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News and Notes

20th Biennial Conference of Indian Association of Leprologists

The 20th Biennial Conference of Indian Association of Leprologists was held at the Gandhi Medical College, Bhopal from November 28–30, 1997. About 316 delegates from different parts of the country and a few delegates from abroad were registered for the conference. Dr S. K. Noordeen, WHO consultant on Elimination of Leprosy inaugurated the conference and delivered the key note address. He spoke of the prospect for elimination of leprosy as a public health problem within the deadline of the year 2000 and the three pronged strategy of 1) Leprosy Elimination Campaign (LEC), to reach hidden cases and bring them under treatment; 2) Special action approaches for the elimination of leprosy (SAPEL) to reach patients in in-accessible areas and 3) Making MDT available in every general health facility so as to make leprosy treatment universally acceptable.

There were two state of the art lectures on 'Vaccines against leprosy', by Dr B. R. Chatterjee and 'Pathology of nerves in leprosy' by Dr Vanaja Shetty. Dr Chatterjee stressed the need for a vaccine with dual potential—the ability to boost the immune system thereby protecting against infection and the ability to suppress misplaced immune and auto immune responses thus preventing nerve damage. Dr Shetty through her detailed light, semi-thin and electron microscopic work elegantly described the various pathogenic mechanisms involved in nerve damage and the frontiers for research in the prevention of nerve disability.

There were 11 scientific sessions spread over the three days with both oral and poster presentations. Areas covered included Microbiology and Biochemistry, Immunology and Pathology, Clinical Leprosy, Treatment, Reconstructive surgery, Epidemiology and leprosy control, disability prevention and social aspects.

A special session was held on 29th November '97 to address the issue of mono-lesion treatment with ROM and shortened MDT for MB leprosy. Dr Noordeen introduced the discussion and Dr Ganapathi outlined the magnitude of the problem of mono-lesions. Brief reports on ROM were presented from different centres involved in the Multi-centric WHO Trial. Dr Katoch, Dr Diana Lockwood and Dr B. N. Reddy gave short presentations on the advantages and limitations of WHO ROM treatment.

Dr Britto from TRC, Chennai was chosen for the best publication award for the paper entitled 'Regional lymphadenitis following a leprosy vaccine' and Dr Anurag Tiwari received the best presentation award for his case report entitled 'Punch grafting for trophic ulcers'.

The main conference was preceded by pre-conference Symposia on 'The Relevance of Leprosy Research in the present Scenario' and 'Leprosy Scenario in low endemic areas'. The Chief Guest at the closing session was Dr Kamlakar Singh of University Grants Commission. Dr J. A. Ponnaiah was elected president and Dr Porichha as Secretary of the Association for the next Biennium.

The conference honoured two great personalities in the field of Leprosy—Dr S. K. Noordeen and Dr G. Ramu for their doyen services.

LEPRA INDIA was one of the voluntary organisations who contributed by way of sponsorship for the conference.

Dr Sujai Suneetha,
Dhoolpat Leprosy Research Centre,
Hyderabad, India

New tools for leprosy control

Taken from *TDR News*, no. 55, February 1998

With regard to leprosy, WHO's goal is 'elimination as a public health problem', i.e. reduction in prevalence of the disease to below one per 10,000 head of population in all endemic countries, by the year 2000. This implies that leprosy will exist well into the next century, although at a much reduced level. One reason for having a current goal of elimination as opposed to one of eradication (complete disappearance of a disease from the face of the earth, as has been achieved for smallpox and is currently being undertaken for poliomyelitis) is the current lack of tools suitable for eradicating leprosy.

In order to eradicate a disease, amongst other prerequisites, we must know how many people are carriers of the pathogen, in this case *Mycobacterium leprae*. So-called skin test reagents (e.g. Mantoux test, lepromin) are used to estimate the number of people exposed to the mycobacterium and hence the number who may be carriers of the pathogen. The reagents are bacterial preparations which, when scratched into the skin of a person who has been exposed to the pathogen, produce a skin swelling which is immune-dependent. The major problem with existing skin test reagents is that they lack specificity and often cross-react, detecting exposure to all kinds of mycobacteria other than the one used for production of the skin reagent. This is a particular problem in leprosy endemic countries, where people may be confronted by a whole range of mycobacteria which are closely related to *M. leprae*. With a long-term view to eradication of leprosy, TDR has been supporting the development of a skin test that would be specific for leprosy only. An immediate benefit would be easier monitoring of the effect of multidrug therapy on the circulation of *M. leprae* in a given community.

The rationale for the TDR leprosy skin test initiative is that, although most individual proteins of *M. leprae* will cross-react with other mycobacteria, certain short fragments of them (peptides) are likely to contain *M. leprae*-specific epitopes that may induce immune reactions comparable to those provoked by the intact proteins. To be useful in a leprosy-specific skin test, the peptides must not only be sufficiently different from peptides of other infectious organisms, especially other mycobacteria, but they must also be recognized by the immune systems of individuals previously infected by the bacterium. Two hundred 15-mer peptides fulfilling these prerequisites were selected as candidate antigens for a leprosy-specific skin test. Selection was based on empirical algorithms which predict association with antigen-presenting (HLA) molecules and on gene-library comparisons between *M. leprae* and *M. tuberculosis*. Ultimate proof of immune recognition however will have to await clinical testing in humans.

