ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH

INTERNATIONAL CHILD HEALTH GROUP

NEGLECTED HEALTH ISSUES IN CONFLICT

Dr. Tejshri Shah, former head of the MSF-UK medical unit

The impact of conflict on the health of children rightly remains a crucial concern for medical professionals. In this article, I highlight four key areas that need attention from policy makers and health providers who work with conflict-affected children. Before doing so, I will outline three reflections that need to be considered in this discussion: firstly, the nature of conflict; secondly, the importance of a broad medical approach rather than focusing on needs exclusive to conflict; and finally, the importance of health professionals remaining as advocates for all people affected by violence, rather than entering a debate that creates a competition between essential needs.

The word "conflict" has many definitions and interpretations, and "violence" may be a more encompassing and relevant word to use. The nature of conflict has evolved from the idea of opposing armies in combat to that of counter-insurgency warfare. As such, we must not restrict ourselves to the front-page conflicts, but should also recognise that many such hostilities are under-reported. We should also be cognisant of contexts where pervasive violence prevents access to health care, as the needs of children affected by urban gang violence in Rio de Janeiro are similar to those in conflict-affected Afghanistan.

Although conflict (or violence) does result in unique health needs, such as the requirement for acute trauma services, many issues simply result from lack of access to health care and the breakdown in resources and infrastructure; through incapacity, willful neglect, and even active harm. As a result,

Inside this issue:

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Join **CHILD2015:** A free email discussion group that explores the information and learning needs of health workers in developing countries.

www.dgroups.org/groups/CHILD2015/

The aim of **CHILD2015** is that "By 2015 every child will have access to an informed health care provider". To join CHILD2015 send your name, organization and brief description of professional interests to

Child2015-admin@dgroups.org

many health needs in conflict are not dissimilar to those resulting from poverty. Thus, when we set-up a life-saving field hospital, we must not neglect children with medical needs not related to violence, such as diarrhoea or pneumonia.

Another reflection relates to the very concept of neglected health issues in conflict. We need to use epidemiology to guide our broad public health measures, but we cannot afford to neglect *any* sick child. As front line physicians our duty is to treat and talk about the health needs as we see them. We should not be tempted to enter into public competitions between different critical needs, such as the treatment of visceral leishmaniasis versus tuberculosis or primary vaccinations versus the treatment of chronic malnutrition. We may have to make painful practical choices in the eye of the storm, but these should be temporary compromises. We must stay unsatisfied and be bolder in our demands for adequate health provision according to need. Advocacy is a commitment that we must also make for our patients.

Having given these reflections, I would like to emphasise four areas in paediatrics that need attention. The first two issues (treatment of childhood malnutrition and the care of newborns) are more pervasive across contexts. The second two (care after sexual violence and mental health) are more associated, but not exclusively, with conflict.

More than a third of child deaths worldwide are attributed to under-nutrition[1]. It is estimated that only 3% of the 20 million children suffering from severe acute malnutrition each year receive the treatment they need[1]. Malnutrition needs dedicated attention in areas of conflict and violence. Although long-term solutions are needed, we have a therapeutic obligation and indeed the necessary tools now.

To quote Gabriela Mistral from 1948 "Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot answer 'Tomorrow'. His name is 'Today'. [1]

Neonatal care has arguably received increased attention in recent years, and there has been

Editors Note

- We would like to welcome Dr Jay Halbert as a new member of the editorial team
- Following the Winter ICHG conference on Conflict and Child Health we present a 'conflict' themed edition including an overview of conflict and the effects on child health, the proposed resolution which came out of the Winter meeting and a personal account of the indirect effects of conflict on child health and nutrition in Darfur.
- This is the first electronic issue of the newsletter, we hope you enjoy the slightly longer format and please feed back to us any suggestions for improvement.
- We would like to wish all members of ICHG a happy and fulfilling 2011!
- The newsletter will continue to be posted on the ICHG website at the end of the year www.ichg.org.uk

Many thanks Dr Delan Devakumar & Dr Helen Brotherton

reported progress[1]. Despite this, we estimate that more than 350 babies younger than one month of age die per hour[1]. Data collection has its limitations and families often do not report the death of a newborn, since for some communities neonatal death is accepted as a norm. How many of these deaths could have been prevented by relatively simple, low technology measures?

