Letters

Learning from low income countries: what are the lessons?

Communities should decide priorities

EDITOR—Women and children continue to die needlessly in developing countries. We know the causes but seem powerless to prevent their deaths. Constraints within health systems are blocking improvements, and we don't know enough about how to strengthen and sustain them without external investment. Individuals and communities have their own priorities for health, and a global solution for disease and poverty is impossible to prescribe.

A village was asked by an aid agency what its priorities for development aid would be, the answer presumed to be a health centre, school, or irrigation system. When the villagers replied that they wanted a football pitch, the agency withdrew its offer. The villagers built their own football pitch, and this engendered such a feeling of community spirit that they built their own health centre the next year without outside help.

During famine we concentrate on nutritional supplementation for children under 5 years old, yet I have been challenged by villagers who argue that the older children should have priority as they have already survived the difficult years of early childhood and are now contributing to their family's potential.

Listening to communities and allowing them to decide on their priorities avoids inappropriate aid. Programmes may require only modest outside support. A recent study in Nepal reports significant improvements in maternal and neonatal mortality rates by establishing women's groups with a facilitator.[1] The process was similar to that used in the child-to-child initiative in the United Kingdom, in which children determine their priorities, plan and implement action, and then review results, all with the help of a facilitator. This approach has also been successful with child refugees.[2]

Community programmes using the simple techniques described by Werner and Bower are easily adapted to other settings whether the objective is a reduction in poverty, morbidity, or illiteracy.[3]

STEFAN BOWERS/PANOS

Female literacy rates are an important predictor of child survival.[4] What is not well understood is the mechanism by which female literacy exerts such an influence. It has far more significance than simply being able to read instructions on a medicine packet. Literate women tend to earn more and are better at accessing health and other services for economic development.[5]

Health for All by the Year 2000 failed to meet its goals in many countries. Those that have improved the health of their women and children in the past 40 years have achieved it by developing health services in parallel with improvements in economic measures, education, and social infrastructure. Aid therefore needs to be widely targeted and supplied in response to priorities that are determined locally.

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Communities improve health systems

EDITOR—In many developing countries policy makers and donor agencies tend to emphasise creating a robust system rather than empowering communities. For them, it is much easier to tackle the system as it does not complain or talk back, whereas it is hard to deal with people, who do not always behave as expected.

Thus an imbalance between system and community occurs. As the power of systems grows, the power of community declines, and as control magnifies, consent fades.[1] As standardisation is implemented, creativity disappears—to build a healthful society both system and community are needed.[1]

To improve the balance between system and community in rural Nepal, we conducted the school and community health project from 1992 to 2004. For example, we trained traditional healers in Western medicine to strengthen their roles in primary health care. Later, their relationships with the government health workers were much improved.[2] In the same communities we conducted literacy programmes for adult women—an entry point for community empowerment.[3] These women then helped in government health activities.

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Community oral rehydration units can contain cholera epidemics

EDITOR—Cholera is closely linked to social, economical, and political change, and outbreaks still occur.[1] After a century of absence, cholera occurred unexpectedly in the American continent in 1991.[2] Peru was the first country to report cases and was the most severely affected by the epidemic, in case numbers (300 000 in the first year) and economic impact on tourism and the imposition of food embargoes. In the first weeks 45 000 cases were counted each week.[3] The case fatality rate was only 0.7%, the lowest rate in South America during 1991-4 and one of the lowest ever reported.[4 5]

Public consciousness and prompt rehydration treatment, in a system with a strategy already in place for diarrhoeal diseases, were the key factors behind the successful rapid medical response to the epidemic in Peru. Training campaigns were carried out among mothers belonging to popular voluntary organisations. Extensive oral rehydration units had been established since 1980 in periurban health centres to deal with childhood diarrhoeal diseases. Later, oral rehydration units were extended to the paediatric departments of hospitals and then to all populations on a large scale.[4]

The cholera epidemic of 1991 taught Peru how to use clinical and epidemiological information and make the most of a system already in place. Sharing this lesson

may reduce the countries affected by current cholera outbreaks.

