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News and Notes

Towards elimination of leprosy, WHO

The above WHO publication (12 pp.) describes the present state of leprosy in the world, with particular attention to what is happening, and what has already been achieved, by the use of multiple drug therapy. Page 2 includes the following: 'Commitment from non-government and other agencies has also increased, as reflected in increased extra-budgetary funding available to WHO, now totalling US$6·4 million for the 1990–1 period and in an increase in public funds—currently US$60 million—raised annually by the International Federation of Anti-Leprosy Associations through its 22 autonomous member associations. WHO estimates that if the current rate of progress can be maintained, the prevalence of leprosy worldwide could fall over the next decade to a tenth of its 1986 level, bringing known cases to less than 500,000, compared with the 1990 figures of 3·7 million.'

Forty-fourth World Health Assembly—elimination of leprosy by the year 2000, WHO

'The Forty-fourth World Health Assembly has called on World Health Organization (WHO) Member States in which leprosy is endemic to take action to eliminate the disease as a public health problem by the year 2000. A resolution adopted by the Health Assembly at its annual meeting in Geneva, Switzerland defined eliminating the disease as a public health problem as "reduction of the prevalence of leprosy to a level below one case per 10,000 population".

Further, Member States in which leprosy is endemic are urged to: (1) to further inrease or maintain their political commitment and give high priority to leprosy control so that the global elimination of leprosy as a public health problem is achieved by the year 2000; (2) to strengthen managerial capabilities within leprosy programmes, particularly at the intermediate level, and to improve training in leprosy for health workers at all levels, including medical students and student nurses; (3) to ensure that coverage of multidrug therapy is maintained at the highest level possible and that patients comply with treatment; (4) to strengthen case-finding activities through various approaches, including health education, community participation and training of health workers.

This marks the first time the Organization has committed itself to the elimination of leprosy, according to Dr S K Noordeen, Chief of the leprosy programme of the WHO, reflecting the significant progress achieved during the past five years in treating people with leprosy through the application of multidrug therapy (MDT).'

National Leprosy Eradication Programme, India, 1990

A recent document, *Guidelines for a modified multidrug therapy in selected districts*, is now available from the Leprosy Division, Directorate General of Health Services, Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi 110011, India. The Foreword by Professor G K Vishwakarma, Director General of Health Services records an important decision regarding the implementation of multiple drug therapy and the primary health services: 'it is important to recognize that MDT could and should be implemented through existing general health care systems. Though 130 out of 196 endemic districts have been brought under MDT, the major concern is how to bring quickly the remaining 66 problem districts under MDT. . . . It is time to

involve primary health care for MDT delivery.' Appendix 8 (Section 2) refers to efforts which will be made to supply blister–calendar packs (all three medicines in 1 pack for 1 month) to facilitate the dispensing of drugs for self-administration, to ensure better compliance and to avoid misuse.

TDR News, December 1990

The following is extracted from *TDR News,* No. 34, published by the UNDP/World Bank/Special Programme for Research and Training in Topical Diseases, WHO, 27 Geneva 1211, Switzerland:

'A resolution adopted at the end of October 1990 (Washington, DC) by the Pan American Health Organization could be the first step towards the disappearance of onchocerciasis, leprosy and Chagas disease from the Americas by the year 2000—or at least their elimination as public health problems. Governments of the region, the resolution states, should now determine whether eradication or elimination of these diseases is feasible, and if so, draw up "appropriate plans of action . . ." Leprosy in Latin America with 295,000 officially registered cases presents nothing like the problem it does in South-East Asia (over 3 million). Brasil, with 240,000 cases accounts for the bulk of the Latin American cases, followed at a distance by Mexico (17,000), Argentina (10,000), Colombia (9000), Cuba (4000) and Venezuela (4000).'

