

# Readers' Forum

---

## *District health libraries*

**Sir** – I refer to the article “Making a start with district health libraries” which appeared in *World Health Forum*, Vol. 15, No.1 (1). There are a number of points I find disturbing, as I have had some experience in establishing district health libraries in Africa.

From 1989 to 1991 I was a US Peace Corps Volunteer assigned to the Ministry of Health, Malawi, where I took over the implementation of a project to provide core collections of reference books for district hospitals as well as peripheral units (health centres, health posts, maternity clinics, etc.) in the districts (2). Funds for the project were provided through the Peace Corps Partnership Program (PCPP), which solicited contributions for each of the 24 districts – budgeted at about US\$ 2000 depending on the size of the district and the number of peripheral units; at the time it was the largest PCPP project ever undertaken. As in the above-mentioned *Forum* article, health professionals at district level were consulted as to the materials which they thought best suited their needs, but they were not limited to a selection from only WHO and Teaching Aids at Low Cost (TALC). Though both WHO and TALC publications were selected, it was found that most mid-level and lower-level health workers preferred copies of standard texts that could be obtained at low cost in ELBS editions subsidized by the Overseas Development Agency and the British Council. Many of the doctors found that what they missed most were current medical and health journals. Granted that not everyone can always get what he wants, it is still not absolutely fair to say that the informational wants of district

health workers are being met if they are only given a limited range of materials to choose from.

It may also be true that current periodical subscriptions for the 5–10 most desired journals for each district is unrealistic. However, it is possible to keep health workers in the periphery informed of the current contents of relevant publications through the distribution of current-awareness bulletins, an example of which is *Current health in Zimbabwe* produced by the University of Zimbabwe Medical Library (3). Such newsletters contain the title-pages or citations and abstracts of selected publications; health workers may then request photocopies of the articles they require from the source library. These current-awareness bulletins need not be restricted to international sources of information but should also include references to extremely relevant – but often overlooked – local health literature, as very few African periodicals are indexed in standard reference sources.

This brings me to what I believe to be a major oversight in the project in Tanzania and Uganda as reported. There appears to be no coordination or collaboration with existing health and medical libraries in the countries mentioned. No national medical librarians are mentioned as having been consulted in the article or the acknowledgements. There are large medical libraries at the Muhimbili Medical Centre in Dar es Salaam, Tanzania, and the Albert Cook Medical Library in Kampala, Uganda, as well as libraries in their respective ministries of health. If district libraries are going to succeed they will need both the moral and technical support that these central

libraries can provide. Central libraries can distribute health information to districts efficiently and effectively, help in ordering books, produce current-awareness bulletins that are targeted to specific audiences, and provide document delivery services which will cut down the cost of periodical subscriptions.

What is needed is not only the provision of health information materials in developing countries, but an integrated approach to the utilization of these resources.

**Marc J. Lippman**

Consultant, WHO Regional Office for Africa,  
P.O. Box 6, Brazzaville,  
Republic of the Congo

1. **Materia E et al.** Making a start with district health libraries. *World health forum*, 1994, **15**: 89–92.
2. **Snyder LA.** Implementation of efficient pathways to health information: the Malawi model. In: *Medical libraries: keys to health information. Proceedings of the Sixth International Congress on Medical Librarianship, New Delhi, 24–28 September 1990, Vol. 1, Papers.* New Delhi, Medical Library Association of India, 1990: 453–457.
3. **Patrikios H.** Health service priorities in a developing country: biomedical and health information support in Zimbabwe. In: *Medical libraries: keys to health information. Proceedings of the Sixth International Congress on Medical Librarianship, New Delhi, 24–28 September 1990, Vol. 1, Papers.* New Delhi, Medical Library Association of India, 1990: 337–342.

**Sir**— We agree with the authors of “Making a start with district health libraries” (1) that libraries can be an appropriate, cost-effective resource for continuing education. However, in our experience, for information contained in libraries to be truly effective these resource centres must be integrated into the learning process and continuing education strategies.