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Palliative care can be delivered through neighbourhood networks

EDITOR—Neighbourhood network in palliative care is an initiative in the south Indian state of Kerala to develop a sustainable, community owned service for long term and palliative care. It aims at empowering local people to look after chronically ill and dying patients in the community.

Most of the problems associated with chronic or incurable illness, being social issues, require interventions by communities. In Kerala's neighbourhood network, local volunteers are trained to identify the problems of chronically ill patients in their area and to intervene socially. These volunteer groups are supported by trained doctors and nurses. The project has managed to bring many groups and social initiatives such as cultural and social organisations and student groups together on a common platform of social justice to work for chronically ill people.

Neighbourhood network programmes have shown exceptionally good success rates everywhere. More than 50% coverage for all chronically ill patients seems to have been achieved within two years of initiation of the project. The district where it was first launched now has an estimated coverage of more than 70%.

Involving the local community in all stages of the project, from planning to monitoring, has ensured sustainability of the project. Neighbourhood groups locally find the resources to deliver care: 80% of the funds for programmes are raised locally. The groups' advocacy role also results in generating support from local government.

Kerala's neighbourhood network in palliative care serves as a realistic option for most of the developing world in organising much needed sustainable services for chronically ill and dying patients.

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Trained medical assistants can successfully do work of doctors

EDITOR—The West might well learn from Tanzania, which in the early 1970s invited the Kilimanjaro Christian Medical Centre in Moshi, Tanzania, to train experienced medical assistants to do nearly all the things normally reserved for qualified doctors.

The teaching was on a problem solving basis; each teacher had just two or three students for their three months. There would be no formal lectures, only practical hands-on teaching, using the trainees as apprentices, sharing the life of their teacher during their attachments.

The results were impressive. The students learnt quickly and enthusiastically, finding us using techniques that would remain available to them in the rural hospitals to which they would eventually be posted. Thus (for instance) they would be taught how to do skin grafts (a most necessary skill) using a modified carving knife (a technique borrowed from MacIndoe in Britain.[1] They would learn how to give anaesthetics with a draw-over vapouriser.

The results exceeded all expectations. We heard of our students doing well all over the country in subsequent years, using viable technology to solve the problems of one of the poorer countries in the world, and often (happily working in very rural areas) doing better than "real" doctors trained in the Western world, who tried to solve the very different problems of rural Africa with inappropriate Western technology that they had been trained with.

Other countries such as Malawi with its orthopaedic clinical officers are now finding similar answers to their own problems.

We felt that this—an African vision—was a development whose time had come. Here was a country solving a problem that had until then defeated many much richer developing countries—that of getting "doctors" to work and stay in those rural areas where "real" doctors tend not to work.

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Hands on course may help deliver obstetric care

EDITOR—We are involved with a scheme in Zambia that has introduced a training programme in emergency skills in obstetrics and gynaecology based on the ALSO (advanced life support in obstetrics) course methods.

The programme, pioneered in the United States by the American Academy of Family Physicians to update practitioners (especially those working in remote areas), has now expanded not only into Europe—about 35 courses are held in the United Kingdom each year—but also into Brazil, Hong Kong, and Australia and, with modifications, to developing countries such as Nepal and Pakistan.

The basic two day course concentrates on hands-on practical workstations, using manikins, on topics such as shoulder dystocia, instrumental vaginal delivery, malpresentations, and the management of postpartum haemorrhage. At the end of the course, skills and knowledge acquisition are tested with a multiple choice questionnaire and "mega delivery" (testing practical clinical skills).

One of us (PBS) has completed several sabbaticals in east Africa and, as a qualified ALSO instructor, thought that ALSO might function effectively there. With the agreement of the ALSO international and UK advisory boards (KH), he undertook a feasibility pilot in Monze Hospital, Zambia, using certain modules from the ALSO curriculum.

