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Chris Lavy

BMJ 2005;331:46-47
doi:10.1136/bmj.331.7507.46

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Open letter to Tony Blair on publication of the report of the Commission for Africa

Chris Lavy

As world leaders prepare to discuss Africa at the G8 summit, a British doctor working in Africa gives his perspective on the continent's health needs and points out some omissions in the recent report

Department of
Surgery, College of
Medicine, Private
Bag 360, Blantyre 3,
Malawi, Africa
Chris Lavy
professor
lavy@malawi.net

BMJ 2005;331:46-7

I want to congratulate you, Prime Minister Blair, on the hard work that you and your team have put into the Commission for Africa's report.¹ It is an honest document, probing gently but fearlessly into the reasons why so many endeavours in this great continent have failed. You emphasise the responsibility of African leaders to drive development from within Africa but at the same time make clear the responsibility of the richer countries to commit to serious partnership in the process, with the aim being Africa's development rather than their own. I am sure you don't need reminding that these principles will be difficult to put into practice, but I am hopeful that the report will be a template for action.

When I heard about the commission last year I tried to contact you, requesting that at least one of the commissioners be involved in health care. Maybe you were overwhelmed by advice, as my letters went unanswered. However, your report has touched on matters of health, with sections on HIV and AIDS, tuberculosis, and malaria. These diseases are of enormous importance and are already being tackled by many groups in Africa. I am not involved in HIV treatment myself, but many of my patients are infected by the virus and my wife is working in a palliative care project for dying children, most of whom have HIV or AIDS, so I know first hand of the misery and hopelessness in so many lives.

You also touch on the enormous need for healthcare professionals. I can echo this in surgery. At present Malawi, a country of 12 million people, has only one Malawian orthopaedic surgeon and one Malawian general surgeon in the entire government health service. The rest of us surgeons are imports. During his training, the general surgeon had two fellow registrars. One is now in the United Kingdom, sadly not the first doctor to leave and help staff the NHS. We hope he comes back, but many don't. The other was tragically killed in a minibus crash on Malawi's roads. Also, not the only colleague I have lost to road trauma.

I was disappointed not to see anything on the surgical needs of the continent in the report—for example, a section on the escalating road traffic injuries in Africa. The World Health Organization estimates that around 200 000 people a year, or 500 a day, are killed on African roads. These numbers are probably an underestimate, and they are predicted to increase by 80% over the next decade. Studies show that for every road death about 15 people are badly injured, thus several million people are killed or seriously affected by road crashes in Africa each year. Your report mentions that a key to development is cheap transport and suggests that halving road transport costs would lead to a fivefold increase in transport. This would undoubtedly be beneficial to a developing economy, but can you imagine what it would



Corrective surgery is available to only the lucky few

DIETER TELEMANN/PANOS

do to road deaths? I am sure you know that the UK's Commonwealth Development Corporation was responsible for 13 trauma related deaths in developing countries last year, more than half of these on roads, and although the corporation made an impressive £15m (\$27m; €22m) profit from the African continent,² I doubt that any of that profit was used to improve trauma services.

I do not want to take anything away from the important research work into HIV related diseases, but WHO reports that a respectable \$85 per quality adjusted life year (QALY) is being spent on HIV, whereas less than 1% of this, only \$0.80 per QALY, is being spent on eminently preventable road traffic injuries.³ I rest those facts with you and the governments that read the report, but I also rest them with those companies that benefit from Africa's cheap labour and use its roads for profit, knowing that most people injured on those roads have a minimal chance of getting adequate care.

Another surgical need closer to my own work is that of the hundreds of thousands of children with a physical disability that prevents them from walking, or walking properly. These children have conditions such as club feet (where they walk on the sides of their ankles), angular deformities (such as bow legs of more than 90°), and osteomyelitis (where infection has destroyed whole sections of their bones). Most of these children are not dying and have a normal life expectancy; they just lack any effective appropriate

treatment. For many of them a single intervention such as corrective surgery or an appropriate appliance can greatly improve their mobility, their future independence, and, of course, their future economic productivity.

