Letter from Zambia
‘Naught for your comfort’

Sirs,

From the privileged position of the academic, removed from the harsher realities of clinical medicine, it is difficult fully to appreciate the health problems of Zambia. The elderly white person, like me – for life expectancy for men is under 50 – can still ‘enjoy’ a somewhat colonial lifestyle with servants, clubs and High Commission. The poor of Lusaka are kept at bay by barbed wire, 24 hour security guards and the apparent invincibility of the expensive motor car over the pedestrian. The statistics of health and disease – so alarming, so inaccurate – do not impinge. The camel has always found the eye of the needle a problem. My change in social status and possession of wealth as a white man in this part of Africa is a sore embarrassment after a life in public health medicine in England, where one neither belonged to the rich elite nor wanted so to do.

Yet life in Zambia in 1997 must be like living in Victorian England, where death was all around and accepted as part of the way of life. Indeed, the culture is imbued with the funeral and attendance at the funeral. Staff are always excused for a funeral and anything is cancelled for a funeral. The funeral is at short notice, and is expensive in time, travelling and in the hospitality extended to very many guests. The frequent funerals can be extremely disruptive in a hospital or business, and cause much unplanned and sporadic absenteeism. Grief is expressed openly and noisily; the coffin-makers ply their trade with profit (the cost of a simple coffin equates to the monthly average wage). There is a major problem in finding burial grounds reasonably near the city of Lusaka – cremation is unacceptable. The University Teaching Hospital alone with some 1800 beds provides 30–40 funerals a day. The death rate in the children’s wards can reach 30 per cent in the wet season, and 70–80 per cent of patients on the adult wards are suffering from terminal AIDS.

The statistics are incomplete and of poor quality. The 1993 data suggest 40,000–50,000 deaths per year from AIDS in a population of 9.5 million, with 1:3 of these deaths in children: the predicted figures for 1997 are 80,000–100,000 deaths. In 1993 there were 70,000 AIDS orphans and by 2000 there will be between 200,000 and 500,000. The population growth rate in Zambia is 3.6 per cent, i.e. the population doubles in number every 20 years; even with AIDS the growth rate will still be 2.5 per cent. The saddest features are the 25–30 per cent of young pregnant woman who are HIV positive at first booking, the 40,000 cases of ‘open TB’ a year, and the early death of the young, bright and educated, leaving behind an increasing number of dependants in growing poverty.

Anecdotally, as a medical student in London in the 1960s, with a resident population of medical and dental students at Guy’s of about 1000, I recall two student deaths: one a suicide, the other a car accident. In the Lusaka medical school in the last two years and with a resident population on campus of 250 students there have been five deaths – an annual death rate of 1 per cent. For nurses the death rate in Lusaka in 1992 was 0.2 per cent; it is now 2.7 per cent. It would seem that being a nurse in Lusaka is more dangerous than being a deep-sea diver or miner, the classical occupations of high mortality. Barclay’s Bank employs some 1800 staff country wide – an educated elite of young bright Zambians. In 1987, the bank paid for six funerals for staff: by 1992 this had risen to 38 in a single year. The Mother Superior of a local convent has had two of her siblings die of AIDS. It is a long, sad rollcall. Nobody is immune.

The medical schools of the United Kingdom are concerned about the risk to their students on elective from HIV. They need not be. A surgeon and missionary doctor just returned to England after nearly 40 years working and up to his elbows in blood daily; but with appropriate precautions was brave enough to have an annual HIV test and has remained comfortingly negative. HIV is very largely an STD.

So we have to live with AIDS and get on with living and dying well for the foreseeable future. Good practice in hospital does work; effective treatment for STDs makes a real difference; discordant couples can continue to live together and have penetrative intercourse regularly and without transmission of infection to the negative partner. Condoms work and work well. There is still stigma, reluctance to be tested and fear of knowledge becoming public. There is reluctance to put HIV on the death certificate. Thus even simple prophylaxis against TB and candidiasis may not be offered, let alone family, social, financial and personal support. The screening of saliva may help, but there is no programme of population screening and the best data come from the antenatal clinics. The evolution of the disease is much more rapid – HIV positive to death from AIDS in 3–5 years is common, for there are no affordable drugs to treat the debilitating diarrhoeas, or the cryptococcal meningitis, let alone primary treatment aimed at the virus. Even AZT is unaffordable, and ‘triple therapy’ a slave’s dream. People rarely live long enough to develop the complex diseases.
of immunological suppression such as CMV and Pneumocystis carinii.

Between the rich world and the poor world there is already a huge energy gap, a huge consumption and pollution gap, the vital communication chasm gaps wider, and now there are two HIV diseases. In the rich world, AIDS is now a chronic disease afflicting a minority still separated by their sexual mores and chaotic drug use from the rest of society, and it can be held at bay for long periods, albeit with costly combinations of toxic drugs. In Zambia, it is a sub-acute disease affecting a fifth or more of the people and afflicting everyone by its impact upon the society of today and the children of tomorrow. Amidst this poverty, this squalor, the multiple infections and infestations, a positive HIV test is a death sentence to be executed within 3–5 years. There is a dignity, there is too a fatalism — when there is no hope ... just cope.

Note

The above is the personal view of the author and not necessarily government policy.

Yours faithfully
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'Syndromes' and reasons not to do a project

Sirs,

We have all mixed feelings before starting a project — and have at least temporarily tried to escape them. I think this painstaking decision-making process consists of a set of 'syndromes'. One or probably several of the 15 syndromes below have sometimes hit us all. To have suffered from them is a normal part in the life of any scientist.

The syndrome might be based on reality — even be factual — but may also form a hidden or overt excuse to avoid challenges. The natural history varies — cure, remitting or chronic.

You may use this to diagnose the project syndrome profile of yourself and others and use it for prevention and treatment.

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Reason</th>
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<tbody>
<tr>
<td>Technocracy</td>
<td>I must have funding before I start project A</td>
</tr>
<tr>
<td>Corruption</td>
<td>I must have equipment A before I can go further</td>
</tr>
<tr>
<td>Hyperlogism</td>
<td>I must have data A analysed before I take on data B</td>
</tr>
<tr>
<td>Analysm</td>
<td>I want to go more in depth with problem A before I can write something meaningful</td>
</tr>
<tr>
<td>Sequentialism</td>
<td>I must finish project A before I start with project B</td>
</tr>
<tr>
<td>Escapism</td>
<td>I shall take on project A when I have more time</td>
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</tbody>
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Yours faithfully
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NHS performance guides: raising the standard — indirectly?

Sirs,

The NHS performance guides are now published annually to 'help you and your family doctor decide where you can go to get the best services'. The guides award hospitals star ratings for a number of simple 'performance' measures. Like star ratings for hotels, these have been awarded on the basis of percentages: e.g. over 90 per cent in a given measure attracts five stars. Unlike star ratings for hotels, mostly awarded on 'provision' (e.g. proportion of rooms with private bath and WC), hospitals have been awarded stars on 'performance', e.g. proportion of waiting list patients admitted within 12 months.

The performance tables present a very limited picture of the standard of care by NHS hospitals and doctors; other health professionals and hospital managers have ample grounds for criticizing their presentation, emphasis and content under that