

News and Notes

Dr Dharmendra retires as Editor of *Indian Journal of Leprosy*

The name of Dr Dharmendra has been closely linked with the *Indian Journal of Leprosy* from the time of its inception. He was the Editor of the Journal for almost 40 years with a few short breaks; and even during these breaks he maintained a close link with the Journal. Finally with the October 1989 issue of the Journal he retired at 90 years of age; only when he was physically unable 'to hold the baby' any longer. The Journal was indeed Dr Dharmendra's baby which he has carefully nurtured from 1938.

The Journal originally named *Leprosy in India* was started by the Indian Council of the then British Empire Leprosy Relief Association (now LEPRO) under the editorship of Dr Ernest Muir in 1929. It still continues to be the official organ of the Indian Council of BELRA renamed Hind Kusht Nivaran Sangh after India attained independence. In the early years the Journal only contained reports of surveys carried out on the prevalence of leprosy in different parts of India. These reports, although providing useful information, formed very monotonous narratives. After Dr Dharmendra took over as Editor, he converted the periodical into a regular scientific journal, with papers on original research, review articles, news and notes, abstracts of papers, etc. It thus fully justified being re-christened the *Indian Journal of Leprosy* in January 1984. While names of prominent scientists like Ernest Muir, John Lowe, N Mukherjee and C G S Iyer have been associated with the Journal as editors for short spells, it was Dr Dharmendra who gave the Journal its life and sustained it despite several obstacles and difficulties. In the earlier years when there were very few scientists engaged in leprosy research, Dr Dharmendra had to solicit scientific papers from those few scientists, persuade and urge many of the workers to record their findings for publication and at the same time maintain scientific standards. He wrote long editorials for most of the issues. He also had the problems of production; finding good printers and overseeing the quality of print, illustrations and layout of the Journal. While others tried to do all these and gave up, Dr Dharmendra stuck to the editorship for almost 5 decades with admirable tenacity and perseverance. It is only now, with advancing age and natural physical limitations that Dr Dharmendra had to hand over to the new Editor, Dr H Srinivasan, Director, Central JALMA Institute, Agra. The readers of the Journal the world over and scientists engaged in leprosy work greatly appreciate Dr Dharmendra's glorious contribution of editing and bringing out the Journal successfully.

K V Desikan

Report of the African Ministerial Consultation on Medical Education, Nigeria, 1989

The following report is the final one of the African Ministerial Consultation on Medical Education held in Abuja, Nigeria, 8 July 1989:

The African Ministerial Consultation on Medical Education just concluded at Abuja is a logical follow-up of the programme of the World Federation for Medical Education and World Health Organization leading up to the Edinburgh Declaration of August 1988. That Declaration was indeed a unanimous commitment to the improvement of the health of populations through strategies aimed at rethinking the purpose and reshaping the content of medical education worldwide. Responses and reactions to the Six-Themes Document of the World Federation for

Medical Education were followed by activities at the institutional, national and subregional levels in Africa over a three-year period. Then came the formulation at a Regional Conference in Brazzaville in October 1987 of a set of objectives for achieving the desired reorientation of medical education in Africa. These objectives were in keeping with the imperatives of primary health care.

The Brazzaville meeting, sponsored by WHO and WFME, was attended by an assemblage of Ministers of Health, Vice-Chancellors and Rectors of Universities, Provosts and Deans of Medical Schools, Heads of allied professional institutions and Representatives of Bodies such as the Association of Medical School of Africa (AMSA), the International Conference of Deans of French-speaking Medical Schools (ICDFMS), the Confederation of African Medical Associations and Societies (CAMAS), the NETWORK of Community, Oriented Medical Schools, the World Medical Association (WMA) and the Association of African Universities (AAU). It examined present trends in medical education on the African continent in the light of national strategies for primary health care. The Brazzaville Conference proposed to governments and health institutions in the region a plan of action for the implementation of the desired institutional changes for the training and utilization of appropriate medical manpower to meet present and future changes in health development.