Under the supervision of the consultant in charge (MB), the ALSO system has been adapted to spread the lectures and practical workshops over three to four weeks, during which the students (clinical officers at an advanced level) also work on the wards under the direct supervision of MB and PBS. On completing the 16 week module, they should be competent to perform instrumental, breech, and twin deliveries, caesarean sections, laparotomies for ectopic pregnancies, and manage antepartum and postpartum haemorrhages.

In a country such as Zambia, where a severe shortage of doctors especially affects rural areas, this pilot has worked successfully, and we hope that this modified ALSO method may find application elsewhere in the developing world.

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Partnerships in mental health are possible without multidisciplinary teams

EDITOR—In the United Kingdom a generic specialist multidisciplinary mental health service for children and adolescents at tier 3, with teaching responsibilities, providing evidence based interventions for 0-17 year olds, would need a minimum of 20 whole time equivalents per 100 000 population.[1] In the university hospital in Ibadan, Nigeria, one child psychiatrist serves a population of three million without the support of a multidisciplinary team.[2]

This situation creates tremendous frustrations, but it also actively encourages crea-

tivity through the forging of links with schools, religious organisations, and other child services.[3] The lean resources seem to propel practitioners to push ahead and surmount obstacles.

The developed world has much to give and receive from working with partners from the developing world. If each child mental health service in the developed world established a partnership with a similar organisation in the developing world much would be gained on both sides from this process. These links would provide training and educational support to the developing world. Simultaneously, professionals and the community could work together to develop child mental health services in the developing world, using creativity and innovation.

Who is to say that these same innovations cannot be applied in the developed world? This relation would also provide reality checks, especially for those working in better resourced areas, and may question whether resources are really the issue. When links between the United Kingdom and the developing world are established, the United Kingdom could easily fall into the trap of being the expert and advising the institution abroad.[4] But any successful partnership requires mutual respect with an understanding that both parties have opportunities to learn from each other but an acknowledgement that the context and societies in which they work are very different.

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Effective surgery can be cheap and innovative

Editor—Surgical services in the developing world are very different from those in the developed world. High patient load, limited resources, advanced stage of diseases at presentation, and limited number of surgeons (mainly owing to migration to the developed world) are some obvious differences. Although these unfavourable factors have a negative impact on surgical care, they have some advantages.

These include more opportunities to develop surgical skills, less litigation allowing bold decision making, ability to survive without practising defensive medicine, and more commitment from patients in the battle against illnesses. Although academic medicine and research in the developing world have hardly any support, a lack of resources and high case load promote new thinking and innovations.

Although transurethral resection of the prostate is widely performed in the developed world, open suprapubic prostatectomy remains the gold standard in the developing world, where glycine containing irrigant solutions are difficult to obtain.[1] We use sterile water (prepared locally at the hospital) as the irrigant fluid and have performed over 350 consecutive such resections without any deaths. Several years ago, low friction hydrophilic catheters were too expensive and therefore not available—a major drawback to popularising clean intermittent catheterisation in Sri Lanka. A catheterisation programme using ordinary Foley catheters (silicone coated latex), which are freely available, was highly successful.[2]

These are two examples of many improvisations that surgeons in developing countries use to provide effective surgical care to their patients. Large economic advantages of these techniques outweigh the minimal clinical disadvantages. It is important to realise the advantages of developing better surgical skills and cheaper innovations instead of very expensive technological advances to improve care for patients.

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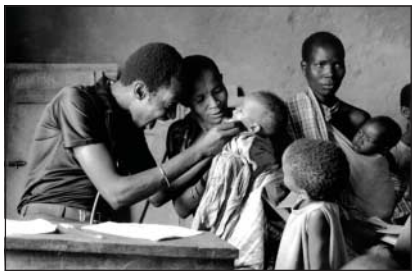
Health information technology need not cost the earth

Editor—In the early 1990s the Soviet Union's disintegration produced a sudden shrinkage of Cuba's economy. US sanctions were tightened, and Cuba was in economic crisis. Long hours of blackout daily became common.