Hospital clinic in Burundi. T.Shah

Sexual violence affects all groups of people in war but especially women and girls. The statistics paint an incomplete picture of this crime; however, when data are available, they are often horrifying. In eastern Democratic Republic of Congo (DRC) in 2010, a survey revealed that around 40% of women had been sexually violated[1]. This problem is not diminishing, and there are continued reports of mass gang rape. The response from health providers is slow: some argue it is too complex; others are possibly ignorant to the fact that this is not only a human rights issue but is also a medical emergency; and others just oversee the problem because they are busy with their "basic interventions".

This is not to diminish the provision of basic interventions but to recognise that the care for survivors of sexual violence *is* a basic human need.

My final issue relates to the wounds that we do not see and therefore do not rush to treat: psychological trauma in children and their carers. The 2010 study in DRC found that half the population met the symptom criteria for post-traumatic stress disorder. Compared to the efforts we make to identify and support children in the UK who are affected by emotional abuse and neglect, we need to invest much more in psychological support and research into effective mental health strategies in violent contexts. For child development, mental health support is possibly just as important as treating malnutrition.

The statistics and the reality of human suffering in today's world are unimaginable, especially given how much can be alleviated with the tools we already have. There is no room for complacency in our words or actions, because every child matters.

1.WHO. 10 facts on nutrition. http://www.who.int/features/factfiles/nutrition/facts/en/index.Html (accessed 14 Nov, 2010).
2. Médecins Sans Frontières. Treatment of malnutrition. http://www.msfaccess.org/main/malnutrition/treating-malnutrition/treatment-of-malnutrition/ (accessed 14 Nov, 2010).
3.Shiffman J. Issue attention in global health: the case of newborn survival. *Lancet* 2010; 375: 2045–2049.
4.Rajaratnam JK, et al. Neonatal, post neonatal, childhood, and under-5 mortality for 187 countries, 1970—2010: a systematic analysis of progress towards Millennium Development Goal 4. *Lancet* 2010; 375: 1988–2008. **5.**Johnson K, et al. Association of sexual violence and human rights violations with physical and mental health in territories of the Eastern Democratic Republic of the Congo. *JAMA* 2010; 304: 553–562.

The Conveners Report from ICHG Winter Conference 2010: Conflict and Health

This year we chose to use the Winter meeting as a springboard to advocacy. Senior members, including Tony Waterston our longtime member and erstwhile 'Advocate General' to the College, has been agitating for some time that we could make better use of our Winter meeting towards this end. So we went for total immersion following in the wake of Retired Professor David Southall into the murky waters of conflict and health care. I was pleasantly surprised that we managed to half fill the Kennedy Lecture Theatre at the Institute of Child Health, London, on such a mine-strewn topic, although admittedly it was strongly supported by our growing student membership.

It was rapidly apparent why so many turned out. The speakers were strong, the cause was clear and there was a campaign to launch. After a morning hearing uncomfortable facts and testimony from varied conflict zones it was inspiring to realise with our principal speakers, Professor Leonard Rubenstein, President of Physicians for Human Rights (PHR) and Dr Robin Coupland, Medical Advisor on Armed Conflict to the International Committee of the Red Cross, we were with seasoned campaigners. PHR were awarded the 1997 Nobel Peace Prize as a founding member of the International Campaign to Ban Landmines. So when we heard that protection for healthcare in conflict zones felt like the landmines issue in the early days I, for one, was encouraged.

Debate on the resolution. D.Devakumar

The afternoon allowed for more detailed discussion of the proposed resolution which naturally led to spirited debate. This allowed the Group to hone the message and the target audience. A couple of us were charged to work the document up and send it round which resulted in some fine tuning and the final version which is reproduced here. There is an extensive pre-amble which gives an introduction and background to the issue, which can be read on the following pages.

