

News and Notes

TDR call for applications for support of research training

The UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), established in 1976, has two objectives:

- (1) research and development of new tools to control the TDR target diseases: malaria, filariasis (including onchocerciasis), African trypanosomiasis and Chagas disease, leishmaniasis, schistosomiasis and leprosy;
- (2) strengthening of research capabilities in countries where these diseases are endemic.

As an important way to achieve its second objective, TDR provides funding to train research workers from disease-endemic countries. TDR support enables research workers to acquire research skills related to one or more of the TDR target diseases or in a discipline related to these diseases, such as molecular and cell biology, immunology, entomology, parasitology, epidemiology, clinical pharmacology, and the social sciences. Applications relating to product development and molecular entomology are also welcome. Funding is available for opportunities in established training programmes for studies leading to a doctoral level degree, or for an individualized post-graduate programme in a centre which conducts research in tropical diseases. Support for Masters level courses will be considered in exceptional cases.

The maximum duration of TDR support for research training is three years. Those eligible to apply for research training include:

- staff members of (i) institutions currently receiving one of the TDR institution strengthening grants, and (ii) other institutions where TDR support for such grants came to end two to three years ago;
- scientists from other institutions who are already engaged in research or committed to doing research on one or more of TDR's target diseases, and whose home institution is equipped with required research facilities;
- staff members of Ministry of Health disease control services who are involved in planning, executing and evaluating disease control programmes related to TDR's target diseases;
- scientists who have had appropriate post-graduate training in epidemiology, social sciences, and other field-oriented subjects and who require practical, hands-on (postdoctoral) training in a research project or suitable institution doing field research in one of TDR's target diseases;
- scientists with post-graduate research training who have been actively involved in clinical, field or laboratory research in one of TDR's target diseases for a minimum of five years and who now want to spend a period of time in a suitable research centre or laboratory to upgrade their skills or to carry out specialized experiments or data analyses.

Address: Dr J A Hashmi, Special Programme for Research and Training in Tropical Diseases, WHO, 1211 Geneva 27, Switzerland.

African Medical and Research Foundation (AMREF)

The following is extracted from the current AMREF brochure:

Good health is a state which very few of us achieve, though we all aspire to it and consider it our due. In many parts of Africa however, it is bad health that is taken for granted. World Health

Organization statistics show that poor nutrition and lack of clean water are the cause of 80% of ill health.

AMREF, the African Medical & Research Foundation, founded in 1956 by Sir Archibald McIndoe together with two of his former pupils, Sir Michael Wood and Dr Tom Rees, is dedicated to changing this. As well as providing better medical care, AMREF is working to assist rural communities to improve social conditions. AMREF is particularly concerned that the health education and medical provision it offers are based on a sound knowledge of the customs, habits and associated beliefs of the people with whom it is working. The aim is for maximum participation of the community in its own health programmes. So AMREF collaborates with governments, developing health education through the training of African staff who are able to introduce change to their own people in a sensitive and appropriate way.

AMREF supports workshops where local people are employed to build homes and hospitals for the community. Projects to provide clean water and improved agricultural facilities are also part of the Foundation's work.

AMREF has responded to the challenge of Africa's vast distances and the isolation of its many tiny rural communities by developing a travelling health service. The Clinical Service has mobile ground units that visit the more remote areas in Kenya, Tanzania and Uganda, carrying out immunisation programmes, teaching programmes and general health care. This works as a cost effective alternative to specialist medicine which is often less appropriate and unobtainable in these poorer rural areas. Maternal Child Health Clinics are one of our major concerns where health workers, chosen by the community, teach the local people about nutrition, family-planning and sanitation.

To supplement these projects, AMREF trains local staff:

- recruiting suitable local people to form an integrated rural health service;
- providing refresher and extension courses;
- preparing teaching materials to be used in the classroom and as manuals;
- distributing a range of publications, audio-visual materials, and making regular radio broadcasts in Swahili and English.