These adverse circumstances affected a country with limited material resources and few computers and telephone lines, as health informatics began its impressive development in most industrialised countries. However, Cuba had an efficient nationwide health system and huge human potential. Thus INFOMED, Cuba's national online healthcare information network, was founded in 1991.

INFOMED is now a national online healthcare information network connecting doctors, hospitals, research facilities, medical universities, and rural clinics throughout the country and providing health news and medical data. The project required an expensive physical infrastructure, so for the first five years the scope of the network was small. However, within only 18 months, a simple network was established. Linux OS was used because it conforms with the Cuban philosophy of an open source approach.

Some funds were supplied by the Cuban ministry of health, as well as by the United Nations development programme (in association with the Pan American Health



SEAN SPRAGUE/PANOS

Organization). Subsequently, the scope of the network was significantly enlarged using finances from consultancy projects and other services offered to several enterprises. It has also received regular help and hardware donations from the US non-governmental agency INFOMED USA. The website (www.sld.cu) has been particularly used and useful. The UN has awarded the network special recognition.

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Emphasis on sophisticated investigations could be reduced, for example

Editor—Developing countries are abandoning their attributes in their quest to become developed countries.

Family culture, yoga and meditation, emphasis on clinical skills rather than sophisticated investigations are a few things that the developed world can learn from the developing world. Instead of placing more emphasis on providing social security, a family culture can be a great individual security factor and prevent many psychological problems. Yoga and meditation can be miraculous in preventing obesity and depression, which are becoming the new public health problems in the developed world. Well conducted clinical examinations with minimal possible investigations can bring down the cost of health care. This sort of experience will ultimately improve health for everyone.

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Health is a dynamic process

Editor—In 1999 I joined as a haematologist the one medical school in Malawi, Africa. I was asked to see a young pregnant woman with fever, confusion, and oral thrush. The pinprick-like marks apparent on her abdomen were explained by the resident, my translator—she had already seen a traditional healer. History and the few available laboratory tests led to a tentative diagnosis of haemolytic uraemic syndrome related to AIDS. Realising that this case may be the

first observed in the country, we presented the latest knowledge on the disease in a seminar, including the roles and interactions of high molecular vW factor, endotoxins, etc.[1] The resident doctor conveyed the probable diagnosis and treatment.

The next day the sister informed me that the family discharged the patient. I felt inadequate and sad; it struck me that such a diagnosis implied a considerable burden of costs. Furthermore, the cause of her ailments sounded like mumbo-jumbo. The village healer may have provided similar sounding explanations with treatment that was cheaper and near home.

A paediatrician in Malawi who spoke the local language treated a child with sudden seizures who died due to meningitis.[2] The mother thought her next door neighbour had cast a spell. The paediatrician explained to the grieving mother that the cause of death was bacteria—invisible enemies present in the surroundings; her sympathetic narration soothed the mother's anger and reunited the neighbours.

Of the two interventions, one seemed to be "successful" and the other apparently failed. In developing countries, health is a dynamic process, dependent on local culture and traditions, doctors' views, and patients' expectations and we must listen to patients with understanding. This also applies in Western countries, where demographic changes have resulted in an abundance of elderly people; we may not always be able to cure their chronic ailments, but we can always listen to them and appreciate their right to explanations.

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The author thanks Professor E Molyneux for explaining local traditions.