This resolution is now being pushed by ICHG in a number of directions involving RCPCH, RCOG, RCN, MPs and NGOs (Merlin have an active campaign in this area see http://www.handsupforhealthworkers.org/). I look forward to the impact this rolling ball will no doubt have as it builds momentum.

As we move into the planning cycle for 2011 do you have a global child health issue that demands action? Would you like to organise a meeting bringing international speakers to a day for knowledge and action? We will be meeting in the New Year to plan future meetings so get in touch.

With seasons greetings, Dr Matthew Ellis

The International Health Protection Initiative (IHPI)

A resolution on the need to ensure the protection of healthcare during armed conflict

David Southall and Rhona Macdonald

"The medical community has a responsibility to speak out collectively to protect health workers in fulfillment of their ethical duties to the people in their care, without risk of arrest or attack on themselves or medical facilities. Governments and non-state actors should be held accountable for abiding by obligations to respect medical functions in war."[2]

Current situation regarding healthcare and conflict

Between 2003 and 2008, 39 countries had active armed conflict within their territories.[3]

Increasingly, warring factions are targeting vulnerable patients through attacks on healthcare professionals, health facilities, and medical transport vehicles, including ambulances and those supplying essential life-saving drugs and medical supplies. Such actions are "part of generalised violence directed towards civilians to achieve a political goal, E.g. ethnic cleansing, government destabilisation, control or forced movements of populations, or demoralisation of a population sympathetic to an enemy"[4]. In addition, some attacks on health facilities, health professionals or patients are designed for military advantage, such as preventing injured combatants from receiving healthcare.

In violation of humanitarian law, in particular the Geneva Conventions and their Additional Protocols, warring factions attack wounded or sick individuals, threaten, intimidate and attack nurses and doctors, attack health facilities, especially hospitals, attack ambulances transporting sick or injured patients and illegally use health facilities for exacerbating conflict. In effect, this targeting of health facilities and patients results in the use of patients as human shields[2].

Furthermore, there is the influx of weapons that are used to terrorise, injure and kill civilians creating even more danger for people who cannot protect themselves[5,6]. In some conflict zones, it is impossible for local staff or incoming international organisations to provide healthcare because healthcare is not only unprotected from conflict, but is also specifically and explicitly targeted. An example of this illegal situation is the "corridor" outside Mogadishu in Somalia, where approximately 150,000 civilians are unable to access any healthcare[7].

Under the auspices of anti-terrorism, in conflict zones and in countries at peace, health care workers have been subjected to harassment, arrest imprisonment and even death for complying with their ethical duty to provide healthcare, irrespective of the political, religious or other affiliation or allegiance of their patients

Effects of armed conflict on maternal and child healthcare

Maternal and child mortality is higher in conflict and post-conflict countries than in poorly resourced countries that are not directly affected by conflict[8]. Girls and women are particularly at risk as they are less likely to be able to protect themselves from violence. Rape is used as a weapon of war[9]. In addition to the psychological effects in women who have been sexually assaulted, they are at risk of serious infection, such as HIV and hepatitis, the possibility of pregnancy that may result in miscarriage and heavy blood loss which, in the absence of blood transfusion or basic surgery, can be life threatening. There is also a high prevalence of septic abortion following self or non-professional attempts to end the pregnancy.

Internally displaced persons camp in Darfur. J. Jacob

Conceptions continue during conflict and, with the absence of contraception and the pressures on women to support often highly disturbed young men, the rate of pregnancy often rises. Women who are pregnant are subject to potentially life-threatening complications that cannot be placed on hold until the conflict has finished.

Most pregnancy-related emergencies can only be treated within hospitals and, apart from the fact that hospitals may have been incapacitated; there is also the great risk of travelling to hospital for treatment. The absence of functioning hospitals leads to many maternal deaths and results in permanent disabilities from untreated complications of pregnancy such as vesico-vaginal fistulae.

