Health in Africa

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Health in Africa

Time to wake up to cancer’s toll
Editor—As exemplified by your theme issue on Africa of 1 October, cancer has remained comparatively neglected in Africa although increasingly prevalent: 70% of people with cancer live in the economically developing world, where by 2020 the annual death toll is predicted to reach 20 million.1

In sub-Saharan Africa measures to prevent cancer emphasised in the developed world—such as smoking cessation and screening—are not nationally adopted. One third of African cancers are preventable, but the influence of tobacco companies with mass media advertising and high crop payments is real. Traditional cancers, such as gastric and hepatocellular carcinoma, and newer cancers, such as lung cancer, breast cancer, and AIDS related Kaposi’s sarcoma, are increasing in incidence.2 3

Patients’ expectations for oncological treatment are low in Africa. Lack of money, or a concern not to place their family in debt, prevents many from seeking medical help.4 Lack of awareness of predisposing factors, warning symptoms or signs of cancer, or treatment options mean that patients present late. Cost and difficulty of travel over rough terrain also discourage service use. After diagnosis patients may tend to look for peace of mind and spiritual comfort rather than a physical cure.5

In Africa disease modifying cancer treatment and basic control of symptoms are largely absent. Even when analgesia is available, patients with cancer may experience severe and inadequately managed pain, as health professionals underprescribe strong analgesics, fearing drug dependency.6

Individual sub-Saharan countries cannot tackle the challenges of cancer in isolation. A new, cooperative approach and research base are being advocated for preventing, treating, and palliating cancer to bridge the gap between developed and developing nations.7

Scott A Murray reader
Elizabeth Grant research fellow
Primary Palliative Care Research Group, Division of Community Health Sciences, General Practice, University of Edinburgh, Edinburgh EH8 9DX
Faith Mwangi-Powell executive director
African Palliative Care Association (APCA), PO Box 72518, Kampala, Uganda

Competing interests: None declared.

4 Murray SA, Grant E, Grant A, Kendall M. Dying from cancer in developed and developing countries. Lessons from two qualitative interview studies of patients and their carers. BMJ 2003;326:368-71.

British mental health trust twins with psychiatric service in Sierra Leone
Editor—Barnet, Enfield, and Haringey Mental Health NHS Trust has formally twinned with mental health services in Sierra Leone.8 This small project, currently funded by UNISON trade union, aims to provide regular, annual, in-service training programmes for staff at Kissy Mental Hospital, Freetown, and other health workers and trainees in Sierra Leone. The programme is formally supported by the British High Commission in Freetown, and the first delegation of trust staff drawn from various disciplines and some originating from Sierra Leone and other parts of West Africa will travel to Freetown next month.

We hope to learn from this programme as much as our colleagues in Sierra Leone hope to learn from us. The population in parts of the trust has a high proportion of refugees affected by war in their country of origin, including those of west central, and the Horn of Africa. And we hope to help our colleagues in Sierra Leone develop sustainable mental health services provided by themselves, rather than depending on the short term interventions of non-governmental organisations.

Shaun Collins assistant director
Child and Adolescent Mental Health, Barnet, Enfield, and Haringey Mental Health NHS Trust
shaun.collins@beh-mht.nhs.uk

Competing interests: None declared.


It’s time for good guidelines on health financing practice
Editor—The intervention of global organisations in the public health systems of African countries is a form of research involving humans and should be subject to the Declaration of Helsinki and good clinical practice guidelines.1 2

In structural reforms, global organisations (the investigators) work to convince the governments of countries (legal representatives of the study subjects) to take part in health financing reforms (or policy experiments, the new “medical” procedure). Since the health consequences of the interventions are largely unknown and the outcomes are used as a basis of an evidence base, these policy interventions are a form of experi-
Let's learn from the success stories from other poor countries...

Etorro—Why is it that donor agencies and policy advisers continue to ignore success stories from poor countries such as Sri Lanka?

Saroj Jayasinghe, associate professor
Department of Pharmacy Practice, Faculty of Pharmacy, Kuwait University, Kuwait
sbhal@bse.edu.kw

Competing interests: None declared.

2 Galbraith L, Mosher D. Removing user fees for primary care in Africa: the need for careful action. BMJ 2005;331:762-5. (1 October.)

...and get back to basics

Etorro—More of the same will not ease Africa's health crisis. As an African with training and work experience in international health, I think that we need to go back to basics.

