Lepr Rev (1997) **68,** 184–192

News and Notes

Health care for women in India

Under the heading 'India's women get poor deal on health care, says World Bank' the following appeared in the *British Medical Journal*, 1996; **312:** 1627–8:

Girls and women in India below the age of 30 have higher death rates from illness than men in the same age group, says a new report by the World Bank. The report says that the poor health status of women in India is a major cause of India's female deficient sex ratio—927 females for 1000 males in 1991.

Overall loss of healthy life from non-fatal illnesses and pathological conditions is also higher for women than for men, according to the report. It says that cultural factors, gender bias, and inadequate health care are all contributing to women's poor health.

According to the report, women in India experience more episodes of illness than men and are less likely to receive medical treatment before the illness is well advanced. Communicable diseases, maternal and perinatal conditions, and malnutrition account for 68% of death or disabilities among Indian girls and women.

Community-based studies in the country have shown that a high proportion of women receive no treatment at all for their illnesses and that among those who do the most common treatment methods entail self care, home remedies, or traditional medicine.

'Women's relatively low status and the risks associated with reproduction exacerbate what is already an unfavourable overall health situation,' the report says. It says that excess female mortality up to the age of 30 is a 'symptom of bias against females'.

Although there are wide disparities in female morbidity and mortality among different Indian states and between rural and urban areas, the worst affected are the so-called northern belt states of Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh.

Drawing on national surveys, hospital records, and community-based studies, the report says that 80% of India's maternal deaths—estimated at 437 per 100,000 live births—result from anaemia, haemorrhage, eclampsia, obstructed labour, infection, or abortion. Although there are big differences in the urban and rural situations, the report estimates that only a quarter of all deliveries take place in health centres.

Anaemia is widespread among Indian women and affects between 50% and 90% of pregnant women. The govenment's anaemia prophylaxis programme, which provides iron and folic acid tablets to pregnant women, is crippled by problems ranging from erratic supply to 'poor and questionable' quality of tablets.

The report says that a lack of staff and facilities is pushing women towards illegal and unsafe abortions (estimated to be at least twice as many as the 600,000 legal abortions each year). Many existing facilities in the rural sector lack qualified specialists, operating theatres, or blood transfusion equipment.

Non-governmental organizations working on women's issues agree that government initiatives to improve women's health need to be strengthened significantly. They say that India's poor and vulnerable are suffering from inadequate government spending on public health, coupled with a growing private health sector.

'Existing government programmes are indeed making a difference, but a lot more can and needs to be done,' says Rebeca Robboy, an external affairs officer for South Asia at the World Bank. The report recommends that the government should expand initiatives to increase adolescent girls' knowledge of health and nutrition.—GANAPATI MUDUR, *Science Writer, New Delhi*

Developing a vaccine for tuberculosis

The following is extracted from an editorial published in the *British Medical Journal*, 1996; **312:** 1495 by Adam S. Malin, Department of Clinical Sciences, London School of Hygiene and Tropical Medicine, London WC1E 7HT and Dougals B. Young, Department of Medical Microbiology, Imperial College School of Medicine at St Mary's Hospital, London W2 1PG:

Tuberculosis is a disease of superlatives. *Myobacterium tuberculosis* causes more deaths annually than any other infectious agent. Globally, it is one of the major pathogens associated with HIV disease. The tuberculosis vaccine, BCG, has been given to more people than any other vaccine. However, although this vaccine confers clear benefit against disseminated childhood tuberculosis, its efficacy against adult pulmonary disease has varied widely in different clinical trials. Curiously, protection induced by BCG seems to improve with increasing distance from the equator. In a large randomized controlled trial in Madras, southern India, and a large observation study in Malawi, BCG was no better than saline. It would be good to do better.

The reasons for the failure of BCG in adults remain unclear. Indeed, immunity to tuberculosis is poorly understood both at a cellular and molecular level. It is possible that the ability of BCG to protect against initial infection may wane with time. Alternatively, BCG may be unable to prevent the establishment of dormant infection, so giving the potential for reactivation later in adult life. An ideal tuberculosis vaccine would be given at birth as a non-living subunit formulation (with a view to safety and quality control) and would confer lifelong protection. Possible alternative profiles for new vaccines include a 'booster' vaccine that could be given to young adults (a high risk age group), 'transmission blocking' vaccine that would decrease positively in sputum smears, and an 'immunomodulating' or therapeutic vaccine that could be used as an adjunct to shorten current treatment protocols.