Infants and young children, because of their immaturity and dependency on mothers, are most vulnerable to malnutrition and infections such as gastroenteritis, pneumonia, malaria, tetanus, pertussis and meningitis. When food is scarce because of conflict, it is usually women and children who are least able to access adequate or appropriate nutrition. Whilst primary healthcare can do much to prevent these infections through immunisation and early recognition and treatment, inevitably there will be around 20% of children who, when ill, will require hospital/health facility levels of care.

Emergency care and surgical services to manage obstetric complications, major trauma from violence and from accidents, and other surgical emergencies are essential requirements for conflict-affected populations. This is particularly the case for conflicts in Africa, where essential surgical services are usually poor or absent before the conflict[10]. In a recent report, there were no operating theatres in seven post-conflict camps for displaced populations[11].

What can be done to minimise the effects of armed conflict on healthcare?

The expectation that countries or non-state factions involved in conflict will adhere to existing humanitarian laws, human rights law and medical ethics has proved to be invalid.

The Geneva Conventions of 1949 and their additional protocols 1977 contain statements designed to protect healthcare. However, as documented by Rubenstein and Bittle[1] these conventions were violated with impunity in most of the armed conflicts between 2003 and 2008. Recognising the challenges involved in providing robust information, regular and systematic documentation of attacks on health workers, facilities, transport and patients is lacking. International criminal justice institutions have potential power, but do not operate in the time frame necessary to protect healthcare during conflict.

UN or other peace-keeping forces are difficult to fund, have themselves been involved in abuses of women and children[12,13] , and have been inadequately mandated with regards to how far they can act in protecting civilian healthcare.

The International Red Cross and Red Crescent Movement, has been the most powerful global organisation "to protect life and health and prevent and alleviate human suffering wherever it is found in the world", particularly in situations of armed conflict.

Recently, Merlin, a UK based international medical charity, has produced a campaigning paper exploring the impact of conflict on health workers and the damage this has had on achieving the Millennium Development Goals. Their campaign, "Hands Up For Health Workers" "calls for national governments and international donors to fund and implement comprehensive national health workforce plans, to ensure health workers in crisis countries are trained, paid, supported, equipped and protected".

In conclusion, conference delegates at the ICHG Winter conference agreed that a resolution is now necessary to address health protection during armed conflict and that attempts should be made to obtain as many signatories of international healthcare organisations as possible to support this.

1.http://www.un.org/apps/news/infocus/sgspeeches/statments_full.asp?statID=387. **2**.Rubenstein and Bittle Responsibility for protection of medical workers and facilities in armed conflict. Lancet 2010; 375:; 329-40. **3.**Uppsala Conflict Data Program (UCDP) Department of Peace and Conflict Research, Uppsala,Universitet,2010http://www.pcr.uu.se/research/UCDP/. **4.**Slim, Hugo, 2008. Killing Civilians: Method, Madness and Morality in War. New York: Columbia University Press. 319 pp. ISBN 9781850658818. **5.** O'Hare and Southall J R Soc Med 2007;100:564–570. **6.** Control arms www.controlarms.org/en. **7.** MacDonald R Save Somalia! The Lancet,2008: 373; 2184. **8.**Spiegel et al PLoS Med 2009: 6; e10000093. **9.**Jewkes R, Comprehensive response to rape needed in conflict settings. Lancet. 2007 Jun 30;369(9580):2140-1. **10.**Chu, Trelles and Ford Lancet 2010;375; 262-267. **11.**Spiegel et al Lancet 2002: 360;1927-34.

12.http://www.savethechildren.org.uk/en/54_5706.htm.