Third World Guide 1991–92, OXFAM, England

Now in its sixth English language edition, the *Third World Guide* is a biennial compendium of information and analysis of the state of the world from a unique Third World perspective. This edition includes articles on global environment, trade, health, culture, aid, and many other issues vital to an understanding of world development in the 1990s. In addition, there are 217 country profiles from Afghanistan to Zimbabwe (with maps and key economic, social and political indicators), country-by-country statistical information, and a full bibliography of reference sources. The *Third World Guide* is now recognized as one of the most comprehensive resources for anyone interested in Third World development. Order from: OXFAM Publications, PO Box 120, Oxford OX2 7FA, England. Price £18.50; 616 pp.

Heiser Program for Research in Leprosy—First Decade

The following is abstracted from the most recent report of the Heiser Program:

'The Heiser Program for Research on Leprosy was initiated in 1974 and made its first grants for research in 1975. The present report includes all of the research awards from 1975 to 1986 that had terminated by the time the review was initiated in 1988. Thus, it covers slightly more than a decade but provides a coherent picture of the activity during the formative period of the program.

The guidelines that were established for the program at the beginning have been maintained without major change, placing the primary emphasis on training of young investigators in leprosy-related research. To provide flexibility in the identification and selection of promising candidates, applications for postdoctoral fellowships were accepted either directly from the candidate or from the head of a laboratory engaged in leprosy research. A second type of award, the small research grant, was included, since it was recognized that many useful projects might be promoted by this mechanism. In a third area, visiting research awards were established to provide travel funds for collaborative studies and for studies involving clinical leprosy.

The 103 research awards represented in this report include all three of these areas. There were a total of 53 postdoctoral fellowships: 19 by direct application and 34 by application of a head of laboratory. Research grants numbered 38, awarded to 30 different investigators, and there were 12 visiting research awards.'

Further information is available from: The Director, Heiser Program for Research in Leprosy, 450 East 63rd Street, New York, NY 10021, USA.

Health Action International (HAI)

Health Action International (HAI) is an informal network of some 100 consumer, health, development action and other public interest groups involved in health and pharmaceutical issues in 60 countries around the world. HAI has participants in Africa, Asia, Europe, Latin America, North America and the Pacific region. HAI believes that all drugs marketed should meet a real medical need; have therapeutic advantages; be acceptably safe; and offer value for money.

In 1988 the World Health Organization (WHO) calculated that of the 5 billion people in the world, between 1·3 and 2·5 billion have little or no regular access to essential drugs. At the same time it is estimated that as many as 70% of the drugs on the global market are inessential and/or undesirable products. HAI supports the Essential Drugs Policy of the WHO which concentrates on the supply and use of some 250 drugs considered to be the most essential. HAI also believes that the problem of the enormous numbers of inappropriate and ineffective products must be tackled.

HAI recognizes that access to appropriate medicines is only one element of health care and that a significant improvement in world health will only be achieved if the problems of poverty, poor sanitation, and malnutrition are addressed.

HAI works at many different levels: with health workers in many countries; with academics and trainers; with government officials and national health associations; with regional decision making bodies such as the Commission of the European Community (EEC); with the pharmaceutical industry; and at international level. HAI participants have taken part in many consultations and discussions organized by the WHO as part of its Revised Drug Strategy and have been active in mobilizing support for the WHO Action Programme on Essential Drugs and Vaccines.

In 1988 HAI groups in Europe set up the independent HAI Europe Foundation whose principal objective is 'to raise and distribute funds . . . to support worthwhile initiatives which reflect HAI ideals and objectives—and in doing so, to extend and strengthen the HAI network'.

The Board of Trustees and the Advisory Board is comprised of health workers, development workers and academics, and includes pharmacologists, who give advice and support to the coordinating team and help to guarantee the standard of project work. Further information can be obtained from the following addresses: HAI Europe, J van Lennepkade 334-T, 1053 NJ Amsterdam, The Netherlands; HAI Asia/Pacific, c/o IOCU, PO Box 1045, 10830 Penang, Malaysia; HAI Latin America, c/o IOCU, Casilla 10993, Sucursal 2, Montevideo, Uruguay.

