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News and Notes

Retirement of Lepra's Director G Francis Harris, MC

Francis Harris joined Lepra in 1962 as Deputy to the then General Secretary Bill Crisham.

Concerned that the Association he had joined was simply one which funded other people's work and aware that the fundraisers of that time would appreciate a treatment scheme that was run by Belra (as the Association was then known) the two men explored the possibility of working in Africa.

Three countries were approached and asked if they would consider having a control project and the most constructive reply came from Malaŵi, where the President for Life, Hastings Banda, was a doctor.

The setting up of this project in 1965 and its progress is now part of history. Suffice to say that our control work in Malaŵi is something of which all of us connected with Lepra are most proud, and the 50,000 discharged patients most grateful.

After a long search for a suitable project director the Lepra Evaluation Project began in 1979. Simply; the project aims to find out who is at risk from the disease so that when a satisfactory vaccine is found, there will be no doubt as to whom it should be given.

It has to be said that the particular project has had to be steered through sometimes stormy waters, but again all of us connected with Lepra are grateful for the way that our Director had encouraged the 200 people who work on this project, to carry on their endeavours.

As readers of *Leprosy Review* know, in January 1986 we began the first trial of a new antileprosy vaccine to be held on the African continent. All of us working with Lepra await the first results with eagerness for the vaccine is the work of the former Chairman of our Medical Advisory Board, Dr Dick Rees.

In 1973 Francis Harris, with the assistance of Dick Rees reorganized Lepra's Medical Advisory Team and from that time onwards we have had a Medical Advisory Board to which both Directors have felt able to turn for support. This work, which is in addition to that for which they are paid and which in itself is at times extremely demanding, is very much appreciated.

As Director, Francis Harris has brought many changes to the home front. He has moved the office three times, saying each time it would be the last and in 1975 the Association began its work in Colchester with a second and smaller Head Office in London. Lepra now has approximately fifty staff working throughout the United Kingdom in eighteen different locations. Not an easy task to manage but to date we are flourishing. Each part of the Lepra Kingdom from Dundee in the north to Exeter in the south-west is working hard and in close co-operation with the research centres in Scotland, through London to Oxford and other compass points too many to mention. All of this takes a great deal of work and much travel, all of which Francis Harris has done willingly and well.

On the fundraising side he has seen the Association's income go from £166,681 to over £2,000,000 (and the management of any organization with an income of this size and expenditure to match, is hard work). Not only in encouraging and improving grants which go forward to Lepra's Executive Committee but the day to day handling of Lepra's monies. Their entry into Lepra's coffers is erratic, two thousand being banked one day and over twenty another if a legacy or unexpected gift has been received. Whether to forward it to our brokers or to keep the money on deposit against a need we expect to arise shortly is always a problem, and takes up time if we are to get it right.

One fundraising task of which he is most proud is Lepra's participation in Help Cards, an organization which Lepra joined in its earliest years and of which he was Chairman for ten years.

Another is his presidency of ILEP (the Federation of Anti-Leprosy Associations) a post which he held from 1984 to 1986.

He recognized the importance of these Associations working for the control of leprosy to be doing so in partnership with one another. Here again he has had to steer this particular ship through sometimes turbulent waters and has done so with strength and sensitivity to the needs of his fellow members.

Francis has a saying with which many of those who read these words are familiar: 'How is this action or that going to help the leprosy patient?' Of one thing he need have no fear. He has, through his work as Director of Lepra, helped the leprosy patient personally and, equally importantly, seen the leprosy patient helped forward in so many ways, not the least of which is the adoption of multidrug treatment and, he hopes soon, of a vaccine which should lead to the eventual eradication of this shameful disease.

JOY MAITLAND, Director
of Fundraising and Publicity

New Director for LEPRA, Neil Winship

Lepra, the British Leprosy Relief Association, has appointed a new Director. Mr Neil Winship, a Natural Sciences graduate, served 22 years in the Royal Tank Regiment before leaving to help with famine relief efforts in the Sudan.