Address: AMREF, 11 Waterloo Street, Clifton, Bristol BS8 4BT, England.

Action in International Medicine (AIM), UK

The following is extracted from the *Observer* newspaper, 4 April 1991:

British doctors are planning international action to stop millions of avoidable deaths in the Third World. A radical new group, supported by 68 medical colleges and academies worldwide, will formally launch its declaration of aims in Toronto in August.

'Any doctor who does not have a conscience about the millions of people who do not have access to medical care of any kind is not a full member of the profession', said Sir Gordon Wolstenholme, former director of the Ciba Foundation and motivating force behind the new group.

Sir Gordon hopes the organization, Action in International Medicine (AIM), will complement the work of the World Health Organization rather than compete with it.

As it is not tied to any government, it is hoped that AIM will prove to have greater flexibility and be considerably less bureaucratic and bothered by red tape.

The group has helped to establish three projects in the Third World, in Brazil, Zambia and Malaysia to train doctors in community and general medicine. Their training will enable them to run district hospitals, providing basic surgery and obstetrics and out-patient clinics to treat diabetes and high blood pressure and deal with paediatrics.

'We are not trying to whip up people to go and practice in the Third World, but to help raise standards and improve the basic training of local people. There is no point in going out and doing 5000 operations unless, when you come away, you leave doctors there better able to do the operation themselves.

'We want to see centres established to train doctors in general practice. Many developing countries provide good training in specialist fields, but are not good at producing the generalist who can cope with the health needs of the general population.

'In many countries, doctors who have just qualified have to work for two or three years in a district hospital to pay the government back for their training. But these hospitals are under-resourced and because the doctors have just qualified and are totally inexperienced, they usually hate it and leave as soon as they can.

'We feel that the best doctors should be put in these district hospitals and these jobs should be made more attractive.'

Address: Sir Gordon Wolstenholme, AIM, Windeyer Building, 46 Cleveland Street, London W1P 6DB, England.

Implants of levonorgestrel for contraception

The following is extracted from a report 'At arms length' in the latest *IDRC Reports*, Volume 18, No. 4, 18:

'NORPLANT capsules are the first contraceptive implants to become available for general use. NORPLANT has been approved in 15 countries and is currently being reviewed by the Food and Drug Administration (FDA) in the United States. It is estimated that close to half a million women are using, or have used, the implant worldwide, and the numbers are increasing rapidly.

The contraceptive part of NORPLANT is not new. The thin rubber capsules contain small doses of a synthetic hormone called levonorgestrel, a substance used in oral contraceptives for years.

What is new is the method by which the contraceptive is delivered: a continuous release of controlled amounts of hormone into the woman's body for a period of up to 5 years.

The development of NORPLANT is a fascinating and surprising story; fascinating, because it demonstrates how complex, costly, and fraught with hazards the process of developing a contraceptive can be. It is surprising because, despite the cost of over \$20 million and 25 years of research, NORPLANT was not developed by one of the multinational pharmaceutical giants, but by the Population Council, an international non-profit organization based in New York.

Wayne Bardin, a vice-president of the Population Council, became involved with the project 10 years after it began. "There was a great deal of opposition to implants from population experts who were convinced that women would never accept the methods", he said. "Even I had some doubts". But the experts were wrong.

From the very beginning, the Council never had difficulty attracting volunteers to test the new contraceptive.

As is often the case in research and development, the creation of NORPLANT required a small measure of chance. It is just possible, for example, that if the Population Council's Dr Sheldon Segal had not had lunch one day in 1965 with a representative of the Dow Corning Corporation, the implant might never have been developed. Over lunch the conversation turned to Silastic, a polymerized silicone rubber material used by Dow Corning in artificial heart valves and other medical implant devices.

To Segal, Silastic material suggested another possibility—a contraceptive implant. If dyes and other liquids slowly dissolved through the Silastic implant, hormones, he reasoned, could also slowly release from the capsules into the body. He began to test his idea that same day in his laboratory on female rats. The concept was workable.'