In March 1995, at a meeting in Madrid organized by the World Health Organization's global programme for vaccines, groups from the public and private sectors met to discuss a global coordinated programme for developing vaccines. Recent progress in mycobacterial genetics has uncovered exciting new strategies for generating candidate vaccines. Scientists are beginning to understand the molecular basis of attenuation of BCG and other avirulent strains of tuberculosis. This raises the possibility of designing new live vaccines, either by inactivating key genes in *M. tuberculosis* or by adding new genes to BCG. For example, BCG has been constructed to express cytokines designed to enhance its immunogenicity. Another approach is based on developing a subunit vaccine. Vaccination with secreted antigens isolated from *M. tuberculosis* cultures has been shown to confer significant protection against challenge in experimental models.

Alternatively, genes encoding appropriate antigens can be delivered using suitable expression systems or vectors for immunisation. Promising results have been achieved by vaccination with nucleic acid or 'naked DNA', and a range of bacterial or viral vectors is also under consideration. With information from the tuberculosis genome project, currently under way at the Sanger Centre in Cambridgeshire, it is possible to consider screening all the genes of *M. tuberculosis* for vaccine efficacy rather than relying on selection of particular proteins from laboratory cultures.

Formidable problems are likely in moving a vaccine from the laboratory into clinical trials. Protection in animal models cannot be taken as a measure of protection in humans. Seventy years of experience with BCG have shown the difficulty of evaluating a vaccine against tuberculosis. There is clearly a need to identify a short term surrogate marker of potential efficacy. The current Mantoux or Heaf tests based on skin test hypersensitivity do not reflect protection. Attempts are being made to develop new skin tests based on improved antigen preparations or using in vitro assays to assess

protective, cell-mediated immune responses. In the longer term, an ideal trial would involve vaccinating neonates and testing for protection against disease in young adults. However, initial shorter term trials of any new vaccine will probably focus on attempts to boost responses in high risk groups who may already have been exposed to infection or BCG vaccination.

Hansenologia Internationalis: leprosy journal in Portuguese from Brasil

Readers in other parts of the world may not be familiar with this excellent twice-yearly publication from *Instituto Lauro de Souza Lima*, Caixa Postal 62, 17001–970, Bauru, SP, Brasil, edited by Professor Diltor V. A. Opromolla. Although mainly in Portuguese, an English abstract is usually printed with each article. Manuscripts may be submitted in Portuguese, English, Spanish, French or Italian. The latest received (December 1995) includes an interesting editorial by the Editor on the role of nongovernmental organizations in leprosy control in Brasil and an extensive article by Marcos Virmond, Division of Research and Training at the above Institute, on 'Leprosy as a Low Prevalence Disease'. The issue ends with a valuable review of recent publications with summaries in Portuguese and English. This Journal is normally distributed on subscription.

Clinical tuberculosis, Crofton, Horne & Miller, TALC (UK)

This Book is sponsored by the International Union against Tuberculosis and Lung Disease and by TALC. A low cost edition for developing countries has been financially supported by the World Health Organization and other bodies. It is written primarily as a practical guide for busy nonspecialist doctors working in areas with few resources. The language is simple, and there is an extensive glossary. The Book can therefore be useful to health (medical) assistants and senior nurses with a limited knowledge of English. It can also serve as a helpful reference for younger doctors in developed countries who now have less experience of tuberculosis.

The Book covers diagnosis and treatment of all types of tuberculosis, pulmonary and nonpulmonary, both in adults and children. It deals fully with the effects of HIV infection on the disease and describes the essential elements of a National Tuberculosis Control Programme. There are many line drawings and flow charts as aids to training, learning and clinical practice. 'Stories' about individual patients highlight practical points.

The three authors have had many years experience of dealing with tuberculosis and of teaching both undergraduates and postgraduates. They have advised in many countries in Asia, Africa and South America. The final text incorporates constructive comments on an earlier draft by experienced consultants from the IUATLD, WHO and consultants working in several countries in Asia, Africa and the Pacific. The Book therefore represents much collective wisdom.

