

Health effects of the Indonesian economic crisis

Sir—In their account of the health effects of the Indonesian economic crisis, Chris Simms and Mike Rowson (April 19, p 1382)¹ suggest that one of the factors for observed inconsistencies is “poor attention to important data sources”. Yet, apparently Simms and Rowson have also overlooked important sources of data in their discussion of the effect of the economic crisis on key health indicators and policy interventions to improve equity.

Indonesia's population of 213·6 million people is unevenly distributed across 13 667 islands. Most of the population is heavily concentrated in the island of Java, which comprises only 7% of Indonesia's total land area. There exists much variation in the capacity and resources available to local governments for health and welfare. In many respects, the provinces in Java are the most developed. Kusnanto² reported that the effect of economic crisis within the country varied from one region to another. A panel survey to monitor implementation of the social safety net for the health sector (Jaring Pengaman Sosial-Bidang Kesehatan), showed that nutritional status among poor children in Java and Bali, which are perceived as the region most deeply affected by the crisis, was better than expected. However, despite social-safety-net programmes and household-food adjustments, nutritional status of children from poor households living in eastern parts of Indonesia continued to deteriorate during and after the economic crisis.

Simms and Rowson fail to take into account such regional disparities that were accentuated by the economic crisis. A discussion of health inequity data would provide an important and useful conceptual framework for tackling fundamental determinants of health in the country, especially those related to socioeconomic factors. Thus, the economic crisis should provide an opportunity to assess the effect of existing and proposed policy developments in Indonesia. As in many parts of the world, we need effective policies for tackling health inequity.

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1 Simms C, Rowson M. Reassessment of health effects of the Indonesian economic crisis: donors versus the data. *Lancet* 2003; **361**: 1382–85.

2 Kusnanto H. Regional differences in the impact of the economic crisis and social safety net on child nutrition in Indonesia. Takemi Program Working Paper. Boston: Harvard University Press, 2002.

Antiretroviral therapy in Africa

Sir—Most of the ministries of health in Africa recommend that antiretroviral drugs should only be administered to HIV-positive patients who have AIDS-related symptoms or a very low CD4-cell count. Symptom-free HIV-positive patients are advised not to take antiretroviral drugs and to maintain a healthy lifestyle. Although this advice may be feasible in developed countries, it is not appropriate for developing countries in Africa. In developed countries, individuals with HIV-1 infection have access to medical care and can afford good nutrition, whereas in Africa most HIV-positive patients without symptoms cannot afford medical care and adequate nutrition. In addition, HIV-positive individuals in Africa are predisposed to various tropical infections, such as intestinal helminths, which may actually accelerate progression to AIDS.^{1,2} Morgan and Whitworth³ have reported that progression of HIV infection to AIDS is faster in Africans than in Europeans and North Americans.

Although it may be cost effective to withhold antiretroviral drugs from symptom-free HIV-positive individuals, African health providers and authorities should recognise that the pathology of HIV infection and progression of the infection favours early commencement of antiretroviral therapy in these patients.

I have been caring for patients with AIDS since 1988. In 1988, as a junior medical doctor, I administered intravenous vincristine on a monthly basis to AIDS patients with Kaposi sarcoma. I observed that patients with minor signs and symptoms of Kaposi sarcoma had a better prognosis and lived longer than those patients who began treatment at a later stage. With the advent of antiretroviral therapy, I am seeing more patients on these drugs but with no change in their general condition. In these instances, it is difficult to ascertain the benefit afforded by these drugs. Rather than adopting a policy of starting antiretroviral therapy only in patients with symptoms or a very low CD4-cell count, ministries of health in Africa should support HIV research that will assess the advantages or disadvantages

of early commencement of antiretroviral therapy in terms of duration of useful life added to an infected individual.

I believe that individuals with HIV-1 infection without symptoms should begin antiretroviral drugs if they are financially able and understand the implications of starting these drugs. Wealthy governments in Africa should be able to support this approach to HIV treatment.

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- 1 Bentwich Z, Kalinkovich A, Weisman Z, et al. Can eradication of helminthic infections change the face of AIDS and tuberculosis? *Immunology Today* 1999; **20**: 485–87.
- 2 Mwanakasale V. A study on the interactions of *Schistosoma haematobium* and HIV-1 in Zambia: the effects of coinfection on the efficacy of praziquantel, egg excretion, and symptoms. Switzerland: University of Basel (PhD Thesis), 2001.
- 3 Morgan D, Whitworth JAG. The natural history of HIV-1 infection in Africa. *Nat Med* 2001; **7**: 143–45.

Causes of fever in travellers who return home ill

Sir—We read with great interest the review of assessment of travellers who return home ill (April 26, p 1459) by Alan Spira.¹ When a traveller returns home ill from a journey abroad, it can be difficult to establish whether the condition is the result of a disease directly related to travel, especially in the case of tropical disease, or whether another disease was acquired during travel.

Spira correctly points out that travellers with fever need immediate attention to rule out serious and potentially life-threatening conditions. This article focuses mainly on infectious agents that cause fever. However, travel is also a well known risk factor for venous thrombosis and pulmonary embolism,² and clinical assessment in patients with pulmonary embolism can be non-specific.³ Fever is present in up to 14% of patients with pulmonary embolism and with no other apparent source of fever.⁴ Thus, thromboembolism should be considered a possibility in travellers who return home ill with a fever.

We have reported⁵ an instance of a 57-year-old man with no previous illness who was admitted to hospital with recurrent fever after returning