A potential problem for peptide-based skin tests, however, is the genetic variation in antigen recognition that may exist in different human populations. Although antigen recognition by each human being is unique, population-specific antigen recognition patterns have been described for other infectious diseases such as malaria and are suspected to be at work in leprosy. Therefore, testing of candidate peptides will be carried out in different leprosy-endemic areas of Asia, Africa and Latin America. Should the project confirm that such genetic differences exist, the skin test will ultimately be tailor-made for a given geographical area or, alternatively, will contain a mixture of several peptides representing all regional 'preferences'.

Currently, the peptides are being tested *in vitro*, using blood lymphocytes from leprosy patients and controls (healthy people from non-endemic areas). Once the laboratory tests are completed and the most reactive peptides have been infected, skin testing will begin in humans. It is hoped that the laboratory tests will be completed by the end of 1998 and that human trials will begin in 1999. Apart from the obvious focus on safety and freedom from side effects, the human trials should determine whether peptides known to react with blood lymphocytes are also capable of stimulating a skin reaction *in vivo* and whether or not they cross-react.

Vaccine discovery research converges to focus on products

Taken from *TDR news*, No. 55 February 1998

Vaccine discovery in TDR has changed. The three disease-specific vaccine committees have become one (the Vaccine Discovery Research Committee [VDR], see *TDR news* No. 54, October 1997); there are revised priorities, sharply focused on goals, objectives and products.

Vaccines for malaria, leishmaniasis and schistosomiasis are the end-point. Research will focus on the identification and evaluation of candidate antigens, adjuvants and delivery systems. For malaria and leishmaniasis vaccines, the objectives and product profiles are clearly defined in terms of percentage reduction in mortality and/or morbidity, reduced incidence, duration of immunity and target populations. For schistosomiasis vaccines, the objectives and product profiles are defined in terms of percentage resistance to infection/re-infection and duration of this resistance.

Safe and effective vaccines would represent one of the most cost-effective interventions amongst the present range of control strategies for these diseases. In the last decade there has been considerable progress in understanding immunity to parasitic diseases, identifying vaccine candidate antigens and their genes, and demonstrating the protection afforded by vaccine candidates in animal models. However, due to the complexity of parasitic diseases and the cost of vaccine development, relatively few candidate vaccines have so far progressed to clinical trials; and it has proved difficult to develop *in vivo* and *in vitro* assays for predicting protection. Today we stand on the verge of the post-genome era. There is currently a mass of new information available on genes and their products but a shortage of research funds and a relative lack of commercial interest in parasite vaccines. Thus, at the global level, there is a need for parasitic vaccine discovery, development and clinical testing to be coordinated, organized and executed in collaboration with leading scientists and institutions in disease endemic countries.

The first meeting of the VDR will take place in May 1998; new and innovative proposals in vaccine discovery research are now being solicited. Please send your pre-proposals to the Manager of the Steering Committee on Vaccine Discovery Research (VDR), Dr H. Engers (engersh@who.ch), for advice as to the suitability of topic.

ALLF

Leprosy Review has received the first two issues of *Bulletin de l'Association des Léprologues de Langue Française* (ALLF). We believe that this publication will be particularly useful for French-speaking African workers. For further information and subscriptions, please contact: Association des Léprologues de Lange Française (ALLF), 4 rue Jean Jacques Bel, 33000 Bordeaux, France.

HIV and TB in children

The following is taken from '*Tuberculosis and children: The missing diagnosis*', published by AHRTAG, Farringdon Point, 29–35 Farringdon Road, London EC1M 3JB, United Kingdom, 1996.

Children with HIV are at higher risk of TB infection and of rapid progression to disease than children without HIV. It makes sense to always consider the possibility of TB in a child with HIV infection.

DIAGNOSIS

Diagnosis of TB in children with HIV can be difficult because:

- children who are HIV positive may be tuberculin test negative even when they are infected or ill with TB, because their immune system is not functioning well;

- several features are common to both infections. Failure to gain weight, weight loss, intermittent fever, chronic cough, and history of recurrent illness are seen in children with TB and in children with HIV.

Accurate diagnosis is important because:

- children with HIV without TB should not be given TB treatment unnecessarily;
- children with HIV and TB need treatment.

PROGRESSION AND TREATMENT

The natural history of TB in an HIV infected child depends on the stage of HIV disease.

- If the child is still well and the immune system is working properly, the signs of TB will be the same as in a child without HIV infection.
- If HIV is more advanced, TB can spread to other parts of the body and progress to serious illness more rapidly. Disseminated disease, tuberculous meningitis and general enlargement of the lymph nodes are more common in HIV positive children.
- A sick child with HIV and TB will respond well to anti-tuberculosis treatment.
- Children with HIV should NEVER be treated for TB with thiacetazone because this drug can cause severe and sometimes fatal side effects in patients with HIV.