Conditions in healthcare institutions in many countries in Africa are getting worse not better. In Malawi's biggest hospital, elective surgery has all but stopped and no plaster of Paris is available. The commission's report makes it clear that one of the factors needed to improve standards in Africa is political will. In many health services this is lacking because those who make policy and govern funding do not use the local health services; they go abroad. Many profitable companies have been set up in South Africa and Europe to jet people from poor African countries to private clinics for everything from backache to heart surgery. A professorial colleague of mine in a neighbouring country gave a public valedictory lecture on his retirement. He said that there was one simple thing that would improve national health services dramatically overnight in Africa, and that was to make government officials use them. He could not continue the lecture for five minutes because of the standing ovation.

Humans are born with hope, and although standards of health care are dropping, some encouraging exceptions to the general rule keep us going. In orthopaedics, your Department for International Development has sponsored a scheme in Malawi to train orthopaedic clinical officers for every district hospital. They are not doctors or orthopaedic surgeons and they have minimal equipment, but they have a useful training in common trauma and save lives every day. I must mention also an international initiative by the newly formed College of Surgeons of East Central and Southern Africa, which comprises 10 countries, to train African surgeons in Africa, for Africa, and by African surgeons. Such locally driven training programmes are far more appropriate than scholarships to the West. They are also more cost effective. Projects like this bring results but need the support of G8 countries.

I was intrigued that your report found it necessary to defend overseas aid, presumably from the cynics who say that it is the root of all Africa's problems. I agree that it can be useful if it is well thought out, but it can also be misdirected. For example, international donors are building two new district hospitals in Malawi complete with several beautiful operating theatre suites. But the hospitals do not have surgeons or sufficient other staff to run them. Maybe half of the money spent on theatres could have gone on training staff. Aid gaffes can also be amusing—for example, a hospital in another part of the country was recently built with interruptible infra-red beams instead of taps. State of the art plumbing may be useful in the urinals in Amsterdam airport but it is not too sensible in rural Africa where electricity is unpredictable and infra-red engineers not plentiful. They were fun to play with, but I am told they all broke in the first few months.

Prime minister, thank you for lifting our eyes to see that there are health problems bigger than those of the NHS. But I want to end with a challenge for you and for all of us. UK doctors are interested in global health inequalities. You only have to read the *BMJ* to see regular articles on the subject. For example, only recently we read a well argued case proposing a tax on preventive drugs of dubious benefit, demanded by the worried



Restraining a patient with mental illness: conditions in many African hospitals are getting worse

healthy population in the UK, which could be used to fund needed drugs in poorer countries.⁴ With all this professional interest should the UK merely try to do the barest minimum and give its 0.7% of national income to development aid? Certainly we should do that, but perhaps as the country that instigated the Commission on Africa we could take a lead and plan on 1%.

Could we in medicine also take a lead and expand our global outlook? Could we look closely at the ethics of research that only benefits rich minorities? Could research funding be specially earmarked for projects that benefit health care in Africa? Could we look at how our universities can strengthen medical training in Africa rather than training African doctors in the UK? Could the NHS even encourage career paths for the UK doctors that include spending time in Africa? This would need approval of relevant colleges and could be in selected centres but would show solidarity with our colleagues in Africa.

I look forward to hearing from you.

Contributors and sources: CL was born in the UK but lived the early years of his life in Uganda. He trained as an orthopaedic surgeon in the UK and was a consultant at the Middlesex and University College Hospitals London until 1996 when he moved to Malawi. He now works for several charities dealing with the surgery of disabled children, and is a professor in the department of surgery at the university of Malawi. He is supported by Christian Blind Mission International. The ideas in this letter are his own but result from discussions with many colleagues.

Competing interests: None declared.

- 1 Commission for Africa. *Our common interest*. London: Commission for Africa, 2005. www.commissionforafrica.org
- 2 Roberts I. Death on the road to international development. *BMJ* 2005; 330:972.
- 3 Ad Hoc Committee on Health Research Relating to Future Intervention Options. *Investing in health research and development*. Geneva: World Health Organization, 1996.
- 4 Heath I. Who needs health care—the well or the sick? *BMJ* 2005; 330:954-6.

(Accepted 8 June 2005)

Endpiece

Our greatest skill

Many a times I find my patients disturbed by trouble of Conscience or Sorrow, and I have to act the Divine before I can be the Physician. In fact our greatest skill lies in the infusion of Hopes, to induce confidence and peace of mind.

Culpeper

Submitted by Ivor Hughes, chief executive officer, Herbdelta NZ Ltd, West Auckland, New Zealand