medical journal have a moral obligation "for the names and fate of the dead to be properly lodged in the public record"[1] and to guard against articles with such brazen biases.

CHARLES M VYGANTAS
Assistant professor of ophthalmology

University of Illinois Eye and Ear Infirmary,
1855 West Taylor Street,
Chicago, IL 60612,
USA

1 Summerfield D. Raising the dead: war, reparation, and the politics of memory. *BMJ* 1995;311:495-7. (19 August.)

Abduction results in family, emotional, and legal problems

EDITOR,—Derek Summerfield discusses important issues in areas of civil or international disorder, emphasising people's desire to learn the true fate of their loved ones who have disappeared—even if that means uncovering incontrovertible proof of their death.[1] In Angola this situation has taken a particular turn. For the past 20 years the rebel organisation the National Union for the Total Liberation of Angola (UNITA), in its endeavour to create a government in the southern area of the country, has systematically abducted civilians so that it can take over the area. Two groups are particularly targeted: adolescents (for military recruitment) and young women (for sexual and family life).

Eventually, family members may meet again after many years of rumours, hopes, and anxiety, as happened in two cases that I learnt about recently. In one of these cases the parents of a girl who disappeared during UNITA's occupation of a southern city were allowed, under strict surveillance by the kidnappers, to see her in 1992. Her husband, who had also been kidnapped, had died (in fact, he had been murdered to allow the girl to become the wife of one of the leaders), and in her captivity she gave birth to two children, the father being her husband's murderer. She went back to Jamba (UNITA's area), where the children had been kept as hostages. Since then the family has refrained from any action or publicity to protect the children.

In the other case a family was ambushed in the road by members of UNITA, and a young married woman saw her father and two young children murdered. She had left her older child with grandparents; her husband was studying in another country. She was taken to Jamba, where she became a nurse and lived with a doctor. She was presumed dead, and her husband married again and returned to Angola. In 1992 the couple living in Jamba managed to escape to Luanda. Later on, the two couples met, with many familial, emotional, and legal problems.

LUIS BERNARDINO
Paediatrician

Medical School of Luanda,
CP 3067,
Luanda,
Angola

1 Summerfield D. Israeli Medical Association shirks "political aspects" of torture. *BMJ* 1995;311:755. (16 September.)

Land mine injuries in Afghanistan

EDITOR,—Having returned last week from Kabul, I read with interest Neil Andersson and colleagues' paper on the social costs of land mines in four countries, one of which was Afghanistan.[1] I was surprised that the authors believe that hostilities in Afghanistan have stopped: military offensives are being launched regularly throughout the country, and there has been no prospect of peace since the Soviet withdrawal. During the past year southwest Kabul has been devastated by street fighting. In addition, in the past month Afghanistan's second city, Herat, fell out of government hands; the Pakistani embassy was ransacked, with several deaths; and Kabul was subjected to rocket attacks and air raids. The authors' belief is symptomatic of the poor news coverage that this conflict receives.

In my experience, children tend to be killed by antipersonnel mines whereas adults tend to be maimed. The authors did not compare rates of fatal injury in these two groups.

The authors fail to mention a vital facet of education to make people more aware of mines—namely, the provision of picture boards in mined areas. The illiteracy rate in the population may be as high as 70%, and these boards attempt to show pictorially the hazards that people returning to their homes face. As few Afghans speak English and even fewer can afford radios I doubt the impact of BBC broadcasts in English or Dari that attempt to raise awareness of mines in Afghanistan. Also, the authors do not touch on the barriers created by cultural and religious predeterminism among the Afghan population, many of whom think that as their destiny is in the hands of Allah there is little point in keeping clear of mined areas.

Alarmingly, the Jamiat-Islami Afghan government is compounding the problem of mine injuries by encouraging people to repopulate hazardous areas of Kabul in an attempt to be seen to be returning the city to normality. Many streets and buildings in these areas are still densely mined and scattered with live, unexploded ordnance, and civilians are being killed and maimed daily.

Finally, the Halo Trust has repeatedly expressed concern that pressure on other organisations that clear mines to clear them rapidly from large areas of land may be leading them to adopt a less than meticulous approach, giving mine clearance rates far short of 100%. The trust is aware of at least two incidents in which civilians have been injured by antipersonnel mines in areas that had already supposedly been cleared. Strict regulation of practice in clearing mines is urgently required.