The Abuja Ministerial Consultation further reviewed the earlier statements of commitment, now strengthened by the recent World Health Assembly Resolution (WHA) 42.38 on this subject by involving all *Dramatis Personae* (both Intersectoral and Multidisciplinary) so as to ensure speedy and effective implementation of agreed strategies. From the deliberations of this consultation should emerge paradigms of medical curricula relevant to the African situation, with primary health care as the foundation for their structure or at the very least existing curricula that are adapted to the health needs of the wider community.

A revised plan of action thus seems inevitable and should include the following elements:

a, a comprehensive restatement of goals; b, specific strategies for meeting such defined goals; c, definition of the modalities of resource allocation and co-ordination of the various activities in medical education; d, a realistic timescale for the implementation of the objectives; and e, a mechanism for periodic evaluation of the impact of various initiatives in health manpower development in all parts of the African region.

In order to meet these growing challenges, it is necessary to emphasize the importance of the *Political Will* as indispensable in the process of formulation, acceptance and implementation of national health policies within the overall context of national goals. All this calls for a careful appraisal of: the nature and extent of supporting resources, and skills in the organization and management of such resources, limited as they might be; admission criteria into medical schools; the increasing role of continuing medical education; and the challenges of integrating primary health care into existing medical curricula as well as the daunting task of countering traditional resistance by teaching staff of Faculties of Medicine to envisaged changes in the curriculum.

In updating the Brazzaville Plan of Action, it is necessary now to indicate what has been done since October 1987 and how best to proceed from this meeting:

a, all countries in the AFRO region have now received reports of the Brazzaville Conference; b, the World Conference on Medical Education took place in Edinburgh in August 1988 with the African region fully involved in its planning and deliberations. From the Edinburgh Meeting emerged a report which featured a twelve-point Declaration. It also went on to emphasize the need for *international collaborative programmes* for reorienting medical education. This has obvious implications for funding support; and c, the World Health Assembly at its meeting in May 1989, adopted a resolution embodying the essential components of the Edinburgh Declaration and urging member nations to widely disseminate and give serious consideration to its recommendations.

The three themes that formed the basis of the present consultations have been exhaustively treated at both plenaries and group discussions. The conclusions drawn from them are embodied in

the set of recommendations that constitute *The Abuja Plan of Action*. It is sufficient at this stage to highlight the subthemes under each major heading:

a, *Political Will and Mobilization*: implications of political will and commitment; leadership training in medical education; and mobilization in medical education.

b, *Relevance and Resources*: relevance of change for optimal impact; resource imperatives for change; and modalities of change.

c, *Overview of Existing Medical Education Systems in the African Region and their Orientation Towards Primary Health Care*: a round-table discussion featuring the experiences of Cotonou, Ife, Ilorin and Yaounde in integrating primary health care into their curricular structure *ab initio* and what lessons were to be learned from constraints in the implementation process.

Special attention was also drawn to the importance of the health team approach to manpower development and to the need to emphasize intersectoral and multidisciplinary collaboration.

The need for intra and inter country exchanges of personnel was also identified, as were integrated teaching, student-centred learning, problem-solving and community-based activities.

To put the recommendations in proper perspective and accord them the appropriate sense of urgency it was agreed that they should be structured by levels of implementation within a designated time frame.

