Children dressed as soldiers on Africa's Day of the Child

take care of them, that is the recipe," he says. "The attendance should be voluntary. Never lock them up—that is the biggest mistake you can make. Don't force the children to stay. They will run away, but eventually they come back because they receive food and are given attention—things they crave and cannot get elsewhere. This process of demobilisation is also an adventure for

them. After a while they will trust you—that is what it is all about. Give them love, care for them, listen to their story, no matter how horrible it is, and gradually you will see them change. After half a year you will see them play. That is the aim: that they become children again, enjoying football.

"They come in as criminals, ready to fight, they fight with everything available—bottles, chairs. They are very aggressive; self mutilation is common. They know how to kill." The priest looks me deep in the eyes and speaks softly: "They know perfectly well how to decapitate somebody—the back side first." He does not explain the reason for this approach, and as a doctor I'm too embarrassed to ask. The priest tells me of a child who is deaf from launching rocket propelled grenades from his shoulder and of 8 year old children who take a gun apart while you have a cup of coffee.

"We trace the parents through our Catholic network, and I'm proud to say that the first 100 children recovered well. We plan to follow them up for three years. We will pay for schooling and teach them a trade." I'm impressed with his story and believe that he has hit the right approach. Education and employment are the important issues. The lack of them has caused a decline beyond repair in Sierra Leone.

In the airport I'm body searched by a child. Officially the children take the role of an adult only on this day, but many children in Sierra Leone have no youth at all. By the time I board the plane I have already worked out a plan to offer support for the displaced people in the camps. I also have ideas for giving aid to child soldiers that we could use in other countries. It was a tiring but useful trip.

Letter from Haiti

Fighting for survival

César Chelala

The political crisis in Haiti has had a severe impact on the health of the population. Mortality among Haitians is 13 per 1000, much higher than the Latin American rate of seven per 1000, and the incidence of AIDS, tuberculosis, and malnourishment is increasing among children. Although food and medicine are exempt, United Nations sanctions have had a negative impact on most of the population. In particular the embargo on fuel has limited most people's access to health care. The difficulties of distributing aid and health care without softening the embargo on fuel are immense, and the health of Haitians is not likely to improve until the political crisis is resolved.

The recent strengthening of United Nations sanctions against the military regime in Haiti has accelerated the critical situation in the country and has had serious consequences for the already low health status and quality of life of the Haitian people. Although humanitarian aid to soften the impact of the sanctions on the civilian population is an obvious need, delivering it presents almost insurmountable logistical problems. How to overcome these problems is a serious challenge to health related organisations working in the country.

The crisis in Haiti has been evolving over several decades, although it has been more severe since 1986, when the overthrow of Jean Claude Duvalier

inaugurated a period of political instability and economic chaos that continues today. The overthrow of the democratically elected president Jean Bertrand Aristide in 1991 by a military group led by General Raoul Cédras was followed by sanctions imposed by the Organisation of American States. In June 1993 a United Nations embargo—that included oil and armaments—was initiated and has now culminated in the current, even stricter, sanctions.

Paradoxically, the crisis resulting from the military coup is hurting the middle and lower sectors of the population most while economically benefiting the upper bourgeoisie and the higher ranks within the military. The oil embargo has sharply limited people's access to health care facilities, severely affecting the health status of the population.

The prominence of AIDS and tuberculosis

Statistics collected by the Pan American Health Organisation show that Haiti has among the highest mortality rates in Latin America and the Caribbean. In 1990 the crude death rate was estimated at 13 per 1000, which is much higher than the Latin American rate of seven per 1000. Although infant mortality has improved greatly over the past two decades it is still high at 94 per 1000. The principal causes of children's deaths are intestinal and respiratory infections. Malaria and measles continue to be serious health problems among children, as well as AIDS and tuberculosis.¹

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The incidence of pulmonary tuberculosis in children is estimated at 80 per 100 000; the incidence of AIDS has shown a sharp increase, especially among street children, who are prone to high risk behaviour.^{1,2} A seroprevalence study carried out in 1992 in Grace Children's Hospital found that among those admitted for tuberculosis 14.5% tested seropositive for HIV.¹

