Readers' Forum

Humanitarian assistance should include aspects of sexuality

Sir – The recent article by Antequera & Suárez-Varela contains a comprehensive description of how a nongovernmental organization can tackle the health needs of displaced people in Rwanda (*1*). However, we were surprised by the omission of the reproductive health needs of the population in question. Only a casual reference occurred, concerning the availability of Caesarean sections.

The status of refugee women has long been recognized by the United Nations High Commissioner for Refugees, and attention to reproductive health needs for displaced people has been put firmly on the agenda. It must also be included in any analysis of the health needs of people affected by disasters and in consideration of action to overcome the difficulties. The United Nations Convention to eliminate discrimination against women requires all states to "help ensure the health and well-being of families, including information and advice on family planning" (*2*). Displaced persons should definitely not be excluded from such services. It might be argued that their need is even greater, as the desire to have children could be expected to be diminished and procreation postponed until more secure times.

Because of the breakdown of social fabric during emergencies and disasters, the risks of having unwanted pregnancies, being submitted to sexual violence, or contracting sexually transmitted diseases are considerable. An editorial in the *Lancet,* in 1993, pointed out that sexuality always remains an important issue in human life, even in refugee situations (*3*). We should not dictate to displaced people how to behave; by not offering reproductive health services we limit their possibilities to take decisions concerning their sexuality.

Our experience with the nongovernmental Reproductive Health Group, working with approximately 300 000 refugees from Sierra Leone and Liberia in southern Guinea, confirms the enormous need for reproductive health services. As soon as such services were offered the demand for them increased spectacularly. We strongly recommend that reproductive health services should be part and parcel of any relief effort for refugees or other displaced persons, as they are an indivisible part of the promotion of well-being of people in very difficult circumstances. ■

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1. **Antequera MG, Suárez-Varela MM.** Lessons on humanitarian assistance. *Bulletin of the World Health Organization*, 1999, **77**: 607–609.
2. *Convention on the Elimination of All Forms of Discrimination against Women, Article 10(h).* New York, United Nations, 1979.
3. Reproductive freedom for refugees. *Lancet*, 1993, **341**: 929–930.

Survey of malaria treatment and deaths

Sir – We read with interest the inquiry into malaria deaths by Dürrheim et al. (*1*). The authors emphasize very pertinent points. Mortality and morbidity in severe falciparum malaria are influenced by various factors, such as the level of transmission, the presence of multiple complications, age, pregnancy, etc. But scant attention has been given to the management of decisions (*2*). If the duration of illness or of coma is prolonged before a patient receives medical treatment, the prognosis becomes poor.

We conducted an internal audit of the patients treated for falciparum malaria in our industrial hospital, situated in a tribal belt of Orissa in central India. We analysed 901 consecutive patients (195 were under 15 years of age, 371 were aged 15–30 years, and 335 were over 30 years). Chloroquine was administered to 24.61% of the children and 35.55% of the adults (χ^2 test = 8.24, $P<0.001$). Quinine was given as the initial antimalarial drug in 57.6% of all patients (139 children and 380 adults, χ^2 test = 19.6, $P<0.001$). Mortality was lower among the children (1%) than the adults (4.4%).

Stahel et al. have demonstrated that the use of chloroquine has an antagonistic effect on alternative antimalarial drugs (*3*). It is therefore important to take the decision to administer the required drug from the very beginning, which may be a key factor in subsequent prognosis.

We believe the low mortality of children in our survey may be ascribed to the prompt use of intravenous quinine; early blood transfusion when indicated (*4*); and the recognition and management of multiple complications. ■

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Reference

1. **Dürrheim DN et al.** Confidential inquiry into malaria deaths. *Bulletin of the World Health Organization*, 1999, **77**: 263–266.
2. **Emerton DGC.** An audit of the management of malaria in a Tanzanian district hospital. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1992, **86**: 476– 478.
3. **Stahel E, Druilhe P, Gentilini M.** Antagonism of chloroquine with other antimalarials. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1988, **82**: 221.
4. **Lackeritz EM, Campbell CC, Ruebush TK.** Effect of blood transfusion on survival among children in a Kenyan hospital. *Lancet*, 1992, **340**: 524–528.