Mr Winship, who first came face to face with leprosy in the course of his widely travelled army career, commented: '. . . Having witnessed the effects of leprosy at first-hand in Southern Sudan and elsewhere, I wholeheartedly support efforts towards its eradication.'

When he left the army in 1985, critical conditions in the Sahel prompted him to volunteer to help Band Aid with their Sudan Trucking. Six months later he became Logistics Manager for the International relief charity, World Vision, working in Central Sudan. He soon became involved however, in the task of getting emergency food supplies through to the Churches' Relief Committee in the Southern Sudanese two of Wau, which at that time was surrounded by rebel troops.

He returned to England in March 1987 and worked alongside Mr Francis Harris, Lepra's Director since 1962, before formally taking up his post on 1 January 1988.

'Clearly it is vital that I gain a sound, if layman's understanding of leprosy; its enigmatic nature, the treatment, and hopes for prevention' said Mr Winship. 'While a passing but rusty knowledge of organic chemistry, and a familiarity with microscopy should help a bit, far more significantly by scientific background has helped me appreciate the scope and complexity of the leprosy clinical and research fields.'

Mr Winship travelled to Malaŵi in October to observe the large scale epidemiological survey and vaccine trial, as well as the treatment programmes that Lepra is carrying out there. 'This is our flagship project' he said, 'and my visit will be an essential, as well as, stimulating part of my induction.

However, what has already become clear to me during my short time with Lepra is the challenge in extending our activities in co-operation with host Governments to make the multidrug therapy available to a greater number of sufferers worldwide.'

Editorial Note: Leprosy Control and Field Work; Teaching Materials and Services; News and Notes

Due to the extraordinary number of articles awaiting publication, we have taken the decision to use various blank spaces and pages in the main body of the journal for items normally printed separately, under the above headings. We apologize for any adverse effect this may have on reprints and for any inconvenience to our readers in locating information on the items concerned. *Editor.*

Material for 'Leprosy Control and Field Work' 'Teaching Materials and Services', 'News and Notes'

In recent years it has become increasingly apparent that many readers of this journal, particularly those for whom the scientific articles are of limited significance, greatly appreciate the 'general' pages devoted to the above subjects. These sections are intended to carry information of *practical* value in leprosy control and the clinical management of patients. Teaching–learning materials, courses of instruction, sources of funds for travel and further study, are amongst the most helpful items. We have no shortage of material for these pages from various parts of the world and would be happy to continue selecting and publishing what seems most helpful. However, it would be preferable (and possibly less biased . . .) if suitable items of information could be supplied *by readers of the journal.* The presentation should be brief and should include addresses for further contact, details of costs, postal charges, etc, if relevant. We have a circulation of about 1500 to over 100 different countries, with considerable international indexing, 4 times yearly. Please submit suitable material, so that these pages can be used to maximum advantage. *Editor.*

Zimbabwe Leprosy Association

Dr J A Warndorff, leprosy specialist in Zimbabwe, has kindly written with the following information, which is extracted from the Report of the Chairman of the ZLA, 1987:

'The main focus of activity during the year—indeed of the past four years—has been on the leprosy settlement Mutemwa where the building programme has replaced most old huts. A policy of reintegration of leprosy victims into communities is being actively pursued and a significant step forward was taken when fourteen leprosy victims, together with some eighty 'dependants' who had joined them at Mutemwa over the years were resettled, with the help of social welfare grants, on small plots in the rural areas. With the completion