Such levels of implementation should take the form of institutional, national, regional and global arrangements and the designated time frame would be categorized as immediate, medium and long term. On the basis of this format, a flow-chart was thought most practicable:

| <i>Activity</i> | <i>Immediate 1989-90</i> | <i>Medium Term 1990-91</i> | <i>Long Term Beyond 1992</i> | <i>Level and Linkages</i> |
|---|------------------------------|--------------------------------|----------------------------------|--|
| Establishing of Medical Education Task Forces | | | | National, Regional (WHO, AMSA, CAMAS) |
| Meeting of Deans (National Plans for Implementation) | | | | Directors General—Health Education; Deans, & Provosts, Chief Medical Directors |
| Establishing of broad-based faculty curriculum committees with PHC emphasis or national curriculum committees | | | | Institutional (University, Faculty, Student, Allied Professions) Government, Institutional, Community. |
| Organisation of Workshops, Reorientation & Training of Faculty and other categories of Health Manpower | | | | Institutional, National, Regional, International |
| Establishment & Strengthening of Practice Areas with Intersectoral Approach | | | | Institutional, Governmental (local, state), Community |
| Community Mobilisation/HFA | | | | Community, Ministries (National, State) Medical Institutions |
| Staff Development with emphasis on leadership. Student exposure to Innovative Programmes | | | | National, International |

The medical school, the medical student and the control of leprosy in Africa (LEPTAC)

The above was a background paper for the Ministerial Consultation on Medical Education held in Lagos, Nigeria, 5–7 July 1989 (see previous item) for Leprosy Teaching and Training in African Countries (LEPTAC) and is reproduced here:

1 Leprosy is no longer regarded as a scourge with patients hidden away in leprosaria and none but a few benevolent workers to care for them. This disease can now be cured and has consequently been brought into the mainstream of medicine. Just as it is unthinkable that a medical student will graduate unable to diagnose, treat, manage and have the right attitude to malaria, tuberculosis or even AIDS, so too should be the case with leprosy. Leprosy is still a major problem in Africa. It is therefore paramount that urgent and serious consideration is given to the inclusion of adequate and appropriate instruction in leprosy, in the curriculum of all medical schools in Africa.

2 Doctors in Africa usually have important and varied roles not just as providers of care, but also as educators, supervisors, planners, decision-makers and implementors. All these roles are crucial for successful leprosy control. This paper aims to point out that it is important for leprosy control to ensure that all medical students in Africa reach a desired level of competence regarding leprosy patients.

3 *Leprosy in Africa*

The Continent of Africa (estimated population in 1985: 421,782,000) has a total of 886,465 registered cases of leprosy. Although there has been a considerable reduction in prevalence rates in the past 20 years, mainly due to the discharge or release from the control of cases following chemotherapy, many countries still report large numbers of registered cases, many of whom would normally be eligible for discharge or release from control if carefully assessed. Although there are some notable exceptions, most countries have shortcomings in the design and operation of their national leprosy control programmes, including the necessary training and supervision of health personnel.

4 *Multiple drug therapy: available, effective and in need of implementation*

In 1982, WHO published recommendations for the treatment of all cases of leprosy with multiple drug therapy ('*Chemotherapy of leprosy for control programmes*'; *Report of a Study Group; Technical Report Series 675, WHO, Geneva, 1982*), using combinations of dapsone, clofazimine and rifampicin in regimens of relatively short duration. These have now been applied in most parts of the world and at the *13th International Leprosy Congress in the Hague* (September 1988) it was reported that over 2 million of the registered cases had been put on multiple drug therapy and that of these, over a quarter had completed their treatment and were no longer considered to have active leprosy. Despite these advances, however, the pace and extent of the implementation of multiple drug therapy worldwide calls for improvement, and in the Continent of Africa there are particularly serious grounds for concern in that only 8% of all patients with leprosy have so far received this form of treatment.