Scientists discover how HIV enters cells

The following appeared in the *British Medical Journal*, Volume 312, 29 June 1996.

A new, recently discovered cofactor that allows HIV-1 to enter and infect human cells could prove a useful future therapeutic target, according to US scientists writing in the 28 June issue of *Science* (272; 1955–8).

HIV-1 infects cells by binding to the cell surface molecule called CD4. Although this mechanism has been recognised for the past decade, researchers had noted that the presence of CD4 alone was not sufficient to guarantee infection. It became clear that a cofactor was needed.

One of the authors of this recent paper is Edward Berger, chief of the molecular structure section at the National Institute of Allergy and Infectious Diseases at the National Institutes of Health in Bethesda, Maryland, United States.

Berger said: 'We knew that the basic mechanism was rather like two soap bubbles: a large one representing the cells, and a small one, the virus. They stuck to each other, but their contents did not mix. It was this mechanism of viral mixing which we all knew to be crucial, but no one understood how it was achieved.'

Last month scientists from Dr Berger's team identified the cofactor as fusin, a molecule that allows HIV to fuse with its target before entry (*Science*; 272: 872–7). However, only certain strains of HIV-1—those identified in the late stages of HIV infection—seemed to need this cofactor. Other strains, most commonly passed between individuals in the early stages of the infection, seem to have a different mechanism for entering cells.

Along with other teams of colleagues, who published an article in the 20 June issue of *Nature* (381; 667–673), part of the same research group has identified a second fusin-type molecule called CC CKR5. Unlike fusin, which is found on T cells, CC CKR5 is found on macrophages.

CC CKR5 is a receptor for chemokines known to inhibit HIV infection. Chemokines have been shown to stop in vitro replication of HIV. They may achieve this by blocking HIV's access to their receptors, which act as viral docking sites.

'The number and distribution of these cofactors may help to explain why some individuals stay asymptomatic for a long time, while others become rapidly infected with HIV and progress to full blown AIDS faster,' said Dr Berger. The race is now on to create transgenic animal models that have not only human CD4 receptors but also the two newly identified cofactors, fusin and CC CKR5.

'Many of the therapeutic implications of this discovery remain speculative, but we have reached a better understanding of a vital process in HIV infection which has remained unclear until now,' said Dr Berger.

WHO: proactive role in advancing policy of health for all

Under the heading 'Future of international health', the following letter, with the above title, appeared in the *British Medical Journal*, Volume 315, 1st November 1997.

Editor,

A recent article on the new world order and the future of international health and an editorial on reform of the World Health Organisation are valuable contributions to discussions about the future of international health.[1,2] Within the WHO substantial progress has been made over the past 18 months in addressing issues raised in the renewal of the Health for All process.[3] However, the richness and breadth of this process were not captured in Fiona Godlee's editorial, which focused on selected internal and external debates without indicating that they have been formally and informally linked to the renewal process.[2]

The WHO regards the renewal process as integral to the future course of world health. This view is shared by its member states and its governing bodies. During the 50th World Health Assembly in May, discussion on renewal overlapped with the issues raised in the article and the editorial.[1,2] Furthermore, during the subsequent session of the executive board, members expressed support for fundamental actions that should form the basis of the new policy and for specific future roles for the WHO (box). These fundamental actions include the establishment of a universal Health for All value system that explicitly considers the pursuit of human rights and health security, equity, ethics, and a gender perspective, thereby making health central to development. The complexity of future health demands requires consideration of a broader agenda for global health action, not one that is narrow and disease specific.

The Health for All consultation process has been deliberately wide. The early call for dialogue, both through formal consultative documents[4] and through the World Health Forum round table (which drew on a wide range of global reviews[5]), has resulted in a draft policy. This policy incorporates the views of countries, non-government organisations, leading academics, United Nations bodies, and the private sector. The guidelines contained in this draft, however, will need substantive discussion at country level before specific priorities for action can be decided. The draft policy is now available on the WHO's web site (/www.who.ch). Consultations planned until late October include meetings with countries during the meetings of the regional committees in September and October, and with UN bodies, the World Bank, the World Trade Organisation, and a wide range of non-government organisations.

The WHO is taking a proactive role in defining actions that will advance the policy and ensure that it leads to tangible improvements in the health of populations. It is committed to continue working with all who share a common vision of Health for All.

F. S. Antezana *Assistant director general*
World Health Organisation, CH-1211 Geneva 27, Switzerland

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Eliminating World Poverty. 'White Paper' on International Development, Presented to Parliament in the United Kingdom, November 1997

This momentous and potentially far-reaching document was presented to Parliament in London by the Secretary of State for International Development by Command of Her Majesty, November, 1997. The Foreward by the Secretary of State reads as follows.

