Patient population movement in a Cape Town obstetric service

To the Editor: Recent funding constraints in the Western Cape coupled with an increased workload at our institution prompted us to conduct an exit survey of our patients, with particular emphasis on their province of origin and movements.

The question of movement was prompted by concerns regarding the provision of formula for patients in the PMTCT programme (prevention of mother-to-child transmission of HIV). The survey was conducted by contract workers in the patients' mother tongue using pro forma pilot-tested questionnaires. Delivered patients were surveyed at discharge over a 2-month period at Mowbray Maternity Hospital and over a 1-month period at Khayelitsha Midwife Obstetric Unit, in the latter part of 2002 (Table I).

During the last week of data collection the contract workers were asked to collect comments from patients.

The majority of women who had lived in Cape Town for more than 1 year but less than 10 years commented that they did not consider it their home. They returned to their places of origin for holidays, and many lived in informal settlements while in Cape Town.

One of the main reasons given for coming to Cape Town was inadequate health facilities in the place of origin. Students attending school, technikon or university were likely to be in town for 2 - 6 years. Babies born to these women were sent to relatives in the Eastern Cape while they remained to complete their studies, returning 'home' for breaks. On qualifying the women often returned home or went wherever they could find work.

Women also commented that they preferred to spend their pregnancies in Cape Town and to stay there for the duration of their babies' immunisations. They would return 'home' between pregnancies or after their childbearing years.

Less than half the hospital patients had always lived in the Western Cape, and the origin of the majority was the Eastern Cape, Seventeen per cent of all women (hospital plus midwife unit) had been resident in the Western Cape for less than 1 year (Table I).

Our study suggests that the Western Cape is the preferred health care provider for many obstetric patients from the Eastern Cape. Although we did not directly study the reasons in depth, this preference may be the result of a perceived deterioration of the health services in the Eastern Cape and the availability of an organised PMTCT service in the Western Cape.

Out study highlights the mobility of certain parts of the population. This has clinical implications in terms of basic understanding of the current culture, follow-up care, particularly PMTCT, and the choice mothers make in terms of formula feeding or exclusive breast-feeding.

Table I. Results of exit interview survey (%)

	Hospital (*N* = 439)	Midwife unit (*N* = 184)
Always lived in Cape Town	186 (42)	9 (5)
Origin Eastern Cape	234 (53)	169 (92)
Resident in Cape Town < 1 year	57 (13)	33 (18)
Resident in Cape Town < 1 year returning < 6 mo.	43/57 (74)	17/33 (51)
Reason for visiting Cape Town		
Study	79 (18)	60 (33)
Work	82 (19)	57 (31)
Medical	13 (3)	12 (7)
Unspecified visit	87 (20)	57 (31)

Our findings also have administrative and financial implications. Funding has been diverted from the Western Cape to the Eastern Cape in terms of provincial equity based on population, yet the patient flow is in the reverse direction. Funding of Western Cape health services must be maintained to prevent their collapse from overload until such time as the Eastern Cape health services are sufficiently developed and inspire confidence in the local population. Failure to do so will result in suboptimal care to mothers and babies in both provinces.

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Israel, Iraq, Zimbabwe — should we care?

To the Editor: Professor Ncayiyana's editorial in the April *SAMJ*[1] clearly illustrates the dangers of medical journals dealing with political questions. Presumably health issues relating to political conflicts should be of primary concern to medical specialists, yet it seems that Professor Ncayiyana is more interested in using the forum to expound his political views. This is illustrated by his editorial, which devotes five paragraphs to the Israel/Palestine question and three sentences to Africa and Zimbabwe in particular.

In 2½ years of the Intifada, 3 000 Palestinians and Israelis have been killed. Should these deaths be of greater concern than the deaths of millions of others around the world, including in Africa, who have died violently during that period? According to a World Health Organisation report issued on 3 October 2002, some 1.6 million people die every year from acts of violence that encompass war, murder and suicide.

The reality is that in today's climate of uncontrolled crime a South African has a far greater chance of meeting a violent death than a Palestinian. Palestinians, moreover, even under current circumstances, have access to a greater level of medical care than vast numbers of people in the Third World.

Reality is also not reflected by the nature and number of headlines. The impression being created is that Israel has used its military might to kill Palestinian civilians at random. The statistics, however, completely disprove this contention. While Israeli civilian deaths display a varied age distribution, Palestinian civilian fatalities are heavily concentrated among male teenagers and young adults, reflecting the age groups that have directly confronted the Israeli army. In addition Israeli civilian females, in comparison with Palestinian civilian females, have been killed in a ratio of 3:1 in direct contrast to the overall casualties in the conflict.

Simplistic statements such as that the Israel Medical Association has 'consistently declined to condemn the use of torture' have no place in a medical journal without accurate research having been done. The question can also be asked how many medical associations in the 47 Muslim and Arab countries have condemned the endemic torture in those countries or how many of those associations have condemned suicide bombing.