13.http://www.unifem.org/news_events/story_detail.php?StoryID=685.**14**http://www.merlin.org.uk/images/libimages/2243.pdf (accessed 18 Nov 2010)

15. Signatories will be as many as possible of the global organizations and charities involved in providing healthcare

16.The Lancet January 7, 2009 DOI:10.1016/S0140-6736(09)60015-5

The International Health Protection Initiative (IHPI)
THE RESOLUTION

In response to escalating abuses of the rights to the provision of healthcare for all injured or ill persons affected by armed conflict, this resolution reinforces current international conventions. It aims to ensure the security of all health workers and healthcare facilities in situations of armed conflict[14] by enforcing all appropriate measures as follows:

1. We[15] call for international health organisations and their individual members, with the assistance of governments and the United Nations, to advocate urgently for the **protection** of the following basic rights for all people, particularly women and children, in areas of conflict:

   a. Freedom of all health care workers, patients and facilities from attack or interference, including the freedom of health personnel to provide care consistent with their professional duties.

   b. Freedom from interference with humanitarian initiatives to provide essential drugs and medical supplies

   c. Freedom from interference with safe transport of sick or injured people to and from health facilities

2. We call for support to improve the effectiveness and integrity of healthcare during armed conflict and to ensure that humanitarian health activity is more robust, predictable and accountable.

3. We call for States and non-State actors to fulfill their legal obligations to comply with international humanitarian law, including the Geneva Conventions and their Additional Protocols and customary international humanitarian law.

4. We call for leadership by the World Health Organization to develop methods and mechanisms for the documentation of all violations of international humanitarian law against patients, health workers, facilities, and transports and to provide guidance to member States in how to increase protection of health functions in zones of armed conflict.

5. We call for domestic and international prosecution of those responsible for intentional attacks on healthcare facilities, health workers, patients and the transport systems for providing drugs and medical supplies, which constitute war crimes under the laws of war.

6. We advocate for further support to be given to the efforts of the International Committee of the Red Cross in its ongoing and innovative attempts to protect healthcare in conflict.

As indicated in a recent editorial in The Lancet[16]: " it is time for a different group to step in and sign up to be the guardians of, and advocates for, the humanitarian health needs of civilians caught up in conflict. Who better to take up this role than the medical profession?"

Personal Account from Darfur

Dr Joseph Jacob, Specialist Registrar Radiology

Kings College Hospital, London

I was working in South Darfur, Sudan in 2006, as a doctor in a small town, whose well-tended paths and ordered compounds camouflaged recent troubles. On a background of intermittent janjaweed attacks, the original population of 35,000 had reduced by over a third in the preceding year as a split along tribal lines had splintered the cohesion of the town and resulted in the displacement of whole neighborhoods. In this setting we worked in a hospital that catered to a widely scattered community, some of whom could only access us by hitching rides on trucks that carried goods into town on a Wednesday, our weekly market day.

From one such truck, we received a seven-year-old boy whose family lived in an area that, with a lack of access to local health services had brought cases of meningitis, malnutrition, typhoid, eclampsia and several outbreaks of diarrhoea to be treated at our clinic. The family's village I was told, was sited in an area gorged by low valleys and carpeted green thanks to an abundant supply of water, but while the waterways and beaches of sand allowed quite a nice life to be had, the arrival of the conflict had changed everything. Now many young children with complicated malnutrition would arrive with sad regularity and even as we assessed them, we knew that the deteriorating security situation held total dominion regarding the likelihood of their staying as an inpatient or returning as an outpatient.

This boy arrived as yet another emaciated face with two huge dish-like eyes staring hollowly outwards. Whoever said that eyes were the windows to the soul could easily have been talking about malnourished children. In so many of them, be they acutely or chronically malnourished, the eyes are so magnified in proportion to their faces, that it's all you can focus on and is often the first sign that someone's getting better. A sudden hint of vitality, a flicker of interest in their surroundings may unexpectedly appear one day and then whatever you do or don't do, they'll improve. But in a tragic mirroring, death also shows itself in their eyes. A numb blankness that despite your best efforts all around the clock, seemingly holds a certainty that can't apparently be altered or even postponed.