The continuing spread of AIDS

The following is extracted from *The Guardian*, 18 June 1991:

The future spread of the global AIDS epidemic in the heterosexual population will make drug addict and homosexual cases almost irrelevant in numerical terms, the chief AIDS statistician of the World Heath Organization said yesterday.

Dr James Chin, head of AIDS surveillance and forecasting, said that by the year 2000 around 90% of global AIDS cases would be among heterosexuals.

He told the seventh international AIDS conference in Florence that there may be 'anything from a quarter to a half billion' heterosexuals at very high risk of a sexually transmitted disease, because of multiple sexual partners.

'There may be only 10–20 million homosexual men throughout the world with multiple sexual partners, and 5–10 million injecting drug users throughout the world who share needles on a regular basis.

'The point is to say that the future of the HIV and AIDS pandemic is in the heterosexual population.

'Because of the relative size, even if we were to infect all homosexuals and all injecting drug users, the future really rests with the large number of susceptible heterosexuals.'

Dr Chin said that AIDS cases were likely to peak in Europe and North America in the mid-1990s

if the spread of the HIV virus did not increase. This was because most infections occurred in the early 1980s and would have progressed to the full disease by then.

But he said there would be no decrease in the developing countries of Africa, Latin America and Asia.

'Although all projections must be interpreted cautiously, there can be no doubt that during the next several decades, AIDS in most developing countries will become the leading cause of death among adults in their most productive years, and will also be one of the leading causes of infant and child mortality in many regions.'

Dr Chin warned there were disturbing signs that Asia, which contains more than 50% of the world's population but currently has only 8% of the AIDS cases, was about to see an explosion of the virus.

Figures from Thailand taken among 20,000 military recruits in June last year suggested an infection rate of 2%. Similar tests on the next group of recruits in December showed an infection rate of 6%.

Dr Chin said that in sub-Saharan Africa it was now estimated that one in 40 men and one in 40 women carried the virus.

The Arkleton Trust, UK

The Arkleton Trust seeks applications for a Rural Communications Fellowship in 1992, to be awarded from the Bernard Conyers Fund. An award, or awards of up to a total of £5000 will be offered in the current year. The purpose of the award is to encourage an individual or small organization to disseminate information, findings or ideas related to rural development. Priority will be given to material relating to the Third World, the links between Europe and the Third World, or the lessons which Europe can learn from Third World experience.

The Selection Committee is especially interested in helping to disseminate material which might otherwise remain unpublished or unavailable, relating to unconventional or new and novel approaches to rural development, or to the strengthening of links between small scale projects and programmes to improve the possibilities of self-learning amongst those working at field level who would not normally have access to conventional means of communicating their ideas or findings. However, the work which is the subject of the proposal should already have reached the dissemination state, as it is not the intention that this particular fund should be used to support research.

The means by which information or experience may be disseminated and/or shared may also be unconventional or novel. Whilst it could include a book, monograph or series of information leaflets or a newsletter it might also involve a film, video or digital communications system or a workshop or meeting at which ideas and experience can be exchanged. The Committee will be anxious to encourage the use of new media where relevant and useful.

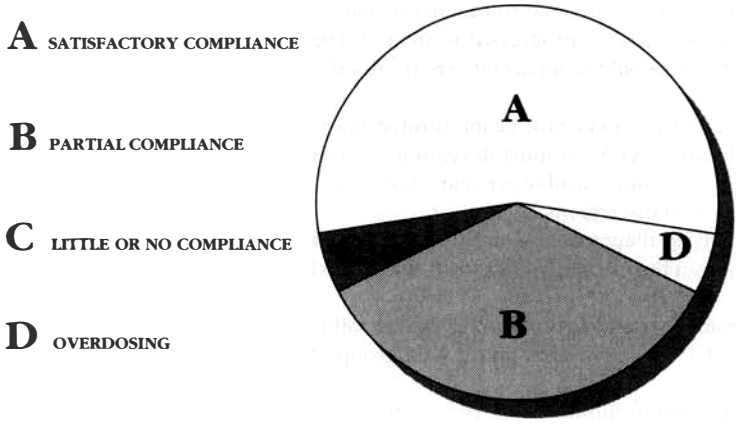
Applicants may be of any nationality or origin, although preference will be given to suitable applicants from individuals or groups working in the Third World, or from under-privileged regions or groups in Europe. The Committee would also welcome enquiries from anyone who is acting on behalf of an individual or group who would not be in a position to see this advertisement and/or submit a conventional application. The closing date for applications for the 1992 award(s) is 14 May 1992 and details of how to apply are available from:

The Administrator, The Arkleton Trust, Enstone, Oxford OX7 4HU, UK.