This White Paper sets out the Government's policies to achieve the sustainable development of this planet. It is first, and most importantly, about the single greatest challenge which the world faces—eliminating poverty. It is about ensuring that the poorest people in the world benefit as we move towards a new global society. It is about creating partnerships with developing countries and their peoples, on the basis of specific and achievable targets, to bring that about.

We can succeed. The overall successes of development in recent decades have been remarkable—people live longer; fewer mothers die in childbirth; fewer infants die from preventable diseases. But the numbers living in poverty are continuing to grow. Too many people—1·3 billion too many—live in extreme poverty. The major UN Conferences of recent years have drawn together an agenda that could deliver sustained progress. There are good reasons for optimism. But to succeed we need to mobilise greater political will across the international community.

It is our duty to care about other people, in particular those less well off than ourselves. We all have a moral duty to reach out to the poor and needy. But we also owe it to our children and our grandchildren to address these issues as a matter of urgency. If we do not do so there is a real danger that, by the middle of the next century, the world will simply not be sustainable. The combination of population growth, environmental degradation and the conflict and disease to which this will lead could impose catastrophic pressures upon the planet. This White Paper outlines the ways in which we can make progress. To succeed, we need the active support of the people of Britain. In this area we could give a lead which would make us all very proud of our country and also secure a safe and decent future for all of us.

The detailed text is interspersed with a number of 'panels' on key issues. That on *Essential Health Care* reads as follows.

THE CHALLENGE

The poorest billion people in the world are ten times more likely to die young (under 15 years of age) than the richest billion; they are nine times more likely to die of communicable diseases (diarrhoea, malaria, pneumonia and TB) and twice as likely to die from accidents and injury. Women, who are more at risk in all cases, are also at least ten times more likely to die of causes related to pregnancy and childbirth. This massive burden of ill-health affects poor people's chances of escaping from poverty and taking advantages of opportunities to do better.

Tackling high death and disability rates among poor people poses real challenges. For example, millions of people throughout the world cannot access sufficient water for personal use. As many as half the world's population lack access to effective means for disposing of excreta. Water, sanitation, shelter, food and education, as well as essential health care, are all vital requirements if efforts to improve poor people's health are to succeed.

Recent studies have indicated that a spend of just £9 per person per year on essential health care is sufficient to make a real difference to the suffering of poor people. This would allow a basic package of immunisation and nutritional supplements and public education of family planning, prevention of AIDS and sexually transmitted diseases and substance abuse, to be provided. Currently, many developing countries spend less than £3 per person per year for all health needs, and these funds are not distributed in a way that ensures equitable service provision.

OUR RESPONSE

The UK has signed up to a series of relevant international targets to be achieved by 2015—specifically

halving proportions of people in poverty, halving child mortality rates, reducing maternal mortality by three quarters and ensuring accessible reproductive health services. These call for coherent action to improve the livelihoods and well-being of poor people in poor countries.

We are committed to:

- helping ensure that all the world's people—particularly those in the poorest countries of Africa and Asia—can access and benefit from essential health services;
- establishing long-term partnerships for better health with countries, international organisations and UK-based groups;
- supporting local (as well as global) initiatives on specific issues—for example, to help young people improve their sexual health and reduce HIV, enable all to lessen dangers for women associated with pregnancy, to reduce poor people's suffering due to communicable disease—especially malaria, tuberculosis, diarrhoea and the like, to access clean water and sanitation, and promote health environments;
- working with governments to develop sector-wide approaches to better health;
- increasing our support within the United Nations system to promote international standards for human health and health care;
- the better application of scientific knowledge and techniques to the health and well-being of poor people.

Available from Her Majesty's Stationery Office, HMSO Publications Centre, 51 Nine Elms Lane, London SW8 5DR.

The Nippon Foundation (formerly The Sasakawa Foundation) Tokyo, Japan

Readers of the 6th June 1997, No. 23, issue of *Weekly Epidemiological Record* (WHO, Geneva) may have noticed a reference on page 168 to the supply of multiple drug therapy (MDT) by WHO, but through a contribution from The Nippon Foundation, for more than 1·7 million leprosy patients living in 35 endemic countries.

Mr Koichi Takagi, until recently Director of International Affairs for The Nippon Foundation, has kindly written to clarify the relationship of his Foundation to the Sasakawa Memorial Health Foundation (SMHF), which may be better known to many of our readers. The essential information reads as follows.

'The Nippon Foundation, formerly the Sasakawa Foundation, is a private, non-profit organization. It was founded in October of 1962 when it was written into law that a portion of revenues from motorboat racing would be channeled to philanthropic activities. According to the rules and regulations governing the motorboat racing industry, 75% of revenues must revert back to the public in the form of winnings. Of the remaining 25%, the bulk of which is slated to cover organizers' costs, 3·3% becomes the operational funds of the Foundation.