5 *The curriculum content; teaching modules; the availability of teaching-learning materials on leprosy*

The subject of leprosy is outstandingly well supported by a wide range of teaching-learning materials, in English, French, Spanish and (to a lesser extent) in Portuguese, which have been produced, printed and distributed by various agencies during the past 20 years. The International Federation of Anti-Leprosy Associations (ILEP) has a working 'sub-group' of 7 members (TALMILEP) coordinated by the German Leprosy Relief Association (P.O. Box 348, D-8700 Würzburg, West Germany) which is responsible for the origination, assessment, printing, publication, distribution, and translation of suitable items of health learning materials for various grades of leprosy worker. The 'English language book list' of all items will be available at the Ministerial Conference. In addition, videos, colour transparency text teaching sets, exhibits, atlases and other teaching aids (not necessarily included in the above book list) are also available. Finally, three points with regard to curriculum content and the teaching of leprosy in medical schools bear

emphasis: 1, the remarkable range of teaching–learning material described above is available now, much of it free or at low cost. It can be supplied, with minimal delay, to both teachers and students and there is no reason why the medical school libraries in all leprosy-endemic countries of Africa should not have on their shelves an up-to-date selection of books and other items for study and reference; 2, the construction of appropriate teaching modules would present no difficulty to professional people with experience of teaching in leprosy and, if required, they are available to help, and 3, if the education ‘formula’—a sound basis of accurate information, plus all the necessary teaching–learning materials for both teacher and student, plus appropriate modules, backed by problem-based, self-instructional and distance-learning techniques—is acceptable and successful, it might well have ‘spin-off’ for the teaching of other subjects of major public health importance in Africa.

Global evaluation of the introduction of MDT, 4th edition, *WHO Leprosy Epidemiological Bulletin*, No. 4, 1990

This Report is mainly statistical and is divided into three sections: 1, detailed statistics of WHO regions; 2, summary of statistics by country; and 3, detailed statistics by country. The Introduction includes definitions used, sources of data and limitations of the report. It opens as follows:

Introduction of Multidrug therapy (MDT) was recommended by a WHO study group in 1981 mainly because of the ever increasing threat caused by the worldwide development of secondary and primary resistance to dapsone.

With the experience gained so far, it becomes more evident every day that if a major breakthrough is to be made in leprosy control, it is through the worldwide use of highly bactericidal multidrug regimens.

Besides the effective capacity to cure the leprosy patients harbouring dapsone resistant bacilli, the WHO MDT regimens permit:

- a shortening of the duration of treatment, leading to a better compliance of the patients, and an increased rate of self-reporting;
- a rapid decline of the leprosy prevalence resulting in a decreased workload for the health workers;
- a reduced risk of post-therapeutic relapses.

More important, generalization of MDT in an area seems also to result in a sharper decline of the leprosy incidence than was experienced with dapsone monotherapy.

Nowadays, multidrug therapy regimens are used in most endemic countries. Effective coverage of the patients with MDT differs however widely from country to country. The ‘Bulletin’ presents information on MDT from 174 countries and territories worldwide. It does not intend to be just one more compilation of figures, but rather a stimulus for all those in charge of leprosy control programmes to implement MDT in the field and to collect the necessary information to monitor the process.

The *Bulletin* was prepared in consultation with Professor M F Lechat of the International Federation of Anti-Leprosy Associations (ILEP) and Département d’Epidémiologie, Université Catholique de Louvain, EPID 30/34, Ecole de Santé Publique, Clos Chapelle-aux-Champs 30, 1200 Bruxelles, Belgium.

Tropical Diseases, Progress in International Research, 1987–88, WHO

This book reviews recent progress in international efforts to combat the huge scale of suffering caused by tropical diseases. Prepared by the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), the book concentrates on progress made in controlling the Programme’s six target diseases: malaria, schistosomiasis, filariasis, trypanosomiasis, leishmaniasis, and leprosy. Though work supported or coordinated by TDR is emphasized, the report also considers advances in any area of academic or industry research that may contribute to the control of tropical diseases. Throughout, an effort is made to illustrate the diversity of

approaches, whether involving the tools of molecular biology or the use of simple insect traps, that are needed to match the complexity of these difficult and dangerous diseases.