Recent information from TALC indicates that over 46,000 copies of this Book have been distributed in the 11 languages in which the book originally appeared; these include Chinese, French, Spanish, Portuguese, Thai, Vietnamese, Farsi (Iranian) and Mongolian. A Russian edition has recently been completed, as also Arabic; an Italian one should appear soon and funds are being sought for Urdu and Croatian editions. The level of interest and demand has thus exceeded all expectations and appears to be increasing. The price in developed countries is £10.99, but for most of those mentioned above it is £3.00 per copy. For those with absolutely no access to foreign currency, a free copy may be available, on application to TALC, P.O. Box 49, St Albans, Herts AL1 4AX, United Kingdom.

Minding your health abroad (MASTA)

MASTA, The London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK (Tel: 0891 224100), offers information and a wide range of products and equipment for health

protection for people travelling abroad, including the tropics. This includes mosquito repellents, broad spectrum UVA and UVB protection for the skin, anti-malarials, water purifiers, and pumps, mosquito nets for beds and cots. The Blood Care Foundation provides fully screened and tested blood to travellers in countries where this is not readily available. Sterile medical equipment packs, with needles, syringes, dressings etc. are also included.

Global Tuberculosis Programme & Global Programme on Vaccines: statement of BCG revaccination for the prevention of tuberculosis

The following is reproduced from *Weekly Epidemiological Record* (1975) **70,** 229–30:

The Bacillus Calmette-Guerin (BCG) vaccine is derived from a live, attenuated strain of *Myobacterium bovis*. It has been used for the prevention of tuberculosis in humans since 1921 and approximately 3000 million doses have been administered. BCG is the most widely used vaccine in the world; in 172 countries where BCG immunization is given, 85% of infants received BCG in 1993, with average coverage ranging from 62% in Africa to 92% in South-East Asia and the Western Pacific.

The use of BCG vaccine has been controversial for decades, largely owing to disparate results from clinical trials evaluating its efficacy and the debate surrounding these differences. BCG vaccine is routinely administered in developing countries, whereas its usage has been discontinued or has diminished in many industrial countries of Western Europe and North America. There are different policies regarding the use of BCG in different countries and regions of the world, with different vaccine preparations. Where BCG is used, the vaccine is most commonly administered at birth or in the first year of life. In some countries, BCG revaccination is given to children at school entry, and in some regions, especially Eastern Europe, multiple revaccinations have been administered throughout childhood and adolescence. This document is intended to clarify WHO recommendations on BCG revaccination, based on currently available scientific evidence.

Efficacy of BCG vaccines

From 1927 to 1968, 21 controlled clinical trials of the efficacy of BCG vaccines were initiated in 10 countries, of which 19 were completed and evaluated. The protective benefit was found to be extremely variable, ranging from 0% to 80% with different vaccines in different settings. In the most recent and largest trial, performed in Chingleput, India with over 200,000 participants, the results were disappointing, as BCG showed no protective effect. Of 7 trials which reported on survival, the protective effect against death ranged from 7% to 88%, although in most studies there were few deaths. In trials which reported specific morbidity, protection against meningitis or miliary tuberculosis in children ranged from 46% to 100%.

In the past decade, there have been 14 case-control studies in 12 countries, comparing cases of tuberculosis to selected controls by BCG vaccination status. Efficacy has ranged from 2% to 83%, and against meningitis or miliary tuberculosis in children, 58% to 100%. Evaluation of household contacts of known cases of tuberculosis has also shown protective efficacy of 53% of 74% in those contacts who received BCG vaccine.

BCG vaccine does not appear to prevent primary infection with *M. tuberculosis* nor does it prevent an appreciable number of infectious pulmonary cases, and therefore does not significantly decrease transmission of tuberculosis within a community. Taken together with the variable efficacy noted above, BCG vaccination has a relatively low impact on the global control of tuberculosis.

[1] Earlier recommendations concerning BCG and HIV infection remain unchanged (see No. 40, 1987, pp. 297–299)

Tuberculin skin testing and BCG revaccination

Use of BCG vaccine results in conversion of tuberculin skin tests in most recipients; the duration of this hypersensitivity is variable, and the size of induration wanes with time. In some programmes, negative tuberculin skin tests have been used as indicators for the need to revaccinate with BCG. However, there is poor correlation between skin test conversion rates or size of induration and protective immunity, and there is no evidence that waning of post-BCG vaccination tuberculin sensitivity is associated with waning protective immunity. Once an individual has been vaccinated, there is no reliable way to distinguish tuberculin reactions due to BCG from those caused by natural infection. The risk of administering BCG vaccine to persons with positive tuberculin reactions due to either prior BCG vaccination or natural infection is minimal. Numerous studies have shown that direct vaccination, i.e. BCG vaccination without prior tuberculin testing, is safe and acceptable to populations being vaccinated.