In keeping with the late Chairman Ryoichi Sasakawa's motto, 'The World is One Family, All Mankind are Brothers and Sisters,' the Foundation's activities are geared toward the alleviation of human suffering, the advancement of human welfare, and the promotion of world peace. The scope of its activities transcends politics, ideology, religion and race.

The Foundation has the largest operating budget of its kind in the world. Funds are allocated to support both domestic and international projects, including those implemented by the United Nations. In 1995, 65 billion yen (US$650 million) was available for disbursement; of this amount, 8·5 billion yen (US$85 million) was earmarked for overseas assistance.

The Foundations's overseas support covers a broad range of areas, including welfare, human resource development, academic and physical education, health care, population, agricultural and rural development, human rights, environment, hunger relief, refugee aid and international understanding.

Some of the Foundation's major projects have been:

- agricultural development in Africa to foster self-sufficiency in staple food production (since 1986);
- establishing fellowship funds at major universities throughout the world to enable promising young scholars to pursue post-graduate studies;
- leprosy control, in collaboration with WHO (since 1975);
- promotion of primary health care in developing countries, in collaboration with UNICEF and local governments (since 1992).

'Over the last 22 years, the Nippon Foundation and the Sasakawa Memorial Health Foundation have been closely involved in the global leprosy control program through our contributions of more than US$100 million to two organizations: the Sasakawa Memorial Health Foundation (SMHF) and the World Health Organization (WHO).

Although only slightly infectious, leprosy has been feared and misunderstood globally because of its tendency to produce visible deformities, and consequent physical and social disabilities, through peripheral nerve damage. This in turn has resulted in extremely unjust treatment of victims throughout the ages.

With the use of effective drugs, however, leprosy is no longer an incurable disease. Deformities can now be prevented, provided that the patient receives early treatment.

Since its establishment in 1974, SMHF has been closely collaborating with health authorities in countries where leprosy is endemic. Beginning in East and Southeast Asia, and then expanding into Southern Asia, Africa, and Latin America in the mid-1980s, we have helped countries strengthen their national leprosy control activities by supplying drugs, medical instruments, training materials, transport equipment, technical expertise, and funding.

In 1982, WHO published a recommendation for multi-drug therapy (MDT), a new approach to an effective leprosy control scheme in the field. Thanks to MDT, the number of cases of the disease worldwide dropped from 10 million to 12 million in the mid-1980s to fewer than 2 million in 1995. Encouraged by these remarkable results, the World Health Assembly passed a resolution in May 1991 calling for the elimination of leprosy as a public health problem by the year 2000. In numerical terms, this means reducing the rate of the disease to no more than one case per 10,000 people in every country where it is now endemic.

In order to support the Leprosy Elimination Program, we are providing the WHO with an additional $50 million over a five-year period for the purchase of necessary MDT drugs. Our commitment is firm: We will continue to support this program until its successful conclusion in the year 2000 by strengthening our cooperative ties with both WHO and health authorities in each country.'

Further information about The Nippon Foundation: Mr Takashi Ito, Director of International Affairs, The Nippon Foundation, Senpaku Shinko Building, 1-15-16, Toranomon, Minato-ku, Tokyo 105, Japan.

Bangladesh Rural Advancement Committee (BRAC)

Sadia Chowdhury, Director, Health & Population of BRAC, has written with information about this remarkable organisation in Bangladesh, originally created in Sulla (Sylhet) as a relief agency.

When BRAC was born in 1972, its initial aim was to bring succour to affected people in the genocidal war of 1971. Starting its work in the Sulla area of Sylhet district in the north-eastern part of the country, BRAC provided relief and rehabilitation for war ravaged victims who had lost all and had no means of livelihood. Although BRAC began its operations with relief work it eventually underwent two basic transitions, first from relief to development work, then from a community development effort to development oriented to target groups only. In the first approach, adopted in 1972, while basic human needs were met by providing welfare assistance to the village poor, a state of utter dependency crept in amongst them. Thus in 1973, BRAC shifted its approach towards community development. However, lack of access to resources also continued to create a situation of dependency for the poor on the rich people of the village. Despite being well-intentioned and meant to benefit the poorer community, this

strategy was misused by the influential and by-passed the resourceless. Based on better understanding of the dynamics of the rural power structure, in 1976 BRAC underwent its second transition towards the target group approach. The target populations consist of the poorest of the poor: day laborers, fishermen without fishing tools, *rickshaw* pullers, farmers working on land that is share cropped, service or petty traders and craftspersons. These people sell their manual labor to earn an income, lack adequate leadership and have low status in society. By organizing landless people with programmes directed towards their development, BRAC operates as a self-help initiator, and tries to make them aware of their own problems, and provide them with the tools to improve their socio-economic status. Through various shifts in its approaches BRAC's goals became clear:

Learning by doing, in developing the target group approach BRAC aimed not only to change the conditions of the poor in the village through microeconomic growth oriented programmes, but also to educate the poor about the mechanisms of exploitation and the basic causes of poverty through a process of conscientization. BRAC believes development programmes should not be focused on felt needs only. BRAC programmes, therefore, do not only meet the immediate needs of the rural poor, they also generate new demands. In all its efforts BRAC is careful to encourage and to ensure participation and involvement of the group members.