Together with the Continuing Education Programme of the Ministry of Health, Tanzania, we have been working to establish or develop six zonal continuing education resource centres countrywide. Later this year a number of

district level centres will be built. This project, which receives support from the Overseas Development Administration in the United Kingdom and the Baring Foundation (UK), is providing a range of health information literature and audiovisual and teaching aids, supporting the local production of health learning materials, providing training to resource centres in documentation skills, and developing outreach strategies to encourage the use of the centres.

While we agree that TALC and WHO publications are useful, we nevertheless feel that access to other sources of information is equally important. For example, various information needs assessment studies (2, 3) have found that newsletters and journals are a particularly valuable source of up-to-date knowledge. Resource centres need to provide a range of information in a variety of formats that are appropriate for various target audiences.

Our experience has indicated that it is not sufficient for a resource centre or library just to have a relevant collection of “essential” books available. It is also necessary to provide training to staff to help workers find the information they need. Furthermore, it is simplistic to assume that the mere acquisition of new information is sufficient to enable health workers to carry out tasks: the active use of information needs to be part of an integrated continuing education process.

Newly emerging resource centres are in danger of becoming mere depositories of information, and mechanisms are needed to ensure that they are responsive to the needs of the continuing education programme and its various components. We believe the challenge in the second phase of our project is to work closely with programme coordinators to ensure maximum use of the resources contained in the centres. This can be achieved

through problem-solving approaches within continuing education along with outreach and marketing strategies, activities which are often overlooked.

Because of a lack of bibliographic control of locally produced material in developing countries, especially in Africa, it is often easier for librarians to continue to acquire health information published in Europe and North America. Yet some of the most valuable health information is produced locally and should most certainly form a significant part of any zonal or district library or resource centre. In the Tanzanian project an important activity is identifying locally produced health learning materials and research documents. Working with colleagues from the Ministry of Health, zonal continuing education centres, medical libraries, and nongovernmental organizations, attempts are being made to ensure that copies of their documents, training manuals, etc. are sent to the zonal resource centres. The Centre for Educational Development in Health, Arusha (CEDHA) is also participating in the African Index Medicus project of the WHO Regional Office for Africa, Brazzaville, which aims to improve access to bibliographic and other information resources relating to health issues of African countries.

Where documentation skills have been found lacking in the resource centres, basic training has been provided. Again, our experience has shown that this, too, must be seen as a process: training that is confined to a short workshop often results in low impact. Following a skills training workshop for zonal resource centre staff, visits by trained librarians and an on-the-job training system were initiated to provide the continuing support necessary for strengthening skills and enhancing the provision of information services.

### **Sheila O'Sullivan**

Informations Systems Coordinator, AHRTAG, Farringdon Point, 29–35 Farringdon Road, London EC1M 3JB, England

### **Wilson Lendita**

Librarian, Centre for Educational Development in Health, Arusha (CEDHA), P.O. Box 1162, Arusha, Tanzania

1. **Materia E et al.** Making a start with district health libraries. *World Health Forum*, 1994, **15**: 89–92.
2. **Lendita W, O'Sullivan S.** *National continuing education programme: resource centre needs assessment, April–May 1991.* Arusha, CEDHA, 1992.
3. **Muya EW, Mbatia EW.** *A report of an evaluation of library development services for rural health facilities and institutions in Kenya.* Nairobi, AMREF, 1988.

### **Reflections of a psychoanalyst**

**Sir**—No one can deny the importance of the issues raised recently in a Round Table by Dr Jean Martin based on the premise that uncontrollable consumption of resources in the industrialized countries (the North) plus rapid population growth in the developing countries (the South) will exhaust the planet and, in the longer term, threaten its very survival (1). Aware as I am of Dr Martin's deeply humanitarian concern, I am sure that his intention was to alert public opinion and not to shock—still less to offer cut-and-dried solutions.

