NUTRITIONAL DIALOGUE: A LESSON FROM FRANCOPHONE AFRICA

SIR,—On Oct 4–10, 1987, the Groupe d'Etudes et de Recherche sur la Malnutrition (GERM) brought together in Nianing, Senegal, more than 140 workers from Africa, Europe, South America, Asia, and the USA. The main theme, predictably, was Malnutrition in the Third World Countries. The arrangements for this conference in Francophone Africa and the spirit in which it was conducted achieved an educational dialogue both between disciplines and between scientists and field workers. The scientists presented their observations in the field or their laboratory findings and this was followed either by a resumé from an expert or by a round-table discussion, with vigorous participation from the floor. The confrontation between "*labo*" and "*terrain*" (the meeting was in French) was both outspoken and productive.

In what way might the emphasis have been different if this meeting had been held in Anglophone Africa? The audience seemed relatively unfamiliar with the use of nutritional status as a predictor of risk of death. On the other hand recent work on the effects of malnutrition on the metabolism of toxins and the influence of inflammation on indicators of iron status were new to me. Other recent advances covered were the relation between thymulin, malnutrition, and infection and the conjunctival blot test of hypovitaminosis A. Those working in countries torn by drought or war contributed equally to the dialogue. It was salutary to hear that maggots make a significant contribution to the nutritional intake of children in one central African country.

The challenge, to the Anglophone, of attending a conference in French with no translation is to be recommended. The limits of one's pocket dictionary are a great spur to concentration and some words are unexpectedly attractive; "*echantillon*" surely sings in comparison with the cross-stitched flatness of "sample". The British were congratulated on their linguistic efforts; the excellence of the French spoken, also as a second language, by black participants was taken for granted.

The atmosphere was unusually open. Was this normal at Francophone meetings, I asked? The answer was uncompromising; GERM meetings are noted for the absence of those cliques and self-interest groups that characterise so many conferences. Also refreshing was the absence of destructive north-south confrontation. The meeting was supported by the French Government, the EEC, and UNICEF. There was also support from half a dozen commercial companies but this was unusually discreet and the lecture rooms were uncluttered by the promotional literature one sees at other gatherings.

GERM was founded in 1983 to promote exchange between people working on malnutrition in developing countries. It soon became clear that much nutritional research was being done in French-speaking countries but was published in English and was thus inaccessible to some workers. To strengthen links between French-speaking research workers, the proceedings of the 1984 and 1985 meetings were published in French, as the 1987 one will be. GERM members in Europe are enthusiastically supported by colleagues from sister institutes in Africa, notably the Association de Nutrition et d'Alimentation du Senegal which organised the 1987 meeting. The group is open to workers in human nutrition and associated sciences and to teachers and administrators with an interest in nutrition. GERM now has more than 200 members from thirty countries and plans to hold biennial meetings alternately in Europe and Africa. Africa and the needs of its research and field workers are well represented on the planning committees. In response to a request from Zaire, for example, the 1989 meeting in Belgium will probably include sessions on research methodology.

Surely this idea could be emulated in the British Commonwealth? Britain has two tropical medical schools and several other centres teaching overseas students. There are Anglophone centres of excellence in research in Africa, the Caribbean, the Indian subcontinent, and South East Asia. And there is much goodwill among that generation of African and Asian graduates who trained in British universities and among those Britons who have worked in Africa and Asia. We pay lip service to the idea of dialogue by developing special-interest groups (eg, in international child health) but all too often visitors from the Third World, though they may be seen, are rarely heard at medical and scientific meetings. In learning from the success of GERM we could go further than just a Commonwealth research group or society. A Commonwealth Institute of Nutrition would be an even more effective way of pooling ideas and resources. Research-workers could be trained and supported, and those talented workers born in Africa or Asia who now enrich many institutes in Western countries would find the resources and the encouragement to work in their native lands again.

My visit to Senegal was supported by the Wellcome Trust. Further information on GERM may be had from its president Dr D. Lemonnier, U1 INSERM Nutrition, Hôpital Bichat, 170 boulevard Ney, 75877 Paris, France.

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LOT QUALITY ASSURANCE SAMPLING IN HEALTH MONITORING

SIR,—Traditional survey methods commonly used to evaluate the delivery and impact of primary health care programmes are time-consuming and expensive, and often the results are for population units too large to be of use to lower level managers. We have been testing an industrial sampling procedure known as lot quality assurance sampling (LQAS)[1] to identify small population units (lots), such as health districts, that do not meet a pre-set level of performance in primary care. This trial should allow managers to focus supervision on the units thus identified.