AIDS is also spreading rapidly in the adult population, especially in rural areas, the result of internal migrations due to unemployment and political repression. Those displaced by internal migrations probably amount to more than 200 000.³ In the slums of Cité Soleil, in Port au Prince, HIV seroprevalence was 10.3% in 1989, and in prostitutes the seroprevalence rose from 61% in 1987 to 72% in 1990. A high prevalence was also found in adolescents (15-19 years old) from urban areas.¹

Sixty per cent of children aged below 5 are estimated to be malnourished, and 3% of them have severe malnutrition. Before 1990 immunisation coverage with diphtheria, tetanus, and pertussis vaccine was 41%, with polio 40%, with BCG 72%, and with measles 32%.³ After the political crisis in 1991 those already low coverage rates fell further, and only in 1992 and the beginning of 1993 were they increased as a result of collaboration with the private sector.¹

Although difficult to assess precisely, the incidence of mental illness is believed to have increased because of the climate of social and political instability, violence, and the rise in the use of drugs.^{1,4} In 1992 there were 360 registered admissions in the Beudet mental hospital, 135 more than in 1991.¹ Most people affected, however, do not even go to the hospitals because of the widespread belief in the supernatural nature of mental disease.

Logistic nightmare

These considerations underline the extent of a situation of crisis and the urgent need for humanitarian help. How to do it effectively, however, is a logistical nightmare. Any assistance should be preceded by fuel distribution. Yet how is it possible to distribute fuel without the military taking advantage of it? How are those most in need—the poor living in remote areas—going to be reached? And how would what some see as an impending invasion affect the situation?

Perhaps the only way out is to organise humanitarian aid under a single leadership from one of the organisations working in Haiti, with the collaboration of an indigenous organisation with experience in providing aid and services. Among those, the most qualified is probably Les Centres pour le Développement et la Santé, which at present provides health services and economic help for over 500 000 people throughout the country.

In a country such as Haiti a political crisis cannot but have devastating consequences for the health of its people. If anything the situation shows the close relation between political events and the health status of a population. Without solving the political crisis the possibilities of solving the health crisis remain low. In the meantime, however, the suffering Haitians continue to live on the edge.

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3 *Relance de la politique de santé en Haiti*. Port au Prince, Haiti: Ministère de la Santé Publique et de la Population, 1993.

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Persistent post-traumatic stress disorder

Often missed but worth treating

Post-traumatic stress disorder has a lifetime prevalence of 1% in the community and up to 20% in veterans of the Vietnam war.¹ The term is used to describe emotional disorders after traumatic war experiences or other trauma that is outside normal experience such as rape, serious vehicle accidents, and earthquakes.² The symptoms may persist for many years and psychiatric morbidity is often associated.³ We present the case of a soldier in the second world war who had experienced severe trauma.

Case history

An 80 year old man was referred urgently by his general practitioner to the psychogeriatric service with depression and suicidal impulses. Since the second world war he had had recurrent flashbacks and frequent nightmares. He was the sole survivor of the tank he commanded and had witnessed the death of his crew when the tank was struck by a German shell. He had been outside the tank but was hit by shrapnel in the left temporal area.

He had been treated for shellshock, possibly with abreaction, with partial remission. Ten weeks later he had returned to downgraded operational duties. After initial "survivor guilt" he had tried to block out memories of the event. He did not talk about it and avoided watching war films or documentaries. He

developed an aversion to social groups as they reminded him of his life as a soldier.

He became a heavy bout drinker with periods of abstinence. He had increased his alcohol intake to get rid of memories of the war and drank at least one and a half bottles of whisky a week. He described craving, loss of control, and morning withdrawal shakes. Over the past four years he had also developed auditory hallucinations of a male and female voice, giving him orders or apologising to him. He had insight into these voices and did not feel frightened or the need to obey them. He also described feelings of unjustified persecution and ideas of reference for the same length of time.

In the past three months before presentation he had become depressed with biological features of sleep disturbance, early morning waking, loss of appetite and weight, poor concentration, and diurnal mood variation. He withdrew, neglected himself, and had saved antidepressant tablets as a result of suicidal impulses.

He had received no psychiatric treatment since the war and had no other relevant medical history. His general practitioner had started paroxetine 20 mg each morning one month previously.⁴

His elder sister had had depression and died of senile dementia of Alzheimer type. Before the war he had been sociable and outgoing and had played in the