Thankfully this child had life that grew by the day as we fed him up; a life we could register in

the creases around his lids and the narrowing of his canthi when amused or when half smiling at something his younger terror of a brother did. When it came to examine him, he lay down on his bed with some effort, out of breath, and maneuvered his distended abdomen for us, till he laid down perfectly flat. His disposition reflected his gaunt features as he spoke quietly and moved like an elderly patriarch, rather than the child his birth date attested to. His regal demeanor was further accentuated by his lordotic walk, a result of a swollen abdomen, which appeared subsumed with a tender mass so large that it shrunk all other viscera in comparison. Along with the generalized lymphadenopathy this clearly marked him out as a case of visceral leishmaniasis.

This child had the misfortune to be born in a conflict zone and then the additional bad luck of being bitten by the wrong sand fly but thankfully his situation finally did change after we were able to fly in some liposomal amphoteracin. With the initiation of treatment, the first sign of potential success was a beaming smile in response to his brother cheekily assaulting the latest new arrival in the therapeutic feeding centre. Soon after, he was able to physically pick his brother up and though he eventually required two courses of treatment, by the end of his stay with us, despite remaining thin and reserved, his slightly rounded face and rare bouts with his brother gave us short glimpses into the uninhibited child he had once been.

2011 David Morley Student Bursary 2011

The ICHG David Morley Student Bursary aims to fund an elective bursary in memory of David Morley, a founder member of our group, who died last year.

The bursary of £500 will be awarded to the best proposal from a student member of ICHG planning to study child health in a low-income setting during an elective period of study.

The application should take the form of a structured proposal of no more than 1000 words covering the student's aim, process (including brief details of place and local supervisor) and planned output.

Applications will be judged by members of the ICHG committee and should be submitted via email to ichg@rcpch.ac.uk.

Closing date 5pm, Friday 11 March 2011

The winner will be announced on Thursday 7 April 2011 during the ICHG session at the RCPCH Annual Conference at Warwick University.

The bursary of £500 will be presented in two stages: £250 on award and a further £250 to be presented on receipt of short report for the ICHG newsletter.

* ICHG Student Memberships cost £10 per year. Visit the ICHG website www.ichg.org.uk to download the membership form.

From Hiroshima to Afghanistan A brief outline of Medact's work in conflict and health

Marion Birch, Medact

Medact is an organisation of health professionals with a long history of working in health and conflict. Our aim is to mitigate and prevent the health consequences of violent conflict through policy and educational work. Medact has roots in the anti nuclear movement of the 1950s and is the UK affiliate of the International Physicians against Nuclear War. We approach this part of our work from several angles: working towards a Nuclear Weapons Convention and making the case for abolition on health and humanitarian grounds.

Health professionals have a key role to play in conflict prevention and mitigation; many deal with the devastating effects of violent conflict directly, all know in detail its potential to cause physical and mental damage, including the longer term public health effects. A bomb dropped on an electricity generating plant may kill few people immediately, but vaccines destroyed as a result of a break in the cold chain will leave children without immunisation.

Medact has written four reports on the health consequences of the invasion of Iraq that have documented its effects on the health of the Iraqi people and their health services. As a consequence we have hosted talks by Iraqi colleagues, contributed to numerous publications and events, and submitted evidence to the Foreign Policy Centre and to the Chilcot Inquiry into the Iraq war.

The health of those who have fled conflict to seek asylum in the UK is also a concern for Medact. We coordinate the Refugee Health Network which aims to ensure that vulnerable groups such as asylum seekers in the UK have access to the health care they need. A successful court case against the Department of Health in which we were involved helped to draw attention to the issue and clarify advice for health professionals.[1]

challenging barriers to health

Ensuring there is access to health care for vulnerable groups in the UK may become even more essential given the proposed changes to the NHS. Medact's submission to the recent NHS White Paper raised issues of conflict of interest, misuse of 'choice', and the inappropriateness of the market model for health.

Information that is as accurate as possible is essential for good health care and for an effective public health response to disasters and conflict. It can also shed light on how a conflict has been conducted. Medact is presently working to try and ensure that health information is not manipulated for political ends, and that the health workers who collect it are not at risk as they were in Sri Lanka in early 2009.