Since 1993, BRAC has been focusing its programmes specifically on women and children. The experience that BRAC gained by observing rural women through their long-term involvement with the organization brought the realization that the reason for rural women being placed in a helpless position is their continuous state of powerlessness both economically and socially. Female members of the household receive less nutrition, lack health care, and have little or no access to education. Employment opportunities are limited for them with the few seasonal jobs available offering low wages. Yet, women are responsible for the lion's share of the work within and outside the domestic sphere. Women provide food for the family, perform household chores and assist the male members in farming or other activities in the public sphere. Furthermore, the growing number of female headed households as a result of death, divorce, desertion and male migration have left many women as sole providers. Looking at these factors, BRAC felt that it would be most beneficial to focus mainly on rural women, giving priority to their needs. This will ensure a meaningful transformation of women's lives. Recognition of these facts led BRAC to develop gender perspectives in its programmes.

Numbers give a sense of the magnitude of BRAC in 1997: the organization has almost 18,000 staff and more than 33,000 part-time teachers in villages through Bangladesh. By the beginning of 1997, there were 1·8 million members in almost 54,000 village organizations, most of them women. Collectively they had saved over one *billion* taka—about US$30 million. And in 1996 they borrowed over five billion taka (US$128 m) for productive enterprises, repaying virtually all of it on time. A million women were actively involved in poultry projects. And 25 million mulberry trees had been planted to support a sericulture enterprise which produced 43·5 metric tonnes of silk between 1992 and 1995, half the entire national production. Twelve million notebooks, 21 million textbooks and readers, and more than three million pencils were purchased in 1996 for BRAC's 34,000 nonformal primary education schools. Every three years, these schools convert a million dropouts into literate children ready to enter the formal education system. In 1996, BRAC purchased 42 tons of corn seed, 200 tons of corrugated iron sheet and 120 motorcycles. Every month, BRAC buys one million day-old chicks. An estimated 12 million people are covered by BRAC's health and population programmes.'

Further information: Sadia Chowdhury, BRAC Centre, 356 Mohakhali, C/A, Dhaka 1212, Bangladesh.

The Jaipur Limb Campaign

The latest issue of *Jaipur Limb Campaign News*, issue 2, August 1997, includes the following information.

The Jaipur limb was developed and perfected over the last 20 years by Dr P. K. Sethi, an eminent

orthopaedic surgeon in Jaipur, India. Dr Sethi, then Head of Orthopaedics at the SMS Hospital in Jaipur noticed that more and more amputees he had treated were discarding their prostheses and reverting to crutches. He found that limbs based on Western designs were proving unsuitable to the needs of the mostly rural population and set about designing a prosthesis which would suit their needs. His ideas were brilliantly translated by local craftsmen and after many trials, the Jaipur Foot was born. The Jaipur Limb can also be worn by the shoe wearing urban amputee and is now used by over a hundred thousand people in many developing countries.

THE DESIGN CRITERIA

- flexibility at the ankle, allows user to sit crosslegged, squat and even to climb trees;
- strong, durable and waterproof, permits walking on uneven ground and in wet fields;
- utilises locally available labour, skills and materials;
- the production process and technology is easily transferable;
- can be worn barefoot or with shoes;
- low cost and rapid-fit (takes about 50 mins to fit with ready made feet);
- aesthetically excellent, matching skin colour, lifelike appearance;
- once established, projects can be sustained without long term external aid;
- mobile units can make and fit limbs in remote villages.

The Jaipur Limb Campaign was thrilled to hear on the 20th of May that it was amongst the 130 UK agencies to receive funding from the National Lottery for projects overseas. A total of £25 million was distributed in this, the first round of the Board's international grants programme. The JLC has received funding for 3 of its projects partners in India over a three year period. They are Gandhigram Trust in Tamil Nadu, Mobility India in Bangalore and the Research and Rehabilitation Centre ay Santokba Durlabji Hospital in Jaipur.

The grant over a 3 year period will cover training and salaries for more technicians, and resources and materials to enable our partners to reach more people. Some funds have also been earmarked for follow-up work and feedback into a research and development programme. Our partners can now put into practice ongoing Research and Development strategy and disseminate the outcomes to many other limb fitting projects within India and those being developed in Africa.

Further information: Jaipur Limb Campaign, 7th Floor, Windsor House, 83 Kingsway, London WC2B 6SD.

ILEP: International Federation of Anti-Leprosy Associations

International Federation of Anti-Leprosy Associations
Fédération Internationale des Associations contre la Lèpre
Internationale Vereinigung der Leprahilfswerke
234 Blythe Road, London W14 0HJ, GB
Tel.: +44/171 602 6925, Fax: +44/171 371 1621, E-mail: ilep@ilep.org.uk

THE FEDERATION

ILEP, the International Federation of Anti-Leprosy Associations, exists, as stated in its constitution,

To support medical, scientific, social and humanitarian activities throughout the world for the relief and rehabilitation of persons suffering from leprosy and the prevention and eventual eradication of that disease.