I am neither an anthropologist, nor a demographer, nor a moralist. I am a psychoanalyst. In that capacity, I am interested in unconscious mechanisms, whether individual or collective. For many years past my principal research areas have been domestic suffering and the problem of AIDS (prevention, psychological support and solidarity). From that viewpoint, I see the prolific exchange of views elicited by this Round Table as hinging on three implicit (unconscious) themes: briefly, the anguish of death (individual and

collective); man as consumer in the North; and woman as procreator in the South.

■ **Individual and collective death.** Scientists, just as much as the media, contribute to shaping a mentality rooted in the denial of death. We should like to be immortal and we therefore expel from our consciousness the anguish of death, which is nonetheless very much there in our unconscious. Commercial advertising promotes belief in the possibility of eternal youth; death is not the natural conclusion of life, but is seen as an affront to our individual narcissism and an avoidable accident. The people of the North have evidently forgotten that "to practise philosophy is to learn how to die".

■ **Man as consumer in the North.** Till now, it has been mainly men who originated the technological discoveries which have gradually changed our environment. But men have also become the theoreticians of a new world, of a new manner of life in which progress – particularly in medical research – will cure all diseases and avert the prospect of death. And yet we must all die one day.

■ **Woman as procreator in the South.** Woman in the developing countries is at the core of this debate, for it is she who contributes, physiologically at least, to the near-exponential population growth of the countries of the South. In our unconscious, she is held responsible for this birth-rate explosion and is therefore guilty in relation to society, however great the value we attach to motherhood. In my concern with AIDS, I have had clinical confirmation of the fantasy of the wicked, death-bringing mother, unconsciously held responsible for the spread of the epidemic although the epidemiological data belie any such responsibility. In areas with high birth-rates, due to the natural desire to bear and rear children, we should try to understand what is

experienced at the deeper level by women in countries where there is high infant mortality. As Dr Martin says in reply to those contributing to the debate: "the improvement of the health of mothers and children is the best 'pill'".

Women should have priority in our health aid and development drive. That, I feel, is the key to "natural" birth control. It is also essential that women be better represented in our committees on ethics, development and other issues. In that connection I greatly appreciated the contributions of Vangie Bergum and Cécile De Sweemer-Ba.

In conclusion, I should like to thank *World Health Forum* for drawing our attention to one of the major problems of our time which, in sociological terms, can be epitomized as the conflict between what psychoanalysts since Freud have called the pleasure principle and the reality principle. I would add that, unlike Dr Martin, I do not believe in such an opposition between collective interest and individual interest. The individual possesses a capacity for altruism, for antinarcissism, which is too often underrated, perhaps owing to exacerbation of egocentricity by certain media and, in particular, by advertising. In the final analysis, is not the real opposition that between society and political and other pressure groups?

**André Ruffiot**

Professor Emeritus,  
Pierre Mendès France University,  
B.P. 47X, 38040 Grenoble, France

1. **Martin, J.** Would Machiavelli now be a better guide for doctors than Hippocrates? *World health forum*, 1993, **14**: 105–114.

### ***No place for herbalists in modern medicine***

**Sir**— In modern medical care diagnosis plays a key role, whereas traditional medicine treats only the symptoms. For example, jaundice may be due to infectious hepatitis, a block in the biliary passage, or malignancy in various sites such as the liver or pancreas. As self-limiting viral hepatitis is the most common cause, a successful “cure” can often be claimed by traditional herbalists; however, their treatment for the other conditions mentioned above could have disastrous results.

There is an urgent need for extensive research to evaluate the claims of traditional methods; until then we remain in ignorance of their validity. After investigation and evaluation, yoga and transcendental meditation have been accepted in modern medicine as having some benefits, and several traditional drugs have similarly been recognized. After a correct diagnosis of illness, the patient could be allowed to choose the method of treatment, and a later comparison of results might lead to new discoveries.

I believe it is dangerous to promote traditional practitioners as an official link in the health delivery system. The fields of maternal and child health, surgery, traumatology, oncology, pathology, and bacteriology are unknown to them, and it is impossible to integrate modern medicine into traditional systems, which are basically different.