Education and awareness raising are key to all Medact's activities and together with colleagues in 10 European countries we have developed an on-line course in peace medicine (http://www.medicalpeacework.org/). Based on Galtung's concept of peace, it covers a wide range of health issues from structural violence to the treatment of migrants.

If you would like to know more about Medact's work on conflict or other issues please do get in touch, mentioning the ICHG newsletter, at info@medact.org or go to our website at www.medact.org. We welcome new members, who will receive regular updates about our work through our magazine Communique and monthly e-bulletins, and who can discuss issues with other members on our Medactivist email discussion group.

1. Cassidy J (2008) NHS Care for Overseas Patients Free for all? BMJ 2008;337;a1111 http://www.bmj.com/content/337/bmj.a1111.full accessed 14/12/10

ICHG meeting, Warwick University

Thursday 7th April
12:30-17:00

Business lunch followed by scientific papers

2nd Morley Lecture: **Prof Anthony Costello**

Participatory Groups for Development: an emerging evidence base

Other International Child Health events:

Tuesday 5tn April: **3.6 million neonatal deaths: are we delivering?**

Dr Joy Lawn

Saving Newborn Lives/Save the Children USA, South Africa

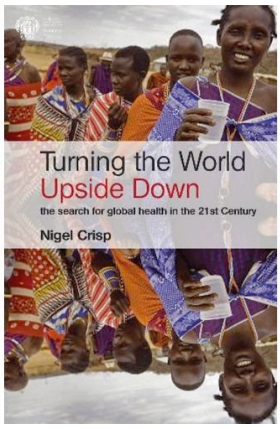
Turning the World Upside Down – the search for global health in the 21st Century

Nigel Crisp

2010: Royal Society of Medicine, London

ISBN 978-1-85315-933-6

Review by Matthew Ellis, Consultant Paediatrician, Bristol.



The reviewer must begin by declaring an interest. I took this readable, personal account of the state of global health with me to Uganda this month whilst participating in the Bristol – Mbarara LINK programme. This Tropical Health Education Trust and British Council funded programme supports bilateral links between UK NHS Trusts and Low Income Public Sector Health Institutions. This LINK programme goes to the heart of Lord Crisp's thesis eloquently laid out in this book; the old order of development and international health is falling apart and we need a paradigm shift towards a mutual global health movement based on a more bidirectional relationship which he calls co-development. Global Health, he argues, embraces those health issues that affect us all, rich and poor. These range from our immediately pressing concerns; communicable disease epidemics such as HIV and Influenza, aging populations requiring long term care for chronic non communicable disease and disability, health worker shortages to the longer term priorities; population growth and climate change.

He illustrates his argument with sweeping statistics which whilst illuminating appear at times somewhat unsubstantiated. The percentage of 'dependent people to those able to work is about 10% in Sub-Saharan Africa and 7% elsewhere'. Definitions of disability and fitness to work are a level of detail with which this work is not concerned. This is a book for the big picture lover, for lumpers not splitters. Occasional errors can be found; I know personally many more than the 'one' paediatrician he thinks are to be found in Nepal!

'Having run the world's biggest health service, England's NHS, for more than 5 years' Lord Crisp appears more authoritative when quoting macro health economic data. He pulls together fascinating data from WHO to show that whilst Europe spends 8.4% of GDP on health, 75% of which is governmentally funded and 25% privately funded Africa spends 5.5% of GDP, of which 53% is privately funded, 47% is governmentally funded and a relatively modest 10% comes from external resourcing ('aid').

Building on an extensive public health knowledge base most recently to be found in the Commission for the Social Determinants of

Health and with nods to the rediscovery of Alma Ata and the primary health care revolution he traces the importance of what he coins as wealth and society to the task of tackling disease and promoting health. There follows a brief consideration of health policy before he turns to firmer ground to address the health worker workforce issues.

With a WHO estimated shortfall of over 4 million health workers globally he reminds us that in the global market it is hardly surprising that with scarcity comes value and migration towards higher reward areas of the global market. He puts the problem of migrating health workers in context by emphasising the lack of health worker training as the key shortfall. If all of Africa's 135,000 doctors and nurses working overseas were to return it would make little impact on the 1.5 million skilled health workers required on the continent to enable 4 out of 5 women to have a skilled birth attendant, the current WHO target.