In June 1996, ILEP Member-Associations unanimously adopted the following Statement of Priorities:

ILEP and its Member-Associations are determined to respond to the total and continuing problem of

leprosy. The priority of the Federation over the next few years is, therefore, to assist Members as effectively as possible to achieve:

- Prevention of disabilities for all people affected by leprosy.
- Multi-drug therapy for all who need it.
- Health services capable of sustaining cost-effective anti-leprosy activities under conditions of low endemicity.
- Normalisation of the lives of all people who are or have been affected by leprosy.
- Continuation of essential research into leprosy, especially as regards the development of tools for the prevention of the disease, ever more efficient treatment and the prevention of disability.

This Statement reflects the success achieved in leprosy work in recent years and the view of ILEP Member-Associations that the emphasis is changing from the medical to the social aspects of leprosy for the individuals affected by it.

While retaining their autonomy and making their own decisions the 20 ILEP Member-Associations co-ordinated their grant-giving through the mechanism of the Federation: an Information Network with standardised forms, centralised files and directories and analyses of the information obtained; an annual Working Session in December; and a system of country and project co-ordinators.

These mechanisms help avoid overlap and concentrate resources where they are most needed—a exceptional example of international co-operation by autonomous agencies in the distribution of funds.

STANDING COMMITTEE

Damien Foundation Belgium
President (1995–1997)
Jean-Pierre Schenkelaars
American Leprosy Missions
Chris Doyle
LEPRA
Terry Vasey
DAHW
Horst Franck

CO-ORDINATING BUREAU

The mechanisms of the Federation and its information services are maintained by a small co-ordinating bureau in London.

General Secretary
Angelo Simonazzi
Assistant General Secretary
Dominique Martineau-Needham
Secretary to Medico-Social Commission
Dr Sarah Lacey
Administrative Staff
Andrew Clark
Maryline Delpy
Marilyn Holderness
Pascale Vassie

MEDICO-SOCIAL COMMISSION

The Federation's Medico-Social Commission provides Member Associations with medical and

technical advice on matters of common concern. It is also able to advise on particular projects if so requested by a Member.

The Commission, elected every four years by the ILEP General Assembly, consists of the following members:

Dr Cairns Smith (Chair)
Dr Ju Baohong
Dr Sunil Deepak
Dr Etienne Declercq
Dr Henk Eggens
Dr P. K. Gopal
Mr Ernst Hisch

The Medico-Social Commission holds regular interface meetings with ILEP Member Associations and international multi-disciplinary workshops when appropriate.

MEDICAL PUBLICATIONS

There has been major focus on the availability of Medical Bulletins in Spanish and Portuguese in addition to French and English and the use of leprosy journals to disseminate advice.

Prevention of Disability in leprosy
ILEP Medical Bulletin no. 8, December 1995
The management of Erythema Nodosum Leprosum
ILEP Medical Bulletin no. 9, May 1996
Priorities for leprosy research
ILEP Medica Bulletin no. 10, October 1996
Detecting and treating hard to reach leprosy patients
ILEP Medical Bulletin no. 11, September 1997
Guidelines for the field
Guidelines for writing a healthworkers manual
Volumes 1 and 2, second edition, April 1996
Guidelines for improving the sustainability of leprosy services
July 1997

TALMILEP

An ILEP joint project to produce and distribute teaching and learning materials on leprosy worldwide.

A booklist of English language publications is available from: TALMilep
c/o TLMI, 80 Windmill Road
Brentford, Mddx TW8 0QH, GB
tel.: +44/181 569 7292, fax: +44/181 569 7808
e-mail: friends@TLMint.org

ILEP member associations

ALES

Aide aux Lépreux Emmaüs-Suisse
Spitalgasse 9, CH-3011 Berne, Switzerland
tel.: +41/31 311 77 97
fax: +41/31 318 08 41
President: Rolf Lehmann
General Secretary: Rina Perolini Bohner

ALM

American Leprosy Missions
1 ALM Way, Greenville SC 29601, USA
tel.: +1/864 271 7040
fax: +1/864 271 7062
e-mail: amlep@leprosy.org
Chairman: Mr Edgar Stoesz
President: Christopher Doyle

AIFO

Associazione Italiana Amici di Roaul Follereau
4–6 via Borselli, 1-40135 Bologna, ITALY
tel.: +39/51 43 34 02
fax: +39/51 43 40 46
e-mail: aifo@iperbole.bologna.it
President: Dr Enzo Venza
Deputy President: Dr Enzo Zecchini

CIOMAL

Comité International de l'Ordre de Malte pour l'Assistance aux Lépreux
Place Claparède 3, CH-1205 Genève, SWITZERLAND
tel.: +41/22 346 8687
fax: +41/22 347 0861
e-mail: mission.order-malta@itu.ch
President: Bruno de Preux
General Secretary: Jocelyne Genoud