We now have many government medical colleges for the education of doctors, so to train quacks is unnecessary and dangerous. It will not achieve the desired results, but only enable the government to claim that health care has been delivered to rural areas.

Worldwide achievement of health for all can be nothing short of a sincere attempt to ex-

tend scientific medical facilities, especially in disease prevention, and to stimulate economic progress and education. Then the problems will solve themselves. To talk of utilizing the services of the herbalist is defeatism.

***Yakubu Buba Komta***

Box 429, Gombe,  
Bauchi State, Nigeria

### ***Impediments to breast-feeding in hospitals***

**Sir**— My first experience of breast-feeding my son Aljoshia was not the picture of mother and child bliss that advertisements portray: instead of a calm, confident mother looking rested and happy with a chubby, smiling infant, I was haggard and worried. As he was seven weeks premature he had been in intensive care, and for the first nine days I had been bottle-feeding him with expressed breast milk. When Aljoshia was fit to leave the hospital, the paediatrician said that I should begin breast-feeding him straight away. A nurse whom I had not met before led me to a small, brightly lit conference room with shuttered windows and handed me, first, a pack containing a rubber nipple shield, two gauze pads, and two alcohol towelettes, and then my infant. I had no idea what to do with the pack, so I set it aside and put my drowsy baby to my breast. When I looked up to ask the nurse if he was positioned properly I realized that she had left.

Instead of beginning to suck vigorously Aljoshia relaxed and fell asleep. Twenty minutes later, a different nurse bustled in with her arms outstretched for him, asking me how many ounces he had taken. I was so confused that I just stammered. She shook her head in disgust and swept out of the room with my baby.

This experience left me feeling discouraged and ashamed, and my respect for and trust in the medical establishment was shattered. Although my confidence in breast-feeding was shaken to the core, at home I tried to nurse Aljosha once more. Then I opened the infant formula given by the hospital staff; at the time I was thankful for it, but now I realize that it was not the boon it seemed. The standard breast-feeding education procedures in many of the USA's major hospitals are at best contradictory and confusing: bottles and pacifiers are routinely used by the nursing staff. Mothers who plan to breast-feed should inform the hospital staff that they do not want their babies to be given any artificial teats and pacifiers, in order to avoid nipple confusion before the breast-feeding relationship is well established.

Breast-feeding classes are offered at most large hospitals, either in conjunction with childbirth classes or separately. While such classes often provide valuable information, they cannot give hands-on help to each mother and baby as they take place before delivery. Much of the literature handed out in these classes is provided by pharmaceutical companies: the information is correct but there is a subtle undermining of the dedication to breast-feeding which is vital early in the nursing relationship. An example of this is the typical lack of reference to breast-fed toddlers: I assume this is because the manufacturers hope that mothers will have stopped nursing early and then change to formula.

Many hospitals present gift packs to all new mothers when they return home. If the packs contain formula samples it is easy for an inexperienced, tired and worried mother to give just one bottle to stop a restless baby's crying. Whatever the reason, this experience can signal the end of breast-feeding for many families. The glossy pamphlets of formula companies, frequently offering money-saving

coupons on their products, show beautiful women breast-feeding healthy babies with all the breast exposed, giving the covert message that discreet nursing is not possible and that we may prefer to use bottles in public. Because some mothers have difficulty expressing breast milk, what could be easier than filling the bottles with formula?

Free samples of strained infant cereals or fruits are just as insidious, as a mother may offer them to her baby before she had planned to in order to use them by the expiry date. Early introduction to solid foods not only interferes with breast-feeding by causing a reduction in the mother's milk supply when her full-tummied baby cuts back on nursing, but many paediatricians believe that allergic reactions can be serious in a tiny baby.

I would like to end on a happy note. My second son was born five years later in the same hospital, but this time I was forearmed. I joined my local La Leche League group early in my pregnancy and attended all the meetings, read extensively, and questioned the midwives about breast-feeding at every prenatal visit. I had the support of my husband, who had been out of town for Aljosha's unscheduled arrival, and he intervened whenever hospital procedures seemed to indicate that the baby might be given a bottle. I was able to nurse Sinjin shortly after he was born and keep him with me during our overnight stay.

