

the patients, who are handled mainly as outpatients. A health care delivery unit can be found on average 1.4 km from any home in the country and a free government Western health care institution 5 km from any patient's home; 93% of the population have access to health services, significantly higher than other countries in the region. There are 246 health units throughout the country responsible for the control of communicable diseases, sanitation, school health work, epidemiological surveillance, family health, and health education.

The first health unit in south east Asia was established in Kalutara, Sri Lanka, in 1926. It has since evolved into the National Institute of Health Sciences, which is responsible for the training of health workers required for the primary health care programme.

Table 1 shows the trend of some health indicators over the past 50 years. In addition, 94% of births now take place in a medical institution. Only 18.7% of newborn infants had low birth weight (below 2.5 kg); 97.3% of children are fully immunised.

Table 1—Health indicators, Sri Lanka

Indicators	1945	1993
Crude birth rate per 1000 population	36.7	19.9
Crude death rate per 1000 population	22.0	5.3
Maternal mortality per 1000 live births	16.5	0.3
Infant mortality per 1000 live births	140.0	18.2
Neonatal mortality per 1000 live births	75.5	13.0

Source: Department of Census and Statistics.

Expenditure on health services is about 4.5% of the entire government expenditure while the amount spent on defence is about 10%. In addition, successive governments have implemented poverty alleviation programmes.

The provision of free education from year one to university in 1945 has raised the literacy rate from 57.8% in 1946 to 87.2% (female literacy 83.2%) in 1981—one of the highest rates among developing nations in the south Asia region. While 60% of the population has access to safe drinking water, 50% has access to sanitation.

The health improvements in Sri Lanka have been achieved not only by improving the curative aspect but also by strengthening the public health services. In addition, infrastructural development, free access to education, and a commitment to an equitable distribution of wealth both in urban and rural areas has also been instrumental in the gains made despite a civil war which has lasted for more than 12 years.

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Training in substance misuse for GPs

Services need to be adequately resourced

EDITOR,—I am sympathetic to Edwin Martin's view that training in substance misuse for general practitioners is lacking.¹ Shared care for drug misuse will fail unless specialists in substance misuse and those working in primary care coor-

dinate their efforts and are trained; a sense of failure and frustration will in turn be transmitted to patients. When shared care works effectively it has a significant effect on harm reduction, including a demonstrable impact on the level of drug related crime in the community.²

Unfortunately, current levels of specialist provision in the management of substance misuse are too low, and specialist training is unevenly developed throughout Britain. The report on the mental health of the nation by the Royal College of Psychiatrists in 1992 identified a need for 0.6 whole time equivalent consultants in substance misuse per 100 000 population.³ The number of consultant sessions in substance misuse needs to increase fourfold if general practitioners are to receive anything approaching a proper level of support and locally based training for this complex task. If the rhetoric surrounding tackling drug problems together is to be given any meaning then the services need to be adequately resourced.

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- 3 Royal College of Psychiatrists. *Mental health of the nation: the contribution of psychiatry*. London: RCP, 1992.

Courses are available in Lothian

EDITOR,—Edwin Martin comments on the lack of training available for general practitioners who care for drug users.¹ This problem has been addressed in Lothian by the development of "primary care facilitation." The primary care facilitator team works alongside the local drug service to support general practitioners and primary care teams to share the care of drug users. The medical facilitator is a doctor who has worked in general practice and in the drug service. She is helped by a local general practitioner, who works with the team one day a week, and by a nurse facilitator, who trains non-medical members of the primary care team, including nurses and receptionists.

The team runs courses and meetings for general practitioners, nurses, and receptionists; distributes information about drugs and drug services; and visits practices for training based there. We have recently collaborated in the production of a handbook for general practitioners on managing drug users in general practice. A survey carried out by the team last year (with a 100% response rate) found that general practitioners in Lothian were prescribing for 1500 drug users—an increase of 77% since 1991.²

Those aspects of Lothian's approach that have contributed to its success in sustaining general practitioners' involvement in the shared care of drug users have recently been described.³ Although our focus is on general practitioners in Lothian, our handbook and courses are available to general practitioners from elsewhere. Martin has now attended one of our courses.

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**We received four other letters on this subject, giving details of the training that is being developed by Camden and Islington Community Health Services NHS Trust, Brent and Harrow Family Health Services Authority, and Southampton Drugs Advisory Service and in West Dorset.—EDITOR

Methadone maintenance reduces injecting in prison

EDITOR,—HIV can spread rapidly among injecting drug users in prison, even when HIV prevalence is low.¹ Despite this, few countries have implemented HIV prevention measures for inmates and no evidence exists on the effectiveness of such measures in correctional environments. Condoms are provided to inmates in 19 countries and bleach in 13. Methadone is provided to inmates on a maintenance treatment basis in only five countries and for detoxification in a further six countries including England, Ireland, and Scotland.² Calls for policy reform in the United Kingdom have supported the provision of methadone on a reduction regimen for prisoners.³ Methadone maintenance treatment is well known to be effective in community settings,⁴ but its effectiveness in prisons is not known. Therefore we evaluated the effectiveness of methadone maintenance treatment in reducing risk behaviour among prisoners.

In 1993 we interviewed 185 ex-prisoners with a history of injecting drug use in New South Wales, of whom 64 reported receiving methadone maintenance treatment before, during, and after their period in prison; 80 reported receiving no treatment. Injecting drug users who reported receiving methadone maintenance treatment in the three months before prison were significantly less likely to report daily injecting (42% v 60%, odds ratio=0.4 (95% confidence interval 0.2 to 0.9); P=0.03) and syringe sharing (13% v 26%, 0.4 (0.2 to 0.9); P=0.04) than those not receiving the treatment.

Injecting drug users who received methadone maintenance treatment during imprisonment reported significantly fewer injections per week (mean 0.16 v 0.35; P=0.03 Mann-Whitney test) than those not receiving the treatment but only when the maximum methadone dose exceeded 60 mg and if methadone maintenance treatment had been provided for the entire duration of imprisonment.

These results suggest that the reduction of injecting and syringe sharing that occur with methadone maintenance treatment in community settings also occur in prisons. However, inmates need a daily dose of at least 60 mg of methadone and treatment is required for the duration of incarceration for these benefits to be realised in prison. Methadone maintenance treatment has an important role to reduce the spread of HIV and hepatitis in prison.

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