Book Reviews

Fijian Medicinal Plants

By R C. Cambie and J Ash
Published by CSIRO Press Australia : 1993, 366p
ISBN 0 643 054049

Reviewed by Bill Aalbersberg
Reader in Chemistry
University of the South Pacific

Plant materials form the basis of the health care system for a vast majority of the world's people, including Pacific islanders. The World Health Organisation in the last decade has encouraged the use of herbal remedies as part of its "Health for all by the year 2000" project. Most Pacific countries, however, have been slow in integrating plant remedies into the formal health care system.

" ...[Fijian Medicinal Plants] will inspire additional research and publications on the rational use of medicinal plants as part of health care systems in the Pacific. "

This book presents in an attractive format information on about 450 plants used medicinally in Fiji, that has been previously published in a variety of places. For each plant the scientific name, Fijian name, botanical notes, reported medicinal uses in Fiji and elsewhere, and known chemical components are listed. Photographs or coloured reproductions of about 100 plants are appended. The introduction also discusses the arrival of medicinal plants in Fiji and their role in the traditional life of Fijians and their health care system.

The authors have done a very thorough job of combining data from diverse sources under one cover. This book will be of great value to anyone interested in the use of medicinal plants in the Pacific. It is hoped that this book will inspire additional research and publications on the rational use of medicinal plants as part of health care systems in the Pacific. □

Pacific Islands Social and Human Development

Published by the South Pacific Commission for the 1995 World Summit for Social Development, Noumea, New Caledonia: 1995, 131 pp.

Reviewed by Ichiro Kawachi
Harvard School of Public Health
Boston, Massachussets

The link between economic development and health is now well established. To take the example of infant mortality in the Pacific Islands , there is a clear inverse relationship between increasing levels of per capita gross domestic product (GDP) and infant mortality; the higher the average national income, the lower the infant mortality rate. At levels of GDP above A$10,000, the relationship seems to level off (overall correlation, r = -0.59) It was this kind of association that prompted many policy makers during the past decade to give special priority to economic growth over other social goals. In a version of economic theory known as the "trickle down defence of economic growth", it was argued that increased productivity was the way to cure most of society's problems, including poverty and its attendant burden of ill health. Trickle-down policies, originally devised during the Thatcher-Reagan years, were exported throughout the developing world by the International Monetary Fund (IMF) and the World Bank. The finer details of their "structural adjustment programs" are by now well known. cuts in government spending, promoting more "competition" in domestic and international trade, and turning over public enterprises to private management whilst dismantling administrative control.

The costs and consequences of such policies have yet to be fully documented. In sub-Saharan Africa, for example, 75% of countries had implemented IMF and World Bank sponsored structural adjustment policies between 1980 and 1986. By the mid-1980s, it had become apparent that higher costs of living, rising unemployment, and restricted government expenditures on social services had resulted in widespread declines in literacy and poorer infant nutritional status. As one group of observers noted: "The preoccupation (with) economic growth *per se* represents a retraction from any marginal moves in the 1970s towards a Basic Needs approach to development. In the context of adjustment, education, health and other social services that were

considered basic needs and basic rights are increasingly seen as commodities for purchase."

Which brings us to the situation in the Pacific Islands, where, in concert with the rest of the world, policies for economic growth have apparently been pursued at the expense of social spending. This Pacific report documents widespread declines among Pacific nations in public expenditure on health and education throughout the 1980s (Table 2 of the Report, page 25). In the health field, these budget cuts have particularly affected primary health care programmes in rural areas and all preventive health services. Without question, these expenditure cuts will prove detrimental to the public health. On the other hand, the Pacific report is careful to note that expenditure on medical care services is not the sole determinant of population health. Indeed the report's insistence that the well-being of the population depends on a much broader array of social factors is perhaps its most impressive feature. The broader factors identified included: the preservation of Pacific cultures and the role of the family; protection of the environment; population control; eliminating gender inequalities; and ensuring that the identity and rights of indigenous people are upheld in the development process. As a blueprint for *social* (as opposed to economic) development, the document is exemplary, especially in the section on poverty. Eschewing an exclusive focus on productivity growth, the report stresses the importance of an "equitable distribution of economic and development benefits... Economic growth by itself cannot ensure that poverty will be reduced or eradicated" (page 53).