Compliance and medication monitoring, APREX

The following, headed 'Cutting the compliance pie', is extracted from a recent circular from APREX, European Operations, Postfach 4358, Bundesstrasse 3, CH-6304 Zug, Switzerland:

This pie chart is a reflection of the range of compliance that usually prevails in long-term trials where there are neither unusual incentives for good compliance (e.g., vivid symptom relief, frequent



patient visits to the investigator or use of special compliance-enhancement techniques) nor unusual incentives for poor compliance (i.e. unpleasant side-effects, inconvenient regimen, or large or otherwise difficult to administer dosage forms).

Rule of thumb figures for asymptomatic, chronic treatment are: satisfactory compliance (55%), partial compliance (35%), little or no compliance (5%), overdosing (5%). The definition of 'partial' compliance is: two-fifths to four-fifths of prescribed doses taken. The pattern of gaps between doses taken by partially compliant patients varies widely, often with 2, 3 or even 4 days of consecutively missed doses. Among patients who do take all of nearly all doses, however, dose timing is often poor and quite different from what is assumed by those who design and regulate drug regimens.

Tuberculosis in the Sudan

Professor D A Enarson, Director of Scientific Activities, International Union Against Tuberculosis and Lung Diseases, 68 Boulevard Saint-Michel, 75006 Paris, recently visited the Sudan to advise the Ministry of Health on the further development of the National Tuberculosis Control Programme, with the emphasis of training. The problem is widespread; by no means under control; and has shown no decline in the past decade. Despite the current security and other problems in the Sudan, it was considered entirely feasible to set up a national programme. Particularly in view of recent evidence suggesting that HIV positivity and AIDS are spreading, the necessary steps should be taken as soon as possible, including the provision of chemotherapy for all cases in need.

Neurological disorders in Ethiopia by Redda Tekle-Haimanot

The above, 185 pp plus hundreds of references, is a dissertation from the Department of Neurology, University of Umea, Umea, Sweden. The abstract reads as follows:

There exists only scanty information on the epidemiology of neurological disorders in Africa at large, and Ethiopia in particular. This thesis is the product of epidemiological studies aimed at providing an overview of the pattern and prevalence of neurological disorders in Ethiopia with special emphasis on two rare but important endemic neurological disorders of neuro-fluorosis and neuro-lathyrism. A community-based study was undertaken in the rural sub-district of Meskan and Mareko in central Ethiopia involving a population of 60,820. Epilepsy, poliomyelitis, mental retardation and peripheral neuropathy were found to be the most prevalent disorders (Papers I, II). In the study of 316 identified persons with epilepsy, the highest age-specific prevalence was in ages 10–19 years, with generalized tonic-clonic seizures as the most common type. Ninety-eight per cent of the cases had never been on treatment (Paper III). Concerning attitudes of the community toward epilepsy, traditional views on the association of evil spirits and superstitions were prevalent. Persons

with epilepsy still faced social deprivations and rejection (Paper IV). The results of survey in the fluorosis-endemic area of the Ethiopian Rift Valley for crippling osteofluorosis and its neurological complications (myelo-radiculopathies) revealed that the disorder will in the future be a serious public health problem. The Rift Valley, where artesian wells supply high-fluoride water to the inhabitants, continues to attract many agroindustrial development projects, thus exposing large populations susceptible to the disease (Paper V), Lathyrism, an epidemic neurotoxic disorder induced by heavy consumption of the grass-pea, *Lathyrus sativus*, extensively cultivated in northwestern Ethiopia, was found to have a prevalence rate of 6/1000 in the Dembia and Fogera region, with some villages having rates as high as 2·9% (Paper VI). The changing pattern in the epidemiology of leprosy, the most common cause of peripheral neuropathy in Ethiopia, was evaluated, using the 13 years' records of the Leprosy Control Programmes. A progressive decline in prevalence of the disease was observed, with a dramatic fall in prevalence starting in 1982, a year before the start of the Multiple Drug Therapy programme (Paper VII).

