NA
Total	90 (100)	14 (11 to 18)	42 (100)	14 (11 to 18)	143 (100)	50 (43 to 57)	275 (100)	23 (20 to 26)

NA=not applicable. *Includes fighting and torture.

†3 children had received an injection of polio vaccine before the onset of paralysis and would not be included if WHO definition was strictly applied.

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Comment

The prevalence of disability was three times higher for men than for women and children, whose disabilities are rarely related to war. Women, who spend most of their time indoors, are at less risk from landmines. More people were disabled by poliomyelitis than by landmines, though the difference was not significant and the severity of the disabilities was not compared. Landmines are more likely to kill than to disable.¹ Among those <15 years old the prevalence of lameness compatible with poliomyelitis was in the expected range for a country with poor sanitary conditions and a poor immunisation programme.⁴ Vaccination coverage was low although one third of the population lived in an urban area, where access to immunisation would be above the national average.

We had believed that the largest group of people with disabilities would be those who had had a limb amputated and that they would make up the largest part of the workload for rehabilitation services. However, the need for artificial legs was smaller than the need for orthoses and orthopaedic shoes because people with a wider range of disabilities need them; also, the individual workload tends to be higher for these as more follow up is required (particularly for children). Services in Kandahar do not match the needs of the people. Rehabilitation services provided to disabled people who have not had a limb amputated

are largely insufficient and should be developed. The recent emphasis on injuries caused by landmines has probably resulted in more attention being given to rehabilitation services for people who have had a limb amputated than to those with other disabilities.

Poliomyelitis is one of the leading causes of disability in Afghanistan only 4 years before the target set by the WHO for its worldwide eradication; improving polio vaccine coverage should be a high priority. Community mine awareness programmes should not be the priority when considering the health needs of women.

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A memorable patient Medical care in the Raj

Summer of 1945. Father had just been promoted to the rank of risaldar (junior commissioned officer) in the cavalry. Almost simultaneously, he had also been found on a barium study to have a gastric ulcer, the size of a Victorian rupee. He was promptly admitted to the Satwari cantonment hospital in Jammu. He was responding to medical treatment. I vividly recall accompanying Mother, robed in her satin black burqa, to the cantonment hospital during the strict visiting hours. The tarmac would blaze furiously, and I longed to be bicycling with Dad down the cool side lanes.

One evening while pow wowing with Dad in his cabin, we could make out through the khus-khus curtain the profile of our ward medical officer, a British Royal Army Medical Corps captain. What struck me right away was that he was not white, but a beefy red. He had arrived for his ward round on his favourite chestnut filly. The sahib accosted the ward havildar (non-commissioned officer) who stood to attention at the parapet.

"Well Reddy, all okay?"

"Sir," Reddy replied. "Except that Dafadar Lakshman is readmitted with abdominal cramps."

"Ah. That malingerer. Give him castor oil and start the bull's régime tomorrow."

The epilogue was related by Dad when we visited him the following week. The sahib did arrive for his mounted morning round, clad in jodphurs and sola. He could have been coming after a swat at polo. And there was Reddy tremulous, unblinking.

"Well Reddy, all okay?"

"Sir, except that ..." Reddy was barely audible.

"Except what now? Don't forget, I leave for shikar late today."

"Sir, except that Dafadar Lakshman expired last night."

"Oh that blighter even managed to feign his way into the blessed heavens."

Brahm Dev, professor of neurosurgery, Jawahar Medical College, Dhule, India