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One of the most important ideas to emerge in recent years concerning the determinants of population health has been the notion that a more equitable distribution of income predicts the well-being of members in that society. Comparing countries across the world, it turns out that higher average per capita income predicts longer life expectancy up to about US$5000. Beyond this level of income, however, further increases in GDP have little or no impact on mortality and life expectancy, whereas the degree to which the national income is equitably distributed begins to have much more predictive power. In other words, it matters not just how much economic growth a country generates, but also how equitably these gains are distributed. According to this view, it is not sufficient that everyone's incomes are raised by policies to stimulate economic growth; what also matters is the gap between and the proportions of the rich and poor. To give a practical example, most Americans living in poverty still have access to indoor plumbing, electricity, a television set, and perhaps an old car. Yet the poor in America feel poor simply because their comparison group consists of other Americans living around them, and in relation to this group they are poor. Poverty must therefore be constantly redefined in the light of society's changing living standards. As society becomes more prosperous, the definition of what constitutes poverty has to be revised upwards. The American sociologist Christopher Jencks has elaborated on this theme:

"Contrary to what most economists assume, we cannot eliminate poverty simply by doubling or tripling everyone's income. This strategy would not work, because people need more goods and services when their society gets richer. Needs increase not just because people think they need more when their neighbours have more, but also for practical reasons

Many consumer goods ... started as luxuries but gradually ended up as necessities. Telephones were a luxury in 1900, when hardly anyone had one. Today, when almost everyone has a telephone, those without service are cut off from family and friends, who no longer write letters. Indeed, those without telephones often have trouble keeping a job, both because employers now expect workers to call in if they are sick and because workers without telephones cannot make hasty changes in their child-care or transportation arrangements."

William Dressler's work in developing Caribbean societies has drawn a clear link between health outcomes, such as hypertension and cardiovascular disease, and the stresses generated by thwarted aspirations in the context of modernization and economic development. Dressler defined thwarted aspirations as the discrepancy between an individual's occupational or educational status, and one's desired life-style as defined by possession of material goods, such as a television, air conditioner, and so on. This research found that thwarted aspirations (or "lifestyle incongruity") was related to higher blood pressure, independent of age, gender, and body mass. The implication of Dressler's work is that modernization in developing societies may create widespread expectations of social upward mobility which may not be realized within the constraints of local economies - unless careful attention is paid to the social and human consequences of economic development. The Pacific report makes a similar point in the context of education (p. 44): "A rapid expansion in education that is not relevant, in the absence of other fundamental reforms, will bring with it high social costs as expectations rise but are not met, and traditional cultural ties weaken. Improving the quality and relevance of education is therefore the basis of sustainable human development."

The unique challenge in the Pacific is that of defining and maintaining the "Pacific quality of life", which rests upon so many unique factors, including the dependence of the region on what governments do elsewhere in the world (as illustrated recently by the opposition of several countries including the United States, United Kingdom, Australia and New Zealand, to reduce carbon dioxide emissions by the 2005 to halt the progress of global warming). As a declaration of the principles of sustainable social and human development, this Pacific report represents an important step in the direction of defining the "Pacific quality of life".

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Copies of this report may be obtained by contacting the Secretary-General, South Pacific Commission, B.P. D5, Noumea Cedex 98848, New Caledonia. □

Journal of Community Eye Health

Edited by D.D. Murray McGavin, MD
Published by International Centre for Eye Health, Institute of Ophthalmology, Bath Street, London ECIV 9EL

Reviewed by K. David Khorram, MD
Medical Director
Centre for Eye Disease, Commonwealth Health Centre, Saipan, Commonwealth of Northern Mariana Islands

In surveys, people state that they are more afraid of blindness than death. Yet preventable and curable blindness remain common health problems in the Pacific and world-wide. The Journal of Community Eye Health is a superb resource for any clinician in the Pacific who encounters patients with eye problems and for administrators and other individuals who consider community and public health issues.

Conceived as an international journal to promote eye health, the journal enjoys a circulation of nearly 20 000 in 188 countries. Each issue carries a wide variety of articles presenting up-to-date material. Specific eye diseases are reviewed and discussed. Surgical techniques are described. Reports of community eye care services and public health efforts around the world are given. And abstracts from various other journals are included.

Volume 7 Issue No. 13, 1994 opens with an editorial by Dr McGavin which lays out the future plans of the journal. The lead article entitled 'Retinoblastoma in Turkey' which is a retrospective study of 535 patients with retinoblastoma, a childhood eye cancer. It describes the presentation, management and outcome of these children, most of whom presented for care relatively late in the course of the disease. The authors recommends that families and primary health care workers receive education about the disease, in order to improve early diagnosis and thus survival. The data provides a basis for making future comparisons of outcomes after such education takes place.