Efficacy of repeated BCG vaccination

There is no definite evidence that repeated BCG vaccination confers additional protection against tuberculosis. In Hungary, where systematic BCG revaccination was utilized from 1959 to 1970, incidence of tuberculosis declined significantly in the following decade. However, there was no comparative control group and other factors may have been responsible. In a retrospective analysis in Poland from 1965 to 1977, persons with tuberculin skin tests <5 mm who were not revaccinated, compared with a group who were revaccinated, had a higher incidence of tuberculosis in the ensuing 12 years. The number of incident cases were few, and the groups were not randomized and may not have been comparable. In Chile, where BCG revaccination is given at ages 6 and 14 years, there was no difference in the percentage of young adults with 1, 2 or 3 BCG scars between patients with tuberculosis and controls, suggesting no benefit from repeated vaccination. There are as yet no reports of prospective, comparative clinical trials which have assessed the efficacy of BCG revaccination.

Although BCG vaccine is relatively inexpensive, the administration of BCG vaccines after the first year of life or giving repeated vaccinations may incur significant additional cost and is probably not cost-effective. However, the cost-effectiveness of BCG vaccine is difficult to study owing to the variability in vaccine efficacy, BCG preparations, vaccination schedules, and incidence of tuberculosis in different countries.

Recommendations

Based on the above information, the following recommendations reiterate and update previous WHO statements on the use of initial BCG vaccination and revaccination. Since BCG vaccination has variable efficacy, it should be considered an adjunct to national tuberculosis programmes. Rapid case detection and effective treatment remain the highest priorities for the control of tuberculosis in all countries.

1 In countries where the prevalence and incidence of tuberculosis are high, BCG vaccination should be given to infants as soon after birth as possible, and in any case, within the first year of life.
2 Where tuberculin skin testing is used to make decisions on BCG revaccination, the practice should be discontinued.
3 For persons who have received BCG vaccination, repeat vaccination is not recommended, as scientific evidence does not support this practice. Multiple revaccinations are not indicated in any person.

• A list of references is available on request from the Global Tuberculosis Programme, WHO, 1211 Geneva 27, Switzerland.

Report of 5th Independent Evaluation of the National Leprosy Eradication Programme (NLEP) India, June 1995

The National Leprosy Eradication Programme (NLEP) of India was subjected to a joint Government of India/WHO Independent Evaluation by teams with national and outside expert leprologists, health administrators, planners and communicators as members from 5–14 June 1995. The teams visited 13 states and 29 districts after interacting with authorities at national level. The Report (48 pages) describes the terms of reference, observations and activities of the teams in considerable detail. The main recommendations were as follows:

Political commitment

The political commitment displayed by the Government of India towards the leprosy eradication programme was greatly in evidence and has to be sustained till the goal of leprosy elimination is achieved. However, such commitment was not in evidence in several states where the leprosy programme is considered as the programme of the Government of India. This has to be changed early by interaction with the highest political administrative functionaries in the states.

Plan of action for leprosy elimination

None of the States visited had developed or implemented plans of action towards leprosy elimination based on the national plan which envisages attainment of the goal of leprosy elimination by reducing the leprosy prevalence rate to <1 case/10,000 population by 2000 AD. The Government of India should provide technical guidance to the states/UTs to develop their plans for leprosy elimination within a time frame as well as additional financial support as required. The states be encouraged to take initiatives on their own to achieve prevalence reduction and be considered for financial support towards such ad hoc activities.

The elimination goal calls for intensification of coordination efforts and setting up of intermediate targets to ensure steady progress towards elimination in each State specially the large ones. Such efforts would ungrade the political will and administrative support to the States besides promoting healthy competition for early attainment of the goal of leprosy elimination.

Strengthening of national & state programme headquarters

The staff position of several state leprosy programme headquarters require greater and quicker attention to improve the supervision and monitoring capabilities.

MDT coverage

Geographic coverage: While the Government of India has sanctioned MDT extension to all the 217 uncovered nonendemic districts in the country releasing funds and supplying vehicles during 1994–95, all the nonendemic districts, except in Maharashtra, are in the preparatory phase. Urgent review with the highest functionaries in the States/UTs to expedite the accessibility of MDT to all these districts is essential to accelerate the goal of leprosy elimination.