of the major part of the building programme at Mutemwa, seventy leprosy victims now live there in comfort. There remain some 7000 identified leprosy sufferers in Zimbabwe, most living in the rural areas, and the dermatalogical programme will undoubtedly identify more. Serious cases are hospitalized at the Tropical Diseases Unit in Harare. The Association is therefore turning its attention increasingly to support for the national leprosy programme and has provided equipment for it, as well as for the Tropical Diseases Unit. Communication between Government, the Leprosy Mission and the Association has improved but there is need for better coordination of their activities to ensure maximum impact on the fight against leprosy and to avoid duplication of effort. There is a Leprosy Coordinating Committee on which I represent the Association and I hope that, following today's election of office bearers, I shall be able to give more time to this aspect of work in the field of leprosy. There is some confusion in the minds not only of the general public but also of our members about the aims and objects of the Association. While it is self-evident that, by our very nature and name, we are engaged in the fight against leprosy, our main and best-known activity has been, for twenty years, the administration and maintenance of Mutemwa. It is felt, in some quarters, that we have devoted a disproportionate amount of activity and funding to this area, at the expense of the greater need of the identified leprosy sufferers. I have requested a meeting with the Ministers of Health and of Social Welfare, at which our responsibilities for the village may be confirmed and defined. Once this has been done, it is the intention of the Executive Committee to revise and update the Association's Constitution and then to conduct a public relations exercise with a view to recruiting new members and raising further funds for the fight against leprosy, which will extend beyond the confines of Mutemwa.'

Strong envelopes for posting from India

We are grateful to Dr V V Dongre of Hind Kusht Nivaran Sangh for drawing our attention to the trade name of a strong envelope which is available in stationery shops in India; 'Kaynox Covers'. These are strongly made and reinforced inside with gauze-like cloth. These are ideal for booklets, heavy manuscripts, etc. Please use them! Many of our original articles, mailed in standard envelopes, arrive only by the skin of their teeth. *Editor.*

AIDS; WHO guidelines for the safety of leprosy workers

In a previous number of *Lepr Rev*, 1987; **58:** 207 we printed the full text of the WHO document WHO/CDS/LEP/87.1: 'Guidelines for personnel involved in collection of skin smears in leprosy control programmes for the prevention and control of possible infection with HIV', and once again we draw the attention of all programme managers and leprosy workers to these important recommendations.

Leprosy in South America

The following is from the *Bulletin of the Pan-American Health Organisation*, 1986; **20:** No. 2.

Aside from mainland Chile, leprosy is endemic everywhere in the Americas. Although the recording system is deficient and outdated, 318,001 cases were registered in 1984, 68% of them in Brazil. Overall, around 20,000 new cases are reported each year. The largest numbers of cases appear to occur in Argentina, Brazil, Colombia, Mexico, Paraguay, and some Caribbean countries.

Despite important progress in the understanding of leprosy immunity, much of the health staff in many countries is unacquainted with leprosy epidemiology or with leprosy control methods and lacks the means for diagnosing, treating, and monitoring cases. Moreover, the disease is still an object of social stigma in most communities, primarily because appropriate up-to-date information is lacking, and this circumstance hampers leprosy prevention, outpatient treatment, and rehabilitation.

Close to half of the cases diagnosed as contagious forms (lepromatous and dimorphous cases). In Central America the incidence is generally low, ranging from about 0·04 cases per 1,000 inhabitants per year in Guatemala to 0·22 per 1,000 in Costa Rica. Some Caribbean countries (Guyana, Guadeloupe, and Martinique) have relatively high rates—between 2 and 10 cases per 1,000 inhabitants—but the proportion of contagious cases (lepromatous and dimorphous) is lower than in most other countries. In the Amazon area and some parts of the Andes there are foci of high endemicity where the prevalence can reach 30 cases or more per 1,000. The proportions of unspecified and tuberculoid cases vary widely from one country to another, but account for about 20% and 23%, respectively, of cases in the hemisphere as a whole. In an estimated 30% of the reported cases the disability involved is of grades II and III.

The current strategy for leprosy control is based on reduction of the sources of infection in the community through early detection of cases and the supervised administration of multidrug treatment. It is also necessary to provide for better implementation of control programmes by making extensive use of the health services network.