Reducing poverty may be a starting point. However, even when it comes to rational use of the meagre monetary resources in sub-Saharan Africa, inefficient management of resources and corruption become serious stumbling blocks. Granted that corruption is almost worldwide, its rampant nature in Africa causes problems with monies available, received, and disbursed by the appropriate agencies in some countries.

As to efficient use of meagre resources, some countries outside Africa (for example, Jamaica) that are in the same developmental category as some African countries do far better with less. The general determinants of the health of populations show that an efficient, robust, and performing health services organisation is basic to the health of nations. Human capacity building, as the mainstay of all organisations, especially for health service delivery, research, etc, has suffered in most African countries, more so in recent times from net migration from sub-Saharan Africa to the developed world (or much wealthier developing countries). Sub-Saharan African governments and their developed counterparts need to work hard together to find pragmatic solutions to the brain drain problem.

The health crisis in Africa will continue to be more of the same, unless we seriously tackle the underlying issues driving the crisis.

Albert M E Coleman, associate specialist psychiatrist, Greenacres Community Mental Health Trust, Worthing and Southdowns Hospitals NHS Trust, Worthing, West Sussex BN11 2HH

Competing interests: None declared.

1 Sanders DM, Todd C, Chopra M. Confronting Africa's health crisis: more of the same will not be enough. BMJ 2005;331:755-8. (1 October.)
2 Eaton L. Global fund toughens stance against corruption. BMJ 2005;331:716. (1 October.)
3 Evans DB, Todd C, Chopra M. Confronting Africa's health crisis: more of the same will not be enough. BMJ 2005;331:755-8. (1 October.)
4 Eaton L. Global fund toughens stance against corruption. BMJ 2005;331:716. (1 October.)
5 Evans DB, Todd C, Chopra M. Confronting Africa's health crisis: more of the same will not be enough. BMJ 2005;331:755-8. (1 October.)
7 Johnson J. Mapping Africa’s medical brain drain. BMJ 2005;331:2-3 (2 July.)

Medical brain drain is a consequence of bad policy

Etorro—The medical brain drain is not new. During my undergraduate medical education in Africa, most of our lecturers had at some stage trained abroad. Our impression was that standards were better in Europe and America. Attached to this was a clear message that if you wanted to be the best, experience abroad was crucial. Experience in Europe or America conferred a special status on doctors as most government funded hospitals relied on such doctors to draw on their new experiences to improve local standards.

Apart from the obvious training benefits, the opportunity to earn a good income for a limited period was too good for many to pass up. To think that the brain drain happens purely for financial and economic benefits is, however, an over-simplification. The key is the inability to maintain a “migration equilibrium.”

In the past, doctors who left Africa returned proud of their experience and newly found status, more fulfilled, and keen to pass on their knowledge. They were happy to work in less well funded but nevertheless safe environments.

Years of underinvestment in the health sector, poor management of resources, and government malaise have eroded the previously high standards in many institutions. Doctors returning quickly find that the working environment is not safe, and word spreads quickly.

The prospect of moving to a better environment and living a more fulfilled life transcends professions or origin. The key to retention in Africa is to make people feel valued and create an environment where doctors can feel fulfilled in doing what they do best—saving lives.

Gbola O Sangosanya, specialist registrar
Chebba and Westminster Hospital, London
SW10 9NH
gosango2003@yahoo.co.uk

Competing interests: GOS was trained in Africa and is currently working in the UK.

Insulin pumps: more consultation was needed

Ennor—Colquitt et al recently published a health technology assessment on the clinical and cost effectiveness of continuous subcutaneous insulin infusion for diabetes for the National Institute for Health and Clinical Excellence (NICE). Believing that some important issues needed to be communicated with other readers, we contacted the NHS Health Technology Assessment Programme and were informed that its journal does not offer the opportunity to respond to previous appraisals in forthcoming publications. Through the programme’s website offers a forum for discussion, at www.nchta.org/ correspond/).

Given the potential impact of such publications in the United Kingdom and beyond, this approach caused us concern, as we believe that the website discussion would reach only a limited audience. We here outline certain shortcomings of the assessment by Colquitt et al.