The book opens with an overview of selected recent advances that are either challenging conventional research approaches, particularly concerning strategies for drug and vaccine development, or yielding new practical tools for diagnosis, prevention, patient care, treatment, and control. Examples cited range from new diagnostic tests for malaria and schistosomiasis to the use of insecticidal paints in the control of Chagas disease. Though the traditional emphasis on drug and vaccine development is readily apparent, the report records a number of new efforts to strengthen field research as a major contribution to the development and refinement of disease control strategies.

In keeping with this emphasis, the second chapter, authored by a science writer, presents a series of impressionistic 'scenes from the field'. Focused on the field use of ivermectin for the treatment of onchocerciasis, and multi-drug therapy for leprosy, these first-hand accounts offer a rare opportunity to view the terrain and personalities that compose the real challenge of bringing new technologies to the people who need them.

The third and most extensive chapter profiles international research contributing to the control of each of the six target diseases, including numerous examples of the progress made and problems encountered, the opportunities for intervention specific to each disease, and the actions being taken to exploit these opportunities. Whether concerning the effectiveness of pyramidal traps for reducing the numbers of tsetse flies or experimental work indicating that a safe and effective schistosomiasis vaccine may become a reality, the picture that emerges is one of a vastly diversified and globally coordinated effort to out-smart diseases that strike in an almost infinitely varying environment of ecological conditions. The book concludes with an over-view of several new policies and structures introduced to strengthen research capability, followed by a brief explanation of how TDR is structured, managed, and financed.

This is the Ninth Programme Report of the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), WHO 1989; 136 pages; Order No. 1150327; Price Sw fr. 20, US\$16.00. From WHO, Distribution and Sales; 1211 Geneva 27, Switzerland.

Research on interactions between AIDS and tropical diseases

Special funds have been made available by the World Bank to TDR and the Global Programme on AIDS (GPA) to support high quality research to investigate the nature and expected consequences of interactions of HIV infection with the major endemic diseases in developing countries.

Points of particular concern include the interactions between malaria and HIV in pregnancy and the neonatal period; HIV and visceral leishmaniasis (kala azar); technological advances for ensuring a safe blood supply (e.g. simplified diagnostic tests that simultaneously detect multiple infections such as HIV, Epstein-Barr virus, malaria, and Chagas disease); and operational issues such as effects of multiple diseases on treatment and prophylaxis.

A document titled 'Inter-relations of Tropical Diseases and HIV Infection: Report of an Informal consultation Held at the Kenya Medical Research Institute (KEMRI), Nairobi, December 1987' contains protocol outlines of high priority field research aimed at investigating such interactions and may be useful in preparing the desired research proposals.

For a copy of this document and the standard TDR research proposal forms, please write to: Dr Richard H Morrow, TDR, World Health Organization, 1211 Geneva 27, Switzerland.

The Heiser Program for Research in Leprosy

Beginning Postdoctoral Research Fellowships, Research Grants, and Visiting Research Awards available in amounts up to \$25,000 per year, plus other allowances. Applicants should have an MD, PhD, or equivalent degree. Applications by 1 February 1991, for awards to be activated June to December 1991. For information, write to: The Heiser Program, 450 East 63rd Street, New York, NY 10021, USA.

Editorial and subscription address for *Leprosy Review*

Please note that submission of manuscripts and all subscription queries should be made to: LEPRO, Fairfax House, Causton Road, Colchester, Essex CO1 1PU, England.

WHO *Guide to Leprosy Control* in French, Spanish and Portuguese

It is perhaps not widely known that the *Guide to Leprosy Control* produced by WHO is also available in French, '*Guide de la lutte antilepreuse*'. Published in 1989 it has an extent of 140 pp, WHO Order No. 2152064, and costs Swiss franc 23/US \$18.40. Spanish and Portuguese versions may be requested from: Pan American Sanitary Bureau, 525, 23rd Street, N.W. Washington, DC 20037, USA.