This is a comprehensive account of neurological disorders in Ethiopia including leprosy from a neurologist in Addis Ababa, who is closely connected with the All Africa Leprosy and Rehabilitation Training Centre (ALERT).

Integrated Rehabilitation Clinic for leprosy patients, Bombay

A joint venture between the Bombay Leprosy Project (BLP) and the Vocational Rehabilitation Centre for Handicapped (VRC) began 1 May 1991. The joint venture screens leprosy patients for integrated rehabilitation and is held fortnightly in the VRC premises. It is hoped that the integrated training and rehabilitation offered will help towards the elimination of stigma for leprosy patients.

Wall Journal, Bombay Leprosy Project

Another initiative of the Bombay Leprosy Project has been to start a 'Wall Journal' on leprosy in the Preventive and Social Medicine Campus of the Sion Hospital, Bombay. At the inauguration Dr R Ganapati, stated that the wall chart was intended to keep staff and students up to date on current developments in leprosy. He also reiterated that the fight against leprosy should be done from general medical institutions and not from leprosy hospitals. Mr P V Purandhare, Publications Officers for the BLP proposed that the 'Wall Journal' could become more broadbased if all the doctors from municipal and government hospitals shared their views with voluntary organizations like BLP.

Wellcome Medal for Medical Anthropology, 1990

Dr Zachary Gussow has received the above award for 'Leprosy, racism and public health: social policy in chronic disease control'. It is awarded biennually by the Royal Anthropological Institute of Great Britain and Ireland and in association with the Wellcome Trust. The book is published by Westview Press, San Francisco & London, 1989. A review of the book was printed in *Lep Rev*, 1990; **61,** 196.

Multiple drug therapy manual for Pakistan and Azad Kashmir

Dr Shaukat Ali, Director of Training, Marie Adelaide Leprosy Centre, 'Mariam Manzil', A.M. 21, off Shahrah-e-Liaquat (Frere Road), P O Box 8666, Karachi 03, Pakistan has kindly supplied a copy of this maual which fully describes all aspects of the implementation of multiple drug therapy for leprosy in the above areas in practical terms. The manual should be consulted by those intending to implement MDT, especially in South-East Asia. Amongst many, one item of particular interest concerns the criteria for giving the paucibacillary (PB) regimen, which are as follows: 1, typical TT lesions with clear-cut margin and central anaesthesia: 2, number of lesions: 1–5, including skin AND nerve lesions; and 3, BI (bacteriological index): negative.

UK Training Institutions: Third World and Tropical Health

The following are extracted from a list supplied by the Tropical Child Health Unit at the Institute of Child Health, University of London, 30 Guildford Street, London WC1N 1EH, England:

The Overseas Unit
Health Services Management Centre
Birmingham University
Park House
40 Edgbaston Road
Birmingham B15 2RT
Tel: 021 455 7511

BOMS
Bureau for Overseas Medical Service
Africa Centre
38 King Street
London WC2E 8JT
Tel: 01 836 5833

Christian Medical Fellowship
157 Waterloo Road
London SE1 8XN
Tel: 01 928 4694

Christian Nurses Fellowship
277a Ewell Road
Surbiton
Surrey KT6 7AX
Tel: 01 390 2626

Health Unlimited
3 Stamford Street
London SE1 9NT
Tel: 01 928 8105

HEARU
City of London Polytechnic
Walburgh House
56 Bigland Street
London E1 2NG
Tel: 01 283 1030

Alison Butcher
Hospital for Tropical Diseases
4 St Pancras Way
London NW1 0PE
Tel: 01 387 4411