Colquitt et al based their findings on a literature review made before August 2002 (published in October 2004), at which time no published cost effectiveness analyses on continuous subcutaneous insulin infusion in multiple daily injections of insulin existed. The authors said that they were unable to identify health outcomes that can be quantified for the purposes of cost effectiveness analyses, particularly in terms of translating observed benefits for glycaemic control into costs per quality adjusted life year (QALY) gained. However, publications on at least four health economic models that are able to project the long term change in risk of
complications dependent on concentrations of glycated haemoglobin, and thereby calculate clinical and cost outcomes, were available at that time. Since the completion of the review, at least five other peer reviewed diabetes models have been published that can project cost effectiveness on the basis of changes in glycated haemoglobin, and two further studies have actually examined the cost effectiveness of implementing continuous subcutaneous insulin infusion: multiple daily injections of insulin treatment in the UK, both reporting attractive incremental cost effectiveness ratios (see longer version of this letter).

Colquitt et al did not seek further consultation from competent health economists and modelling groups with experience in diabetes before publishing their report. If they had they would have been unlikely to conclude that they had not found a satisfactory method, in the time available, of converting observed benefits into a cost per QALY. A method has been available for some time and, in the years between completion of the review and its publication, several transparent, valid, and generally well accepted computer simulation models of diabetes have been described in the medical press (see longer version of this letter).

Andrew J Palmer director, medical research apal@theemerch.ch Daniel M D Tucker health economist Joshua A Ray health economist William J Valentine health economist CORE—Centre for Outcomes Research, Buendennstrasse 40, 4102 Binningen, Switzerland

Craig Currie honorary research fellow in diabetes, endocrinology, and metabolism Department of Medicine, Cardiff University, University Hospital of Wales, Cardiff CF14 4UJ

Phil McEwan director School of Mathematics, Cardiff University, Cardiff CF14 4UJ

Michael Brandle director Division of Endocrinology and Diabetes, Department of Internal Medicine, Kantonsspital St Gallen, Switzerland

Competing interests: AJP, DMDT, JAR, and WJV are all employees of CORE. CORE has received an unrestricted grant from Medtronic to perform an analysis evaluating the cost effectiveness of continuous subcutaneous insulin infusion for diabetes.


The CDC also reports that in 2005, 65% of children aged 4-17 with emotional or behavioural difficulties received some type of mental health service for their problem, with 45% receiving help from a mental health professional and 40% from a general physician. Again, this is substantially different from the 20% treatment rate cited by TeenScreen.

Joan McClusky medical writer New York, 10003, USA jmcclusky@medimina.com

Competing interests: None declared.

Letters

Data need to be accurate when screening for depression in teenagers

Emsley—With reference to Lenzer’s news article, one of the problems with promotion of universal mental health screening of children—and a good reason for many people’s suspicions of another agenda—is the often inflated numbers cited. For example, the TeenScreen website notes that in 10 American children and adolescents experience mental illness and impairment, but only one in five receives treatment. The source cited is a US Surgeon General’s report from 2001—in support of a “National Action Agenda on Children’s Mental Health.”

Yet the US Centers for Disease Control (CDC) reports that in 2001-3, 5% of American children aged 4-17 had emotional or behavioural difficulties, based on over 10 000 national health interview surveys. The CDC also reports that these difficulties had an impact on functioning in 80%—in other words, 4% of the total, substantially lower than the 10% cited by TeenScreen and perhaps not the “public crisis in mental health for children and adolescents” that the Surgeon General’s report claimed.4

The CDC also reports that in 2005, 65% of children aged 4-17 with emotional or behavioural difficulties received some type of mental health service for their problem, with 45% receiving help from a mental health professional and 40% from a general physician. Again, this is substantially different from the 20% treatment rate cited by TeenScreen.

Joan McClusky medical writer New York, 10003, USA jmcclusky@medimina.com

Competing interests: None declared.

1 Lenzer J. US teeneger’s parents saw school over depression testing (BMJ 2005;331:714) (4 October).


Competing interests: None declared.

1 Lenzer J. US teeneger’s parents saw school over depression testing (BMJ 2005;331:714) (4 October).


Europe in transition

Biomedical research from eastern Europe may be under-represented

Emsley—The unique database of ISI (Institute of Scientific Information) has well known limitations in assessing biomedical research. The most important one is that its content mainly reflects the mostly English language pool of the “international journals.” Some European non-English speaking countries, and especially east European countries, have a strong tradition of publishing in their native languages. This pool of publications is not closely connected to the one reflected in the ISI database.

The “quality” of research products published in local journals may be disputed, but the quantity or research input of east European countries is underestimated in the study by Sotierides and Falagas.4

Vasilis Vlassov director Russian Branch of the Nordic Cochrane Centre, Cochrane Collaboration, PO Box 13, Moscow 104083, Russia vlassov@cochrane.ru

Competing interests: None declared.