Technical guide for sputum examination in tuberculosis

This well-established Guide, originally published in 1978 as Supplement No. 2 in the *Bulletin of the International Union Against Tuberculosis*, is available from the International Union Against Tuberculosis and Lung Disease (IUATLD), 68 Boulevard Saint-Michel, 75006 Paris, France. It describes in detail: collection of specimens; storage and transport of sputum specimens; the laboratory; receptor and registration of sputum specimens, staining technique; examination by microscopy; results and recording; disposal of examined slides; despatch of results of examination; and formulation of reagents.

Because of the date of publication it does not include advice on the additional health risks to staff brought about by the HIV/AIDS epidemic.

International Community Eye Centre, Adelaide, Australia

The following is extracted from the June 1989 *Newsletter* of the School of Medical Education, The University of New South Wales, PO Box 1, Kensington, New South Wales, Australia 2033.

The human suffering caused by blindness is obvious. Less obvious are the social and economic consequences, especially in developing countries, where the majority of the world's blind live and where economic reserves are minimal. The World Health Organization estimates there are between 28 and 42 million blind in the world today.

There is an opportunity to reduce the impact of visual disability on communities, particularly rural communities in developing countries. To achieve a reduction in visual disability requires the effective application of medicine at a community level.

The International Community Eye Care Centre in the Department of Ophthalmology at Flinders Medical Centre is providing leadership in this important area.

The Flinders' Centre aims to provide the following services:

- (i) Carry out basic and applied ophthalmic research on problems amenable to epidemiologic techniques, collaborating with whomever is able and available to contribute.
- (ii) Serve as a resource for epidemiology and biostatistics for investigators, offering advice and consultation on study design and data analysis.
- (iii) Provide training in epidemiology and public health ophthalmology for physicians from the region either in their own country or in Australia.
- (iv) Provide consultation to national blindness prevention programmes either through existing agencies and foundations (WHO, Helen Keller International, Royal Commonwealth Society for the Blind and Christian Blind Mission International) or on a bilateral basis.
- (v) Develop unique teaching programmes for those delivering ophthalmic care in developing countries. These programmes will be designed to fit the particular needs of the community bearing in mind racial, social, economic and political factors influencing health care delivery.

Limited funding has been provided to set up the Centre and to conduct the first blindness prevalence survey in South Australia. In addition to such specific project related funds, however, both governmental and non-governmental support is required for this unique resource.

More information about this Centre may be obtained from: Dr Henry S Newland, Senior Staff Specialist/Senior Lecturer in Ophthalmology, Flinders Medical Centre, Department of Ophthalmology, Bedford Park, South Australia 5042.

International Union Against Tuberculosis and Lung Diseases (IUATLD)

The International Union Against Tuberculosis and Lung Disease (IUATLD) is a nonprofit, nongovernmental voluntary organization founded in 1920. Its members, an international federation of organizations and individuals, are dedicated to the prevention and control of tuberculosis and lung disease (including the respiratory complications of AIDS), to disseminating information about the hazards of smoking, and to the promotion of overall community health. The IUATLD's headquarters are in Paris, France.

Main objectives:

- 1 To coordinate, assist, and advance the work of the IUATLD Constituent Members throughout the world.
- 2 To establish and maintain close relationships with the World Health Organization and other international health organizations and institutions.
- 3 To collect and disseminate knowledge on all aspects of tuberculosis and lung disease, and on related community health problems. This objective is pursued through conferences, research, and published materials.

Main activities:

- *Communication* with members through circular letters, the *Bulletin* (the journal of the IUATLD), conferences, and scientific activities.
- *Dissemination of scientific knowledge* through publications, world and regional conferences, seminars, lectures, and correspondence.
- *Collaboration* with other international agencies—particularly with the World Health Organization, but also with the International Union Against Cancer, the International Union for Health Education, the International Federation of Anti-Leprosy Association, the International Children's Center, and others.
- *Operational and applied research* through the Scientific Committees and through field projects such as those described below.
- *Field projects* carried out through the Mutual Assistance Program, which was created in 1961. Under this programme, the IUATLD extends technical and material support to efforts designed to control tuberculosis in developing countries. These activities are supported by special funds donated by member associations and government agencies from more affluent countries.