The next article in this issue 'The Surgical Treatment of Cataract' gives a step-by-step description of cataract removal by the extra capsular technique. The article is well written, easy to read, and well illustrated with graphics and photographs. The instruments which the author uses in the procedure are portable, low-cost, low maintenance instruments appropriate for the Pacific. The article is an excellent teaching tool and review for those learning, performing and assisting in cataract surgery.

'Ophthalmology in South-western Ethiopia' is on the background of the country, the ophthalmic services available, the specific services at one of the eye care facilities and a profile of major eye diseases seen there. He goes on to describe the problems faced in providing eye care to the communities in the region, and closes the article by describing various future plans for making ophthalmic services more effective. The approach is based upon primary eye care. The author captures the experience of many of those who have worked to develop eye care programs, and offers insight to those involved in any type of health planning.

The section of abstracts in this issue provides six abstracts on glaucoma, pterygium, and trachoma. They are drawn from such highly regarded international scientific journals as Ophthalmology, Eye and The Lancet. This section is very useful to the eye care professional in that it provides information which may not be easily accessible to many of us in the Pacific. The editors have provided the addresses of the authors so that reprints of the entire articles can be requested.

Also included in this issue is a list of courses offered by the International Centre for Eye Health. In 1995-96 a Certificate in Community Eye Health (one month), a Masters of Science in Community Eye Health (one year) and a Diploma in Community Eye Health (six months) will be offered at the Institute in London, England.

The articles are easy to read and address themes and issues which are of concern in the Pacific Islands. It is highly recommended for any individual interested in evaluating and improving health care in their communities, especially, but not exclusively, as related to combatting preventable blindness. The subscription is provided at no cost to those who do not have the financial resources to meet the $US40 subscription rate. No health care institution in the Pacific should be without the Journal of Community Eye Health. □

Prevention of Non-communicable Diseases in the Pacific: Training Module for Social Mobilisation and Community Action

Handbook No. 32. South Pacific Commission, Noumea, New Caledonia. MC Tessier, M Rosario, SA Finau, et al.

Reviewed by Alistair Humphrey, MBChB, DPH
International Diabetes Institute
260 Kooyong Road, Caulfield South, VIC3162, Australia

Effective primary prevention of non-communicable disease is extremely difficult to maintain against the rising tide of urbanisation in the Pacific. A multidisciplinary approach is essential and any primary prevention programme requires a well organised team which should include behavioural scientists, health professionals, epidemiologists, politicians and, most importantly, participation at every stage from those communities committed to tackling their non-communicable disease problem.

The **Training Module for Social Mobilisation and Community Action** is an easy to read manual which many health workers in the Pacific will welcome with relief. It fills a gap which has existed for years between theoretical texts about health promotion and the depressing epidemiological survey data charting the non-communicable disease epidemic in the Pacific.

The manual defines social mobilisation as "a process for engaging people in action for health improvement". The first chapter expands on the definition of this form of community development which primarily aims to change health related behaviour in a culturally and socially appropriate way towards specific health goals. Key figures in the community who should be involved in the process are identified and their roles are described. Chapter II explains in depth the central role of the health worker in social mobilisation. Health needs analysis, using thorough community consultation, is essential before planning can commence. Next, positive and negative motivating factors for specific risk factors of non-communicable disease need to be identified, and examples of these are provided. The importance of defining and limiting health related objectives with the community and then specifying clear goals for a preventive health programme is explained. Monitoring and evaluation of the programme and networking within the community are all outlined with a final detailed section on running training workshops for the various groups and individuals who will assist in the achievement of the specified goals. Chapter III expands on the workshops theme giving examples of how to facilitate group discussions and develop problem solving strategies.

" The importance of defining and limiting health related objectives with the community and then specifying clear goals for a preventive health programme is explained. "

The fourth chapter deals specifically with risk factors and emphasises the importance of concentrating on those risk factors which are modifiable. This positive approach is encouraging, as some communities where non-communicable diseases are a major problem have come to regard these disorders unavoidable due to "genetic predisposition". The manual works from the premise that in a changing (urbanising) environment, behavioural modifications can be made to minimize non-communicable disease. The risk factors for heart disease, diabetes, cancer and dental caries are listed with behavioural changes which can reduce the risk of these conditions. The overlap between risk factors is evident; a single behavioural modification (more exercise, for example) can reduce the risk of hypertension, cardiovascular disease and diabetes. People involved in preventive medicine should make it clear to the communities with which they work that a single change can have multiple benefits. For further editions, minor improvements in this section should include more emphasis on avoiding fats rather than sugar where obesity and diabetes are concerned. Also, given that cervical cancer and uncontrolled population growth are two important problems in the Pacific region, it was disappointing to see only a passing reference to pap smear screening, despite an incongruous

and confusing section on the cardiovascular risk of the oral contraceptive pill.