Dietary fat is not the villain

Editor—Zatonski and Willett claim that a decrease of saturated fat and an increase of polyunsaturated fat consumption explain the decreased coronary heart disease incidence in Poland. However, ecological data are prone to bias because they are rarely, if ever, adjusted for confounders. In this case they are even contradicted by similar studies in the past. In a review including 105 time periods in 35 countries, I found that in 30 time periods an increased intake of saturated fat was followed by increased coronary mortality, but after 29 other periods with increased saturated fat consumption heart mortality was unchanged in six and decreased in 23. Zatonski’s and Willett’s statement that their finding is supported by epidemiological and clinical evidence is not true either. In a review of all cohort and case-control studies, heart patients had eaten more saturated fat than had healthy controls in three cohorts, but in one cohort they had eaten less, and in 22 cohorts and in six case-control studies no difference was found.5 No cohort study or case-control study has found that coronary patients have eaten fewer polyunsaturated fats either; on the contrary, three cohort studies found that they had eaten more than the healthy controls, and in 29 studies no difference was found.5

The absence of an association between fat intake and coronary disease was recently confirmed in a large Swedish population study.6 No association has been found either between intake of dietary fats and degree of atherosclerosis at necropsy.7 Most importantly, two meta-analyses of all controlled, randomised dietary trials, in which the only type of intervention was a lowering of dietary saturated fats and an increase of dietary polyunsaturated fats, found that the total number of deaths was identical in the treatment and the control groups.8

Uffe Ravnskov independent researcher Magle Stora Kyrkogata 9, 25250 Lund, Sweden ravnskov@tele2.se

Competing interests: None declared.


2 Cochrane Collaboration, PO Box 13, Moscow 104083, Russia vlassov@cochrane.ru

Competing interests: None declared.


The problems mentioned included the deterioration in health and social services since the collapse of the communist system in eastern Europe. The opportunity to study prospectively what is possibly the biggest system reform in our time was missed because the pressure to deliver changes overnight was so strong that a more systematic, planned, and reasoned approach seemed to equal sabotage. Money was spent on reforms but without monitoring because of this pressure. Consequently, baseline data to measure progress and impact of reform are hardly available, although UNICEF’s TransMonoe database was mentioned as a resource.

Human resources were also identified as a problem—not because of a lack of trained people but because of the prescriptive role of doctors, poor resources, and the west Balkans, and the macro-environmental (especially economic and social) components are not the same. Hungary did not experience the rapid changes in the population, the collapse of its health care and welfare systems; or the precipitous economic, social, and cultural crises that took place in Russia. Hungarian drug policy, which contains elements of harm reduction, will also contribute to preventing the massive spread of infectious diseases. For example, qualitative studies on injecting drug users in Hungary underline the importance of unlimited availability of injecting equipment in pharmacies and the help of needle exchange programmes (which are, however, available only in bigger cities).

Although the HIV prevalence is zero among injecting drug users, the prevalence of hepatitis C is about 30-35%. According to our experience, the HIV testing is widespread, but the opportunities for testing for hepatitis C virus are limited: either in absentia of drug clinics or low threshold services. Opportunities for testing need to be improved urgently, and the coverage of the low threshold services in connection with injecting drug users needs to be increased.1

Josef Rácz researcher, psychiatrist
Institute for Psychology, Victor Hugo 18-22, Budapest-1132, Hungary
raczr@t-online.hu

Competing interests: None declared.


Summary of webchat

The aim of the theme issue of Europe in transition was to give a snapshot of countries in political and economic transition. Participants in the accompanying webchat discussed problems that they were facing in the course of their own work, analysed where these problems might stem from, and thought of some tentative solutions.

The idea that “growth in paperwork” is eating into “scarce funding.” How any organisation where spending has doubled in a mere decade could consider funding “scarce” is rich enough. But the idea that all management activity is parasitic on the hardworking real NHS isn’t like that. It’s under-managed and badly organised, and putting good managers in place can often dramatically improve the capacity of the medical staff to treat patients.

The underlying assumption behind the opposition to reform is that the current NHS is as good as it can be and there is no way to do it better. There is legitimate debate about how to do better, but starting with a fairy tale view of how the NHS is now is not a good place to start.

Stephen I Black management consultant London SW1W 9SR stephenblack@iacconsulting.co.uk

Competing interests: SIB has worked as a management consultant in the health system.