ICRC
International Committee of the Red Cross
HELP 89
17 Av. de la Paix
1202 Geneva
Switzerland
Tel: 022 346001

IDEA
International Disability Education & Awareness
William House
101 Eden Vale Road
Westbury
Wiltshire BA13 3QF
Tel: 0373 827 635

Teaching Area
IDS
Institute of Development Studies
University of Sussex
Brighton BN1 9RE
Tel: 0273 606201

DICE
Institute of Education
University of London
20 Bedford Way
London WC1H 0AL
Tel: 01 636 1500

Institute of Ophthalmology
Woolfson Building
27/29 Cayton Street
London EC1V 9EJ
Tel: 01 253 3411 Ext. 480

The Course Secretary
Dept. of International Community Health
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool L3 5QA
Tel: 051 708 9393

Administration Department
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool L3 5QA
Tel: 051 708 9393

The Registrar
LSHTM
London School of Hygiene & Tropical Medicine
Keppel Street
London WC1E 7HT
Tel: 01 636 8636

Medicins Sans Frontieres (Belgium)
24–26 Rue Deschampheleer
1080 Bruxelles
Belgium
Tel: (2)425 03 00

Medicins Sans Frontieres (France)
8 rue Saint-Sabin
75011 Paris
France
Tel: (1)40 21 29 29

Medicins Sans Frontieres (Holland)
Reguliersbreestraat 12
PO Box 10014, 1001 E A Amsterdam
Holland
Tel: (020) 251272

The Open University
PO Box 48
Milton Keynes
MK7 6AB
Tel: 0908 74066

Department of International Health and Tropical Medicine
Royal College of Surgeons in Ireland
St Stephen's Green
Dublin 2
Tel: 0001 780200

Dept. of International Training
Royal Tropical Institute
Mauritskade 63
1092 AD Amsterdam
The Netherlands
Tel: (020) 5688711

The Short Course Coordinator
Overseas Development Group
University of East Anglia
Norwich
Norfolk NR4 7TJ
Tel: 0603 57880

Institute of Health Care Studies
University College of Swansea
Singleton Park
Swansea SA2 8PP
Tel: 0792 295314

Population Centre
UWCC
University of Wales
College of Cardiff
51 Park Place
Cardiff CF1 3AT
Tel: 0222 874 833

WHO regional offices

The following is an up-to-date list of all the Regional Offices of the World Health Organization:

Africa: WHO, Regional Office for Africa, PO Box 6, Brazzaville, Congo. Tel: 83 38 60-65. Telex: Unisante Brazzaville 5217/5364.

Americas: WHO, Regional Office for the Americas, Pan American Sanitary Bureau, 525 23rd Street N.W., Washington, D.C. 20037, United States of America. Tel: 861-3200. Telex: Ofsanpan Washington 248338. Fax: (202) 223-5971.

Eastern Mediterranean: WHO, Regional Office for the Eastern Mediterranean, PO Box 1517, Alexandria-21511, Egypt. Tel: 483 00 90. Telex: Unisante Alexandria 54028. Fax: 483-89-16.

Europe: WHO, Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen 0, Denmark. Tel: 29 01 11. Telex: Unisante Copenhagen 15348. Fax: (451) 18-11-20.

South-East Asia: WHO, Regional Office for South-East Asia, World Health House, Indraprastha Estate, Mahatma Gandhi Road, New Delhi-110002, India. Tel: 331 7804. Telex: WHO New Delhi 3165095. Fax: (91) 331.8607.

Western Pacific: WHO, Regional Office for the Western Pacific, PO Box 2932, 1099 Manila, Philippines. Tel: 521 84 21. Telex: Unisante Manila 27652. Fax: 632/52-11-036.

WHO Liaison Office with the United Nations: 2, United Nations Plaza, DC-2 Building, Rooms 0956 to 0976, New York, N.Y. 10017, United States of America. Tel: 963-6004/5. Telex: Unisante New York 234292. Fax: (212) 223-2920.