Chapter V provides a brief description of human behaviour and its relationship with non-communicable disease. The enormous socio-cultural forces which influence a community's values, beliefs and attitudes cannot be countered even by the most powerfully resourced health promotion programme. However, a close and understanding relationship with a community can enable these forces to be harnessed, and thereby influence behavioural change. Attitudes, values and beliefs form the interface between the collective and the individual and it is here that the health worker needs to be at their most imaginative and resourceful. The effects of smoking, obesity and lack of exercise have produced dramatic and frightening health statistics which excite newspaper editors and worry government treasuries, but may appear unimportant and a long way off to a young woman smoking at a party or a middle aged man putting on weight. Overcoming the individual "it will not happen to me" belief is one of the most difficult challenges facing any primary prevention programme. One way in which the importance of lifestyle modification can be given more relevance to people is by taking advantage of the extended family system which has generally been preserved in many Pacific Island communities, even in urban and migratory settings. The extended family provides an ideal opportunity for older people to pass on personal experiences of the consequences of behavioural patterns which are on the increase in the urbanising youth of the Pacific. Misleading and harmful stories about aunties who smoked thirty cigarettes a day until they died at ninety-six should, of course, be tactfully discouraged! Also, the family based approach to improving dietary change, to which women usually hold the key, is implied rather than made explicit in the manual. Change for an individual is often very difficult unless the whole family change their dietary habits. Since a central female figure usually has to instigate and maintain this change (often with family opposition) emphasis should be placed on the education, encouragement and support of women in the family, as well as family based health promotion and individual responsibility.

The diversity of Pacific island communities means that specific recommendations for health promotion activities are difficult to provide. However, 'Suggestions for Fieldwork Activities' in the last chapter provides a useful framework for workshops devoted to smoking, overweight, exercise, alcohol and stress. Discussion topics are outlined covering all aspects of health promotion, as well as suggested individual and family based techniques for putting preventive approaches into practice.

Community inspired behavioural change needs to be supported by legislation and taxation for changes to be sustainable, and the manual correctly identifies political lobbying as an important means of facilitating environmental change. The nature of policy development will vary considerably from country to country, but community action will always form a part of this important aspect of health promotion and should have been expanded upon. The value of community groups and community leaders is listed in the first chapter, but this section could have been presented in a lot more detail. For example, the importance of role models such as local sportsmen (and even kings!) for encouraging regular exercise. Large amounts of data on risk factors for non-communicable diseases in the Pacific have been collected and are easily accessible, and there are several standard texts on health promotion evaluation. However, more space could have been devoted to evaluation in the manual, particularly for those groups planning larger programmes: health needs analysis should always be performed before programmes are developed, followed by formative evaluation, programme management, impact and outcome evaluation. The difference between impact (behavioural change or risk factor reduction) and outcome (health status improvement) should be clearly stated, along with the importance of using accurate and appropriate indicators at each stage of evaluation.

This handbook has been developed for health workers but will be equally valuable for teachers, administrators or anyone involved in preventive health in a Pacific island community. It provides a framework rather than a blueprint for a community based approach to preventive health and therefore can be adapted to many situations and many Pacific island cultures. In conjunction with the South Pacific Commission's excellent health promotion videos and education leaflets, the **Training Module for Social Mobilisation and Community Action** should form the basis for many prevention programmes. Further editions of this manual could iron out the minor problems and expand on those few aspects where more detail would be useful to preventive health workers, and hopefully the South Pacific Commission will provide a 'feedback form' with the manual for this purpose. The manual and supporting materials are available from the South Pacific Commission at a very low cost. The practical application of standard texts about health promotion can be difficult for both health workers and confusing for the communities with whom they are working. This manual is succinct and easy to follow, it is tailored for Pacific communities, but is broad-based enough to encompass their diverse cultures and rapidly changing environments. It fills an important gap in health promotion literature and health promotion workers throughout the Pacific region will find it a valuable resource.

Copies of this manual can be obtained from the Secretary General, South Pacific Commission, B.P D5, Noumea, New Caledonia. □