All Israeli hospitals are apolitical. Patients and staff at all levels are both Jews and Arabs, wards are mixed and everyone who enters the hospitals receives equal treatment. Israeli hospitals have always treated, and continue to treat, hundreds of Palestinian patients each month. Palestinian doctors are receiving specialist training at Israeli hospitals, and within the Israel medical establishment there is a great desire for co-operation. Yet even before the start of the Intifada the Palestinian Authority was reluctant to co-operate with Israelis in many fields, including the medical field.

Before the outbreak of the Intifada, four joint Israeli-Palestinian health committees functioned fruitfully. Palestinian physicians were involved in residency and training programmes in Israeli academic hospitals, and Israel provided medical services to Palestinian patients. An average of 4 500 Palestinian patients were admitted to Israeli hospitals every year and an annual average of 9 000 Palestinian patients received ambulatory services.

Since the beginning of the Intifada Israeli hospitals have continued to provide medical care to Palestinian patients. About 600 patients from the West Bank and Gaza were referred to Israeli hospitals every month, about 200 of them for hospitalisation and 400 for ambulatory services. This included consultations at outpatient clinics, day care, diagnostic procedures and laboratory tests. The Palestinian Authority stopped payments to Israeli hospitals and its debts have accumulated to more than US$10 million. Nonetheless Israeli hospitals continue to admit Palestinian patients and casualties for treatment without delay and without any restrictions.

The provision of public health laboratory services to the Palestinian Health Authority continues, free of charge. Palestinian patients on haemodialysis treatment due to chronic kidney insufficiency were transferred by the Israeli Defence Force (IDF) to Israeli hospitals in cases where movement to a specific Palestinian hospital was not possible. Cancer patients in need of radiotherapy were transferred to Israeli hospitals by the IDF. When the Palestinian Health Authority requested approval of patient and/or casualty transfers for treatment abroad, Israel responded positively to all requests.

Dr Benjamin Sachs, a Professor of Obstetrics, Gynaecology and Reproduction Biology at the Harvard Medical School, visited Hadassah Hospital in Jerusalem less than 24 hours after a suicide bus bombing in Jerusalem. He recounts the following story: 'Hours earlier, teams of Jewish-Arab doctors had done what they've done for the past 2 years: jumped into action to save the lives of the critically injured. On Israeli television the night before, the father of the homicidal bomber bragged that he was proud of his son who had attacked a busload of schoolchildren and senior citizens. On the day we arrived, that same father suffered chest pains and was brought to Hadassah. He was seen by the same doctors who were still treating the victims of his son's madness.'

As for the pure political issues which Professor Ncayiyana refers to, Abu Mazen, the incoming Palestinian Prime Minister, has made it clear that it was the Palestinian use of guns, bombs and rockets that gave Sharon the excuse (some might say he was obligated) to take the action he did. He also stated that the Palestinians had spurned nine or ten opportunities to reach a ceasefire.

In any conflict one must consider the facts leading to the dispute. The Intifada was initiated in the midst of peace talks in which the Palestinians would have received virtually all they claimed. Barak's government went further than any previous government would go. One must therefore conclude that the real intention of the Palestinians was the destruction of the State of Israel. The Israeli response was initially blunted. Only when the real Palestinian intention became clear did Israel invade in an attempt to stop the bombers at their source.

In Abu Mazen's words, '(Palestinian) terrorism is destroying a just cause'. In Professor Ncayiyana's words, Israel will quickly revert to the 'old' Israel as soon as it is clear that

moving out of Palestinian areas and easing controls will not result in many more dead Israelis.

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1. Ncayiyana DJ. Israel, Iraq, Zimbabwe — should we care? (Mini Editorial). *S Afr Med* J 2003; **93:** 229.

Rural radiology in central Africa

To the Editor: This short report describes radiology management in a rural area in central Africa.
The IME/Kimpese Hospital founded in 1950 is a rural hospital 220 km south-west of Kinshasa in the Democratic Republic of Congo. It serves a population of about 150 000 who are very poor and are unable to afford hospital care. Radiological equipment and supplies are very expensive and difficult to obtain.

The radiology unit at the hospital has a room for the performance of radiology examinations, a darkroom, a radiologist's office, a waiting room, toilets and a storeroom. Two radiographers and a darkroom technician staff the unit. The equipment comprises a single mobile unit manufactured in 1980.

From 1986 to 2001, 61 154 radiographic examinations were performed, averaging 319 per month, of which 97% were simple X-rays. Most X-ray examinations were considered successful, and the 3% that were unsuccessful were attributed to lack of image amplification, inadequate films and patient problems.

Difficulties experienced include the high cost of radiological examinations, lack of technicians to service the equipment, lack of films and other radiological requirements, and lack of further training for the radiographers.

New radiological equipment is required as well as a need to address the other listed problems.

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Erratum

In the scientific letter entitled 'Massive hepatomegaly due to visceral leishmaniasis' by Dawood *et al.*, which appeared on pp. 441 - 442 of the June 2003 *SAMJ*, there was an error in the sixth paragraph. The dosage of amphotericin B should have read 60 mg/day and not 60 mg/kg/day.