Crisp's contribution to the development of a Code of Practice for the recruitment of health workers internationally with WHO is to be applauded. In the concluding section of this book he calls for a massive expansion in health worker training with input from high resource settings. Which brings us back to the LINK programme and small scale efforts at co-development. These will have to be hugely expanded if significant progress is to be achieved.

This book is not solely focused on low resource settings. The need for a more participatory, patient centered approach to chronic non communicable disease is discussed in some depth. For the UK based reader Lord Crisp's reflections on progress achieved pursuing Blair's NHS Plan makes for an interesting, if less sensational, read than the recent outpourings of the inner circle of New Labour. He argues the acute waiting time targets inevitably deflected attention from the more radical agenda, but rightly celebrates the expansion in health workforce achieved over this period. For a community paediatrician like me there were several halleluiah moments of shared vision. But Crisp would be the first to admit there is a journey to travel without any real directions for getting there.

He argues that whilst the days when the market was believed to fix everything may be behind us so is Big Government. We are left with a pluralist, partnership web of interconnectivity to achieve change. This book describes numerous examples of such efforts from the impressive BRAC, the largest NGO in the world started in Bangladesh to Child 2015, the global network of child health professionals facilitated by the International Child Health Group.

These efforts are not top down government driven initiatives, but bottom up movements, participatory in philosophy harnessing practical knowledge for shared progress. Ultimately this 'upside down' approach relies on a shared vision of global health and healthcare and this book is an excellent starting point for British health worker's to explore the bigger picture. I shall certainly be recommending it for our medical students studying global health here in Bristol.

Obituary for Professor Ralph Hendrickse

We would like to report the recent death of Professor Ralph Hendrickse, a well-known and inspirational figure for many years in Tropical Paediatrics and founder of the Department of Tropical Paediatrics at the Liverpool School of Tropical Medicine. The following obituary was originally written by Professor Brabin, Liverpool School of Tropical Medicine, and is reproduced here with his permission.

Professor emeritus, Ralph George Hendrickse, MD, DSc, FRCP, FRCPCH, died peacefully aged 83 years on May 6th 2010, at his home in Heswall, Cheshire, England surrounded by his five surviving children. He was a man of many parts with an exceptional academic record. He was admitted aged 16 years to medical school at the University of Cape Town (UCT) and was among the first coloured persons to graduate MBChB from UCT in 1948. His family moved to Nigeria in 1956 where he was appointed Senior Registrar in Paediatrics at the University College Hospital in Ibadan, which at that time was a college of the University of London.

He returned to UCT in 1957 to write and submit his MD research thesis on sickle cell anaemia that laid the foundation for our understanding of sickle cell anaemia's clinical presentation in African children. After his return to Nigeria in January 1958 he was promoted to senior lecturer and in 1962 was appointed full Professor and Head of the Department of Paediatrics and subsequently named as the Director of the Institute of Child Health at the University of Ibadan, which was by then an independently charted university.

In 1969 Ralph moved to the School of Tropical Medicine in Liverpool to head up a new Department of Tropical Paediatrics where he also established the Diploma in Tropical Paediatrics and Child Health. He was duly appointed by the University of Liverpool as Professor emeritus of Tropical Paediatrics and International Child Health. In 1988 he was also appointed to the Deanship of the School of Tropical Medicine, and administered both posts until his retirement in 1991. He was greatly respected and admired by a generation of students at the School of Tropical Medicine and leaves an enormous legacy for many doctors, both overseas and in the UK, whose work and careers he promoted. He continued to teach for many years after his retirement at the School. He founded and was Editor in Chief of the Annals of Tropical Paediatrics, the author of two books, several book chapters, and over 100 journal articles

In June 1998 he was honoured and deeply moved by an invitation to UCT to be awarded the degree Doctor of Science honoris causa. The first in paediatrics awarded by the University.