JAMES McDIARMID
Medical officer, Halo Trust

Kirk Ella,
Hull HU10 7PB

1 Andersson N, Palha da Sousa C, Paredes S. Social cost of land mines in four countries: Afghanistan, Bosnia, Cambodia, and Mozambique. *BMJ* 1995;311:718-21. (16 September.)

Use of performance indicators for general practice

EDITOR,—In their editorial on performance indicators for general practice F Azeem Majeed and Simon Voss highlight many of the important issues about the appropriate use of such indicators.[1] They emphasise the need for general practitioners to work with authorities to develop such indicators. Authors in other professions that use performance indicators have written similarly of the importance of ownership in their development and the dangers of inappropriate interpretation.[2,3]

I undertook a national survey of 115 family health services authorities and health commissions to ascertain the use of indicators in prescribing; 80 replied (some on behalf of more than one organisation). The table shows the results. Some respondents had no indicator in a therapeutic area for which another had as many as 14. Several respondents gave the derivation of the indicators, although this was not specifically asked for. Some indicators were based on the idiosyncratic view of a local pharmaceutical or medical adviser. In other areas, considerable efforts had gone into involving general practitioners in consensus groups to produce indicators in prescribing agreeable to all concerned.

Respondents also reported great variation in the application of indicators: some were, using them to highlight areas of prescribing that needed further discussion with the practice, while others were tying them to resource allocation measures, in some cases in a puntive fashion.

Table 1—*Performance indicators of prescribing: summary of results of national survey*

Indicators in each therapeutic group (n=698)	No
Cardiovascular	108
Respiratory	102
Central nervous system	93
Infection	90
Drugs of limited therapeutic value	78
Musculoskeletal and joint disease	72
Gastrointestinal	63
Overall	48
Other	31
Endocrine	13
Respondents with indicators in particular therapeutic areas (n=69)	
Respiratory	57
Musculoskeletal and joint disease	40
Central nervous system	39
Cardiovascular	38
Infection	35
Drugs of limited therapeutic value	33
Gastrointestinal	32
Overall	31
Others	18
Endocrine	6
Indicators most commonly used by respondents	
Steroid: bronchodilator inhalers	52
Overall rate of generic prescribing	29
Ranitidine: cimetidine	23
Appetite suppressants	20
Range of non-steroidal drugs used	19
Prescribing of benzodiazepine	18
Use of topical non-steroidal drugs	15
Use of peripheral and cerebrovasodilators	14
Use of angiotensin converting enzyme inhibitors	14
Hypnotics and anxiolytics (items/prescribing unit)	13
Drugs used to treat infection (items/prescribing unit)	12
Generic drugs to treat infection as % of all such drugs	12
Cephalosporin:penicillin	12
Use of selective serotonin reuptake inhibitors	10
Generic non-steroidal drugs as % of all such drugs	10
Use of cough mixture	10

*Eleven respondents were not using any quality indicators.

These results show that the derivation and application of prescribing indicators vary widely. We need to step back from simply applying whatever data we have available and turning them into a battey of performance indicators in order to look at the underlying changes in behaviour that we wish to produce. Performance indicators, especially for prescribing, should be set so as to encourage changes in prescribing behaviour that will lead to an improved outcome among patients or a more efficient use of resources. Much more thought is needed if such indicators are to be widely used, and if chief executives are to be appraised against the indicators then advisers will need to brief them well on the limitations.

SARAH J BAKER
Medical director

Leeds Family Health Services Authority,
Leeds LS2 7RJ

1 Majeed FA, Voss S. Performance indicators for general practice. *BMJ* 1995;311:209-10. (22 July.)
2 Likierman A. Performance Indicators; 20 early lessons from managerial use. *Public Money and Management* 1993;Oct-Dec:15-22.
3 Jackson PM. The management of performance in the public sector. *Public Money and Management* 1988;Oct-Dec:11-6.

Correction

Scare over oral contraceptives

An author's error occurred in the seventh letter in this cluster, by John Guillebaud (16 December, pp 1638-9). The second sentence should have started: "In the original version I argued that, in these trials, the proportion of women who had been exposed in the past to ethinyloestradiol (in any combination) might be lower [not higher] among current users of the newer third generation pills containing desogestrel and gestodene."