Address: Dr Annik Rouillon, Executive Director, IUATLD, 68 Boulevard Saint-Michel, 75006 Paris, France.

MAP International, USA

MAP International (Medical Assistance Programs) is a non-profit-making Christian global health organization. The following is extracted from information supplied by the Organization:

Medical supplies

- MAP receives and distributes more than \$20 million worth of medicines and medical supplies each year.
- These FDA-regulated medicines are donated through MAP by more than 200 leading US health-care industries.
- 650 mission hospitals and clinics in nearly 80 developing countries order these otherwise scarce and unaffordable supplies.
- Cash donations from individuals, churches and other friends help make arrangements for inventory, processing, warehousing and shipping to remote areas.
- Cash contributions for the hospital supply programme provide more than 15 times their value in life-saving supplies because they are donated.

- During emergencies like floods, earthquakes, typhoons and other natural and civic disasters, relief medicines reach victims through professionals working on the scene.
- Cooperative efforts with Christian missions and organizations on location ensure that appropriate and requested supplies reach the people for whom they are intended, and reach them quickly

Community assistance

- MAP's community health assistance helps Third World rural communities work together to detect and eliminate causes of disease, such as impure water and malnutrition.
- Field staff in South America, the Caribbean and Africa assist missionaries and national church leaders in developing projects that improve health in the home and community.
- MAP's Learning Resource Center and training workshops provide current publications and practical help for medical missionaries working in developing countries.
- On-site training programmes develop the skills needed by village health workers, supervisory staff and project leaders to implement effective community health programmes.

For further details write to: MAP International, 2200 Glynco Parkway, PO Box 50, Brunswick, GA 31521-0050, USA.

Intermediate Technology

The Intermediate Technology Development Group (known as IT) works with Third World rural communities on long-term sustainable development projects. Using appropriate technologies to create jobs in some of the poorest areas of the world, IT offers hope and opportunities for people to work their way out of poverty. Founded by E F Schumacher, the author of *Small is Beautiful*, the charity has worked in over 60 countries since its formation in 1965. IT has country offices in Peru, Sri Lanka, Zimbabwe and Bangladesh and is reliant on public donations to fund over half of its work.

Small World is the Newsletter of IT at Myson House, Railway Terrace, Rugby CV21 3BR, England.

International Gandhi Award 1990 for Dr M F Lechat and Dr R V Wardekar

Dr M F Lechat, a leading epidemiologist from Belgium, and Dr R V Wardekar, a pioneer in introducing leprosy control programme on the national scale in India, have been selected to receive the International Gandhi Award for 1990.

The selection was done by the International Gandhi Award Committee: Dr Shankar Dayal Sharma, Chairman, Shri Ramvilas Paswan (Minister for Welfare), Shri P Upendra (Minister for Information and Broadcasting), Shri S K Singh (Secretary, Ministry of Foreign Affairs), Dr S D Gokhale (Convenor) and Shri S P Tare (Director, GMLF).

Dr Lechat is a leading epidemiologist who has greatly contributed to the epidemiological understanding of the leprosy problem. He was President of the International Leprosy Association and is President of the International Leprosy Union. Dr Wardekar is the father of leprosy control work in India and evolved a methodology for leprosy control work which was accepted by the Government of India in 1955-56 with the introduction of the National Leprosy Control Programme. Dr Wardekar was instrumental in the drafting of the first four 5-year plans for leprosy. The International Gandhi Award is given bi-annually and was founded by the Gandhi Memorial Leprosy Foundation, Wardha which is a voluntary agency with a network of centres in seven Indian States. The first recipients of the Award were Dr (Mrs) Turkan Saylan (Turkey) and Dr Dharmendra (India) in 1986; the 1988 Award was given to Dr Ma Haide (China) and Professor T N Jagadisan (India).