I definitely believe that knowledge is power, and I urge all prospective mothers to assert themselves to remove the blocks to successful breast-feeding.

**Angela McCormick Owen**

P.O. Box 98,  
Taylor, AZ 85939, USA

### When do we need to use statistics?

From small beginnings the domain of statistics is now almost universal, and it is difficult to imagine any science worth the name where statistics has not proved its usefulness in one form or another.

Most spectacular in the modern world is the growth of scientific research, which is complex in nature and needs an extensive use of statistical methods. However, despite the fact that at the end of the 20th century statistics has become an inescapable, inseparable part of medicine, there are many instances where statistical methods are not required to accept or dismiss the effect of a factor on the outcome of a study. This is because the observed difference is either unusually high or too small to be of any practical importance. In other words, data essentially require balanced scrutiny by the researchers to decide whether or not there is any need to apply fancy statistics to confirm an observed difference.

We have come across articles in reputed medical journals where various statistical methods have been used pointlessly. For example, if cancer patients receiving chemotherapy survive more than twice as many months as patients receiving supportive care alone (1), we hardly need Kaplan-Meier and log-rank techniques to demonstrate that there is a longer survival time for those receiving chemotherapy!

Similarly, consider discharged patients being studied for compliance with their drug regimens who are randomly allocated to one of four groups, each of which receives counselling but two receive a reminder chart as well. Ten days later it was observed that the two groups of patients who had received reminder charts showed no significant difference in the proportion of correct answers to a questionnaire, and neither did the two groups who

had not received the charts. But when they were compared against each other, 83% of patients with reminder charts answered correctly compared with 47% of those with counselling alone (2). In this example the difference is so obvious that it does not need the chi-squared test to say that the reminder chart is an effective way of improving patients' compliance!

There is no substitute for rational thinking: the ability to judge the potential role of chance, without the aid of complicated statistics, is a valuable saving of time for researchers and for those who read their scientific papers.

It is not our intention to point out shortcomings of published scientific research work or to criticize journals publishing such work. We only wish to make a plea to aspiring research workers to use statistical tools prudently.

**P.A. Somaiya, S.V. Kakade, R.V. Awate & A.C. Urmil**

Department of Community Medicine,  
Krishna Institute of Medical Sciences,  
Karad 415 110, India

1. **Scheithauer W et al.** Randomised comparison of combination chemotherapy plus supportive care alone in patients with metastatic colorectal cancer. *British medical journal*, 1993, **306**: 752-755
2. **Raynor DK et al.** Effects of computer generated reminder charts on patients' compliance with drug regimens. *British medical journal*, 1993, **306**: 1158-1161.

### Health for all on the road

**Sir**—Accidents have become one of the leading causes of mortality in children and an enormous social burden in the developed countries. Much research has demonstrated that accident patterns are predictable and thus largely preventable. It is important to increase public awareness of the preventability of traffic accidents, particularly head injury in

young cyclists and motorcyclists, by encouraging the wearing of safety helmets. Safety helmets are central to many injury prevention programmes of the developed world.

Developing countries are now becoming increasingly concerned with the problems of road accidents. For example, in Iran the traffic department under the Lord Mayor of Teheran has launched a campaign against road accidents, consisting of road checks, radio broadcasts, and encouragement to film-makers to put educational messages into their films. Similarly, in Malaysia health promotional efforts in the media and campaigns such as Ride Bright (use of headlights by motorcyclists to increase their visibility) have been active for some time. National injury prevention seminars also achieved a high profile for accident prevention. All these activities increased the awareness of accidents among the general public and agencies involved in prevention. A further step forward will be to evaluate these campaigns for their effectiveness, and future efforts need to be focused on changing the behaviour of road users: research has demonstrated that a combination of education and enforcement is likely to result in a desired change.

The need to have well-organized multidisciplinary teams for accident prevention should be stressed. Countries should be integrating accident prevention strategies into their overall efforts to achieve health for all, with the aim of making roads safe for users of every category: motorists, motorcyclists, cyclists, and pedestrians.