UNICEF—Facts and figures, 1990

The above brochure gives an account of UNICEF's work in various parts of the world, together with a wealth of factual information under the headings of health, economy, immunization, demography, maternity, education, literacy, mortality, nutrition, water and sanitation. Address:

UNICEF Headquarters, UNICEF House, 3 UN Plaza, New York, NY 10017, USA. (UNICEF has regional offices in Australia, Columbia, Cote d'Ivoire, India, Japan, Jordan, Kenya and Thailand.)

Leprosy control: role of medical institutions—seminar held in Bombay, India

The above seminar was held in December 1990 and was sponsored by the Bombay Leprosy Project and PSM Department, LTM Medical College, Sion, Bombay. The report carries accounts of the talks given by Dr P S N Reddy, Dr C R Revankar, Dr Jerajani and Dr (Mrs) Shantha Sankaranarayanan. The views expressed are of interest to those who still struggle with the problem of persuading medical schools in leprosy-endemic countries to ensure that students receive appropriate training and clinical experience in leprosy. It would appear that India has made more progress in this endeavour than most other countries. The opening paragraphs of Dr Jerajani's contribution include the interesting observation that, '... leprosy is an integrated part of dermatology...' and that the Indian Association of Dermatologists and Venereologists has changed its title to include leprosy.

Blister–calendar packs for MDT in the Philippines

Following the use of locally-produced blister–calendar packs for multidrug therapy for leprosy in the Philippines in a pilot trial 1985–88, the National Leprosy Control Programme has used packs produced by Ciba-Geigy, on over 39,000 cases. Blister–calendar packs have also been used for tuberculosis in the Philippines (see Valeza FS & McDougall, AC, Blister–calendar packs for the treatment of tuberculosis, *Lancet*, 13 January 1991).

Antileishmanial effects of clofazimine and other antimycobacterial agents

The following is the authors' summary of a recent publication with the above title by Evans AT, Croft SL, Peters W in *Ann Trop Med Parasitol*, 1989; **83**: 447–54—'In the search for more effective alternatives to the presently used antileishmanial drugs, the activity of the major groups of antimycobacterial compounds has been examined, both *in vitro* and in animal models of infection. *In vitro*, clofazimine was the most effective compound tested, with a mean ED₅₀ of 2·3 mg l⁻¹ against *Leishmania mexicana amazonensis*, 1·4 mg l⁻² against *L. donovani* and 0·5 mg l⁻¹ against *L. major*. Other active compounds were the thiosemicarbazone thiambutosine and salinazid, a derivative of isoniazid. Isoniazid itself was inactive and rifampicin only partially active. *In vivo*, only clofazimine displayed significant activity, and it was most effective against cutaneous infections. It is considered that antimycobacterial activity is in general a poor predictor of antileishmanial potency.'

Reversal reactions and relapse after multidrug therapy, Hyderabad, India, 2-day workshop, December 1991

Dhoolpet Leprosy Research Centre is organizing a 2-day workshop cum training programme on reversal reactions and relapse after multidrug therapy (MDT) in leprosy on 9–10 December 1991 at Hyderabad. It is anticipated that over 200 doctors involved in leprosy will attend. Participants from the UK and Holland have also confirmed their participation. The subjects covered include: clinical aspects of relapse and reaction after MDT and their management; immunology and immunopathology of reversal reactions; other aspects of leprosy neuritis, other neuropathies; and application of PCR techniques.

The proposed panel of lecturers include: Dr Arundathi, Dr M J Colston, Dr Kumar Jesudasan, Drs Mr & Mrs Katoch, Dr Diana Lockwood, Dr B Naffs, Dr Indira Nath, Dr S K Noordeen, Dr D Palande, Dr P S Rao, Dr G Rarau and Dr Patricia Rose.

For further information: Dr J N A Stanley, Dhoolpet Leprosy Research Centre, Karwan, Hyderabad 500 006, India. Tel: 0842 43236.