LQAS is stratified simple random sampling, except that the samples from each stratum (lot) are too small to provide meaningful confidence intervals about the estimates obtained in that individual lot. Instead each lot is accepted or rejected on the probability of that lot being above or below a critical quality threshold. Results from lots can be combined to provide adequate precision about the estimates for larger population units. We provide here the results of one of the first pilot tests of LQAS to evaluate coverage in a mass immunisation campaign by the Ministry of Health in Lima, Peru, among children 3–14 months of age. Baseline immunisation coverage (children up-to-date in their immunisations) was assessed before the campaign. To identify lots in which coverage was greater than 80% we used a single LQAS scheme in which 9 children were randomly selected from a well-defined sampling frame in each lot. A lot was classified as acceptable if 3 or fewer children were found who were not up-to-date in their immunisation schedule. With this scheme, a lot with an immunisation coverage of 80% or more would have had less than an 8% probability of being incorrectly classified as having a coverage lower than the threshold. At the same time, a lot with a coverage lower than 30% would have had less than a 3% probability of being incorrectly classified as having a coverage above the acceptable (80%) threshold. Of the 12 lots, 8 were classified as acceptable. The combined estimate (and 95% confidence interval) for coverage in all 12 lots was 64% (55–73%) (table).

PILOT TESTING OF LQAS SCHEME TO IDENTIFY LOTS WITH IMMUNISATION COVERAGE BELOW CRITICAL THRESHOLD BEFORE AND AFTER IMMUNISATION CAMPAIGN

Lot no	Population size	First survey (n = 9)		Second survey (n = 14)	
		No not up-to-date	Lot rejected	No not up-to-date	Lot rejected
1	5104	1	No	9	Yes
2	10 203	3	No	8	Yes
3	5289	7	Yes	4	Yes
4	9729	2	No	3	Yes
5	9355	6	Yes	6	Yes
6	8684	2	No	7	Yes
7	4312	5	Yes	5	Yes
8	6491	3	No	5	Yes
9	7681	2	No	4	Yes
10	4446	2	No	4	Yes
11	10 036	4	Yes	3	Yes
12	4597	0	No	4	Yes

After the immunisation campaign, which Ministry of Health officials judged a success on the basis of numbers of vaccine dosages delivered, a second LQAS survey was done. In anticipation of an increment in coverage, a 90% threshold level was used. A LQAS single sampling scheme was selected with 14 children to be surveyed. The lot was classified acceptable if 2 or fewer children were found not up-to-date in their immunisation schedule. A lot with a coverage of 90% or higher would have had less than a 11% probability of being incorrectly classified as having a coverage below the threshold. At the other extreme, a lot with a coverage lower than 65% would have had less than a 10% probability of being incorrectly classified as having acceptable coverage. All 12 lots were classified as unacceptable. The combined estimate of coverage was 62% (55–69%) (table).

Review of the immunisation campaign records revealed relative over-vaccination of older children; only 20% of vaccine doses were given to children under 1 year of age. The heavy use of vaccine in children up to the age of 15 years resulted in shortages of vaccines in some centres, and it had been impossible to vaccinate 20–50% of children who came to the immunisation posts. We estimate that the real increase in coverage of children under 1 year of age could have been 4% or even less.

More extensive testing and evaluation of LQAS in a rural mountainous area and in an urban area of Peru is proceeding. Preliminary results show that LQAS monitoring by local supervisory health personnel is feasible and can identify population subunits with problems. Should the results of these evaluations continue to show the usefulness of LQAS, the possibility of instituting LQAS as a means of routinely monitoring specific health and service delivery indicators in population subunits will be entertained.

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1 Dodge HF, Romig HG. Sampling inspection tables: Single and double sampling New York. Wiley, 1959

GAZA'S HEALTH SERVICES

SIR,—Dr Aqel and colleagues (Nov 7, p 1090) give a misleading picture of health services in the Gaza strip, making it impossible for readers to appreciate what has been achieved. Gaza has been administered by Israel since the 1967 conflict, pending determination of its status in a peace treaty. The senior Israeli official is the military commander but he mainly deals with security. Community affairs are the responsibility of the civilian administration. Permission to visit is normally granted without reservation. During 1986–87 several visits by World Health Organisation consultants were successfully accomplished.[1] A team of physicians from Georgetown University visited UN Relief and Works Agency (UNRWA) health centres and refugee camps in the Middle East. They were prevented from visiting Syria and central-northern Lebanon (which is under Syrian influence)[2] but noted that refugees "are normally free to move in and out the camps". Israel permits such movements too and even allows movement to and from Arab countries which regard themselves as being in a state of war with Israel. She also facilitates pilgrimages to Mecca. Israel's liberal policy includes freedom of speech and information exchange. Since 1967 there have been several medical publications from Gaza, some by local physicians and some in collaboration with Israeli doctors. This collaboration yielded in 1986–87 a special one-year training programme at Beilinson Medical Centre. Palestinian doctors from the West Bank and the Gaza strip were trained in an ambience of complete academic freedom.