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1 Tadessi YE, Das PC. A febrile confused young woman. *Malawi Med J* 2001;13:51.
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Improvement can occur even in resource constrained settings

Editor—Berwick's editorial on the lessons from developing nations on improving health care mistakenly abstracts improvement efforts from the complex context of poverty and inequality.[1] Improvement is "an inborn human endeavour," yet an undernourished or sick child who wants to "jump higher or run faster" cannot do so unless basic needs are met first.[1] In Peru we learnt that notable improvement can occur, even in resource constrained settings. But it takes more than goodwill. Aims, teamwork, and ability to do more with less and handle the political interface are important but insufficient. Consequently, some of the lessons mentioned should be read with caution. What may be waste in wealthy settings may not be so for impoverished ones.

"Dependency is waste." This is not always true. Sometimes, reliance on donor funds may be the only means of providing or improving health care for poor people. Wealthier nations and organisations providing technical assistance should also help find new resources and help pursue technical and financial self-sufficiency.

"Complaint is waste." This is not always true. Had we not complained in 1996, when multidrug resistant tuberculosis was considered "too expensive" to treat in poor settings, we could not have started treating the first of more than 2000 patients in Peru. Had we not complained, we would not have secured concessional prices on required drugs (reduced by 90% compared with 1996 prices). Had we not requested external financial support, today Peru could not provide free treatment for all patients with tuberculosis and multidrug resistant tuberculosis: it would be paying its external debt first.

Improving health care in developing countries cannot rely solely on local strengths. It requires that leaders, advisers, and donors become engaged in discovering and alleviating the structural constraints of poverty. Perhaps then, every child will have the opportunity to succeed in the intent to run farther and keep running.

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1 Berwick DM. Lessons from developing nations on improving health care. *BMJ* 2004;328:1124-9.

Website highlights ethics issues for research in developing countries

Editor—Recent years have seen growing international debate about the ethics of conducting medical research in developing countries. Although many of the issues are similar to those in more developed countries, the limited resources in developing countries can exacerbate the problems. In addition, imbalances in power between the stakeholders—which can include multinational pharmaceutical companies, publicly funded researchers, national governments, and participants—can increase the risk of exploitation.

Aspects of research that have proved particularly controversial in developing countries include the relevance of the research to participants, standards of care provided to participants, the design and conduct of processes used to obtain consent, the appropriateness of international and national guidance on research ethics, and the care provided to both participants and the wider community once research is over.

To highlight these issues and how developing countries are tackling them, the Science and Development Network (SciDev.Net) has produced an indepth online dossier on the ethics of medical research specifically for and about developing countries (www.scidev.net/ethics).

The dossier addresses some of the key issues that face those engaged in funding, designing, reviewing, conducting and participating in medical research in developing countries. It has links to relevant news items, organisations, regulations, reports, and educational resources and is regularly updated. Most authors and contributors are from developing countries, and the articles are reviewed by an internationally renowned advisory panel.

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Sources of information should focus on developing countries

Editor—Both the *BMJ* and the *Lancet* claim to be globally relevant.[1 2] We tested this assertion and assessed the opportunities for readers of these journals in developed countries to learn from research from the developing world.

We abstracted research articles from the *BMJ* ("papers" and "primary care" sections) and the *Lancet* ("articles") from 1 March 2003 to 28 February 2004. We assessed each article independently as relevant or not relevant to developing countries, and as providing or not providing an opportunity for health professionals working in the UK health system to learn from experience from developing countries.

We found that 75 of 292 (25%) and 50 of 163 (31%) papers in the *BMJ* and the *Lancet* respectively were relevant to developing countries, largely in the fields of tuberculosis, HIV/AIDS, and severe acute respiratory syndrome. Only 14 (5%) and 19 (12%), respectively, provided an opportunity for health professionals working in the UK health system to learn from experience from developing countries.

Our results indicate that, despite their claims, both the *BMJ* and the *Lancet* continue to focus on wealthy countries to the exclusion of research relevant to developing countries. Furthermore, the opportunity for the NHS to learn from developing countries is very restricted. Overcoming this could be achieved by providing training in writing for international journals, soliciting submissions, accepting articles in languages other than English, assisting in editing suitable articles, and encouraging collaboration between experienced and less experienced researchers, whatever their origin.

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