Sixty-six endemic districts in the states did not have adequate vertical infrastructure affecting the progress of MDT. The Government of India had released funds during 1994–95 to recruit additional leprosy infrastructure required to cover these districts on a contractual basis. However, none of the districts in Bihar had reported recruiting the staff due to administrative and procedural delays. A few districts in Uttar Pradesh also have to recruit the staff. The states have to be persuaded by the highest functionaries in the Government of India for ensuring full infrastructure.

Coverage of registered cases: MDT coverage of registered cases by and large was reported to be very high in all the states and districts visited. According to Government of India reports, 13 per cent of the leprosy cases were still on dapsone monotherapy at the end of March 1995. The primary health centres in nonendemic districts, except in Maharashtra, have to be assigned a more active role in the leprosy programme. It should be clarified that MLTUs are expected to provide MDT with active support from PHC systems in the implementation of leprosy programme activities.

Poor communication, low population density, high vacancy position of staff and special features of the communities make accessibility of MDT difficult in some areas in the endemic districts. Special flexible innovations should be considered for achieving higher accessibility of MDT to such difficult areas and the states encouraged and guided to initiate flexible, innovative ad hoc activities to accelerate the MDT coverage in such areas.

Fixed duration treatment, though adopted by the programme at national level, has yet to replace the longer duration MDT in some districts, especially to MB cases.

Antileprosy drugs

While it is gratifying to note that there was no shortage of antileprosy drugs during the year 1994–95 some excess stock of dapsone in a few districts some of which had become time-barred should be written off as per instructions for their disposal from the centre. Uninterrupted stocks of MDT drugs be ensured to last at least for 3 months in LCUs/ULCs and for 6 months in a district.

Filling up staff vacancy and orientation

Urgent action should be taken by some of the states to fill the large number of vacancies of different categories of staff.

A large proportion of vertical leprosy staff in some states like Bihar, especially medical officers are functioning under the programme without training, making then ineffective supervisors and motivators. Printed guidelines on MDT in non-endemic districts emphasizing the involvement of PHC staff should be disseminated in adequate numbers to all concerned defining the tasks to be assigned to different categories vis-a-vis MLTUs.

Supervision and monitoring of programme performance

Supervision and monitoring of the programme activities at grassroots level was one of the weak links in some districts visited and requires urgent improvement by identifying poor supervisors and making them answerable for their unsatisfactory performance.

Critical and rapid analysis of data generated and compiled from reports and feedback with suitable comments/clarifications to the reporting districts would help in taking timely corrective steps and careful preparation of future reports.

Periodic review of the progress of NLEP by the Health Secretary in the States/UTs especially those with unsatisfactory progress with all the concerned including district level officers should be undertaken to identify the problems and take correctives without delay.

Updating estimated leprosy cases

While the national figures were being updated annually since 1993, it was not done regularly by several districts. Guidelines on updating the figures should be shared with the districts so that they could start estimating prevalence annually, contributing to realistic estimates at the national level.

IEC activities

IEC activities should be intensified without delay to all the nonendemic district before MDT or at least

along with MDT introduction to increase community awareness which was found to be low in nonendemic districts.

Health education activities should be continued/strengthened in the endemic districts, in view of the low levels of community awareness observed in some of them till the goal of leprosy elimination is attained.

Resource mobilization

While the Government of India has been very active in the mobilization of resources and in providing the states additional funds from its own resources and from outside sources, some of the states remain passive recipients to this support without active involvement in decision-making.

Antileprosy Week, Health Education Activities, Bombay Leprosy Project

Antileprosy Week Observation, 30 January–5 February 1997, culminated in Dr V. V. Pai, the Deputy Director, being applauded for his work in the field of leprosy and assisting the National Leprosy Eradication Programme by Brihanmumbai Municipal Corporation. Listed below are the weeks activities:

Place	Activity		Audience (No.)	Resource person & subject
Thakkar Bappa Colony, Chembur	Slide show	Slum women	(45)	Mr S. S. Deshpande—Leprosy signs and symptoms
Thakkar Bappa Colony Chembur	Slide show	Slum Adults	(35)	Leprosy Signs and Symptoms
Chhatrapati Shivaji Terminus, Mumbai—Suburban Central Railway Hall	Exhibition	Railway commuters, staff, doctors and nurses	(20,000)	'Leprosy awareness' with posters, hand-outs, etc.
RRE Society ALH Wadala, Mumbai	Case demonstration	Postgraduate medical students		Dr R. Ganapati, Dr V. V. Pai
Shastrinagar Municipal Dispensary, Dharavi Mumbai—17	Training and Exhibition	Community health volunteers, health post workers and OPD patients	(CHV, 35; health post workers, 15; OPD patients, 100)	Dr Mahendra Singh, Asst Director of Health Services (Lep), Mumbai. Mr S. S. Deshpande, Mrs R. R. Pai Training on Leprosy 'How to detect leprosy'
Foundation for Medical Research, Worli Manbai—400 018	'Laboratory aspects of leprosy diagnosis. Monitoring and Cure'	Dermatologists	(21 Dermatologists and PG students; 18 other laboratory personnel)	Dr R. Ganapati Dr W. Upalekar Dr Geeta Rane Dr V. P. Shetty Mrs Kamal Sethna Dr V. V. Pai
Lecture Hall, Chetna College. Bandra	Exhibition	NSS students	(500 college students and staff)	On leprosy—with posters and handouts etc.

XV International Leprosy Congress, Beijing, China, September 1998

Basic concept and framework:

The XV International Leprosy Congress in Beijing, to be held in September 1998, may be termed a '*Centennial Congress*.' signifying the end of the first century of modern leprosy control. This century was initiated by the first Congress in Berlin in 1897 and, hopefully, will achieve the 'Elimination of leprosy as a public health problem.' This achievement will signal the start of the second century of our modern fight against the disease which should culminate in the total eradication of the disease and its consequences. Eradication means elimination of not only the disease itself but, also, of all the adverse effects of the disease, including the social problems faced by 'people affected by leprosy.'

Therefore, the Congress is being organized under the heading of '*Working Toward a World Without Leprosy*,' not just hoping but actually intending to achieve that final goal sometime during the next century.

The Congress will deal with leprosy and its problems from a holistic point of view, and try to come up with some practical, appropriate solutions in a closely-integrated manner.

The whole programme of the Congress, including keynote speeches, open panel discussions, workshops, question-an-answer sessions in plenary, oral presentations of individual papers in separate sessions as well as poster presentations and other exhibits, have been planned with this approach in mind.

The date of the Contress of six working days is currently fixed as from *Monday 7 September to Saturday 12 September 1998*. The venue will be the *Beijing International Convention Centre* with accommodation at the adjacent Continental Grand Hotel. Both are located well within the city on the 4th Ring Road of Beijing, less than half an hour from the airport by direct highway link, and about 20 minutes by car from Tian An Men Square, the centre of the city.

The Congress is being arranged quite differently from previous Congresses. Four main changes are proposed: 1, no more pre-Congress workshops; 2, much less time for oral presentations of individual papers; 3, much more provision for poster presentations; 4, much more time to be spent in plenary sessions. There will be short teaching sessions on 10–12 subjects on three or four evenings. The plan reflects the four main characteristics of the XVth Congress which are: '*Integrated*,' '*Action Oriented*,' '*Interactive*,' and '*Participant Friendly*.'

The *first official announcement of the Congress*, a one-page flier with dates, venue, and a broad outline, will be set out *later this year* without details such as daily programmes, which will appear only in the *second/final announcement* scheduled to be published in *October 1997*.

In addition to the daily programmes, we have discussed some other relevant matters as follows: The expected number of *Participants*, 800–1000 overseas plus 300 Chinese. The *Registration fee*, US$250 or less. *Accommodation cost*, with more than 10% annual inflation, the cost of living is increasing rapidly, but we are hoping to settle on US$100 with twin bedroom for two persons per day. *Language*, English only with Chinese translation as required. *Schedule* of events related to the preparation of the Congress: Joint consultation with Chinese Organizing Committee in September 1996. Second Organizing Committee meeting in April/May 1997 to decide the details of the programme, selection of people for key roles, sucy as keynote speakers, moderators and members of open panels and workshops, teachers for short-course sessions, etc. Closing of Abstract submission, end of March 1998, Third Congress Organizing Committee Meeting, June 1998.

Leprosy Review posters: Prevention of disability

The A3 poster enclosed with this issue of *Leprosy Review* is the fourth in a series of four covering important areas of management and research in leprosy and is distributed free to subscribers to the Journal. Additional copies are available from Lepra, Colchester, UK. Further posters are also being planned. 'A questionnaire on the posters is to be published in the September issue so that the choice of topic and other aspects can be guided by you the reader. So please do let us know what you think.'