Local accident prevention groups can do much to stimulate efforts in the community. An admirable example is the Corkerhill project in Glasgow, Scotland. This project resulted in generation of local accident data and the designation of a "safe community", thanks to the collaboration of local commu-

nity leaders and academics (1). Such a partnership highlights the different roles in accident prevention. With a few exceptions, commitment from health professionals is sadly lacking in developing countries, where they are still absorbed in combating infectious diseases.

If the potential years of life lost from domestic or industrial accidents were added to road accidents, the toll would probably be equal to that from infections. Mass preventive efforts are already overdue for this very important public health danger; perhaps "Helmets for all two-wheelers" would be an appropriate slogan for accident prevention in the 1990s.

**Thein Tun Ohn**

2437 Taman Sri Aman,  
Kubang Kerian,  
Kelantan, Malaysia

**Ali Monterazzi**

2 Lilybank Gardens,  
Glasgow, Scotland

1. **Bryce C, Roberts H, Smith SJ.** *Safety as a social value: a community study of child accidents.* Glasgow, Public Health Research Unit, 1993.

---

***Insulin: availability and cost***

**Sir**— Since the discovery of insulin in 1921, attempts have been made to ensure that all people with insulin-dependent diabetes mellitus have access to the drug. This principle was stated clearly by the WHO Expert Committee on Diabetes Mellitus in 1964 and 1979, and all WHO Member States reaffirmed their commitment at the World Health Assembly in 1989. The main nongovernmental organization dealing with diabetes, the International Diabetes Federation (IDF), has pressed for many years for insulin to be available at reasonable cost to all who need it.



Recently the IDF conducted a survey of its 85 member associations to establish a clear picture of insulin availability throughout the world (1). On average in the 60 countries from which replies were received, one sixth of all diabetic patients required insulin treatment: 47 countries reported that insulin was always available, but 11 reported that it was available for 25–99% of the time, and in Tanzania and Uganda for less than 25% of the time. At the same time two separate, smaller surveys of individuals were conducted in Africa, one of which found that insulin was often (64%) not available in small towns and rural areas; even in large centres, half of the 50 respondents said insulin was sometimes or often not available (2). The other study noted that insulin was not on the essential drugs list of Benin, Comoros or the Congo (3).

Even when insulin is available, cost can be a limiting factor. In 39 of the 60 IDF countries surveyed insulin was free when available, whereas in 15 countries the patient bore the whole cost. The mean cost of a vial of the cheapest insulin was least in the Middle East (US\$ 2.70) and South-East Asia (\$ 2.80), but was \$ 9.20 in Africa and \$ 12.20 in South and Central America. This quantity would last no more than a month – and less in many cases – and obviously represents a major financial

burden for many families. So even when insulin is available many cannot afford it and will die as a result. It is estimated that in sub-Saharan Africa there are 163 000 insulin-requiring diabetics and that the annual cost of sufficient quantities of insulin for their treatment should be \$ 25 million. In the current economic climate, where more and more countries are requiring financial contributions from individuals for their own health care, there is a likelihood of more and more diabetic patients dying from lack of insulin. Urgent action is required from donors, industry, WHO, and nongovernmental organizations such as the IDF to ensure that this does not occur.

**K.G.M.M. Alberti**

WHO Collaborating Centre for Training,  
Education and Research in Diabetes,  
University of Newcastle upon Tyne,  
Framlington Place,  
Newcastle upon Tyne NE2 4HH, England

1. **Deeb LC, Tan MH, Alberti KGMM.** Insulin availability among International Diabetes Federation member associations. *Diabetes care*, 1994, **17**: 220–223.
2. **McLarty DG, Swai ABM, Alberti KGMM.** Insulin availability in Africa: an insoluble problem. *International diabetes digest*, 1994, **5**: 15–17.
3. **Savage A.** The insulin dilemma: a survey of insulin treatment in the tropics. *International diabetes digest*, 1994, **5**: 19–20.