Voluntary health insurance (not available before 1967) is offered to all residents at a premium charged per family, irrespective of size or pre-existing illness. UNRWA "reimburses 60 percent of costs for refugees who are not enrolled in the government's medical insurance scheme".[3] UNRWA, husbanding a limited budget, faces hospitals claiming for full reimbursement so it is not surprising that three-quarters of Gaza's Palestinians subscribe to Israeli government insurance, which provides full hospital coverage.[2] Indeed the US university team concluded that care might be provided more efficiently by the established system of insurance than by relief support. According to UNRWA the infant mortality rate in the West Bank camps has fallen to 27 per 1000 in 1986 from 84 per 1000 a decade previously.

In 1986 9 UNRWA staff members were arrested; 5 were charged, tried, and sentenced.[3] Last year 2 out of 12 were sentenced and 2 are still detained.[4] These figures for convicted UNRWA personnel raise questions about staff loyalty. These workers (and anyone else) in Gaza had access to Israeli courts and the fact that UNRWA did not appeal on their behalf to a higher court suggests that it thought its staff guilty. Aqel et al refer to "demolition of UNRWA built refugee homes as a form of collective punishment". On rare occasions houses serving as bases for terrorism have been demolished but never as a collective punishment.

I am not familiar with the Medical Relief Committee. However, during 1986–87 Israel contributed to the occupied territories more than $28 million on top of the UNRWA budget for health, education, and social services,[5] besides financing in kind.[3,4] In the Gaza strip the government operates 24 health centres and 24 mother-and-child health centres, in addition to 5 hospitals and 9 UNRWA clinics. Interaction between medical institutions in the area and those in Israel has promoted efficient hospital administration and patient care and provides consultation opportunities for difficult cases. A direct result of these activities has been a sharp fall in perinatal morbidity and mortality and the eradication of epidemic infections.[1,2] In 1985/86 Shifa Hospital inaugurated large new departments of obstetrics and radiology and purchased a computerised tomographic scanner. The Gaza Health Services Research Center, WHO funded and managed by the UN Development Programme, was opened in 1986. All these activities, with the improved quality of life for the inhabitants in the area (77% have refrigerators, 78% television sets, 88% electricity, and 51% running water as of the mid-1980s in contrast to 3%, 3%, 18%, and 14%, respectively, in 1967) point to substantial improvements in infrastructure since 1967.

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1. United Nations Relief and Works Agency. Annual report of the director of health. 1986. Vienna: UNRWA, 1987.
2. LiLienfield LS, Rose JC, Corn M. UNRWA and the health of Palestinian refugees. *N Engl J Med* 1986; **315:** 595–600
3. Report of the Commisioner-General of the United Nations Relief and Works Agency for Palestinian Refugees in the Near East—1 July 1985–30 June 1986: supplement no 13 (A/41/13). New York: United Nations, 1986.
4 Report of the Commissioner General of the United Nations Relief and Works Agency for Palestinian Refugees in the Near East. 1 July 1986–30 June 1987: Suppl no 13 (A/42/13). New York: United Nations, 1987.
5. Addendum to ref 4 (Oct 19, 1987)

RANK INJUSTICE IN ITALIAN ACADEMIC MEDICINE

SIR,—I fully agree with Dr Fabbri (Oct 10, p 860) on the injustice of some associate professor appointments in Italy. One of my co-workers, Dr G. Cella, entered the "examination" for associate professorship in "medical semeiotics and allied subjects". 18 such posts were available throughout Italy and at most 3 other candidates had a scientific record comparable to his. Dr Cella's curriculum vitae included 65 full-length papers in non-Italian journals. Such papers have been widely cited so, on Fabbri's criteria, would have carried high scores. This candidate has two years of postgraduate training in the UK and two years of postgraduate work in the United States, and he was very well qualified for an associate professorship. The examining board could hardly prove otherwise. It might be claimed that criteria other than scientific productivity are important—namely, the critical evaluation of the papers in the