DAHW

German Leprosy Relief Association
PO Box 9062, D-97090 Würzburg, GERMANY
tel.: +49/931 7948 0
fax.: +49/931 7948 160
e-mail: dahw@geod.geonet.de
President: Hermann Kober

DFB

Damien Foundation Belgium
Boulevard Léopold-II, 263, B-1081 Brussels, BELGIUM
tel.: +32/2 422 5911
fax: +32/2 422 5900
e-mail: damien@pophost.eunet.be
President: Marcel De Doncker
General Secretary: Rigo Peeters

FF

Association Française Raoul Follereau
BP No. 79, 75722 Paris Cedex 15, FRANCE
tel.: +33/1 5368 98 98
fax: +33/1 4856 22 22
e-mail: olphe-galliard@raoul-follereau.org
President: Michel Récipon
Executive Director: Alain Gineston

FL

Fondation Luxembourgeoise Raoul Follereau
151 avenue du 10 septembre, L-2551, LUXEMBOURG
tel.: +352/44 66 06 or 45 78 07
fax.: +352/45 96 53
President: Jos Hilger

FOPERDA

Fondation Père Damien pour la lutte contre le Lèpre
Boulebard Léopold II, 263, B-1801 Brussels, BELGIUM
tel.: +32/2 42 25 939
fax: +32/2 42 25 900
President: François Eeckhout
Vice Presidents: Prof. René Tonglet, Prof. Stefaan Pattyn

HF

Hartdegen Fund
Repperbergstrasse 66, D-66119 Saarbrücken, GERMANY
tel.: +49/681 356 18
fax: +49/681 374 174
President: Dr Horst Müller-Bütow
General Secretary: Eleonore Dagnino

ICLL

Institut Cardinal Léger Contre la Lèpre
130 avenue de l'Epée, Montréal H2V 3T2, CANADA
tel.: +1/514 495 2409
fax: +1/514 495 2059
e-mail: fléger@cam.org
Executive Director: Thérèse Gaudr

LEPRA

British Leprosy Relief Association
Fairfax House, Causton Road, Colchester CO1 1PU, GREAT BRITAIN
tel.: +44/1206 562 286
fax: +44/1206 762 151
e-mail: lepra@lepra.org.uk
Director: Terry Vasey
Deputy Director: Bernard Farmer

LWM

Leonard Wood Memorial American Leprosy Foundation
11600 Nebel Street, Suite 210, Rockville, MD 20852, USA
tel.: +1/301 984 1336
fax: +1/301 770 0580
Scientific Director: Dr Gerald P. Walsh
Administrative Director: Pris Reed

NSL

Netherlands Leprosy Relief Association
Wibautstraat 137 K, PO Box 95005, NL-1090 HA Amsterdam, NETHERLANDS
tel.: +31/20 5950 500
fax: +31/20 6680 823
e-mail: info@lepraned.nl
Director: Kommer Braber
Head of Project Dept.: Bert Zielhuis

PLF

Pacific Leprosy Foundation
Private Bag 4730, Christchurch 8020, NEW ZEALAND
tel.: +64/3 366 3685
fax. +64/3 366 7771
Chairman: Dr G. D. Watson
General Manager: Michael Gousmett

RB

Red Barnet
Rantzausgade 60, DK-2200 Copenhagen, DENMARK
tel.: +45/3536 5555
fax: +45/3139 1119
e-mail: redbarn@omet.uni-c.dk
General Secretary: Niels-Christian Andersen

SF

Fontilles
Sanatorio San Francisco de Borja
E-03791 Fontilles, Alicante, SPAIN
tel.: +34/6 358 3350
fax: +34/6 558 3376
e-mail: fontilles@dirac.es
Director: Vicente J. Almiña S.J.
Medical Director: Dr José Terencio

SJ

Sasakawa Memorial Health Foundation
Senpaku Shinko Bldg., 1-15-16 Toranomon, Minato-ku, Tokyo 105, JAPAN

tel.: +81/3 3508 2201
fax: +81/3 3508 2204
Chairman: Dr Shigeaki Hinohara
Directors: Dr Yo Yuasa, Prof. Kenzo Kiikuni

SLC

Secours aux Lépreux, Canada
1275 Hodge, Bureau 125, Montréal H4N 3H4, CANADA
tel.: +1/514 744 3199
fax: +1/514 744 9095
e-mail: secours-lepreua@msn.com
President: Paul-Emile Legault
Director: Maryse Legault-Savard

TLMI

The Leprosy Mission International
80 Windmill Road, Brentford, Middlesex TW8 0QH, GREAT BRITAIN
tel.: +44/181 569 7292
fax: +44/81 569 7808
e-mail: friends@TLMint.org
General Director: Trevor Durston

AHRTAG (Appropriate Health Resources and Technologies Action Group), London, UK

AHRTAG

- believes that every person, whatever their economic or social position, has the right to good health;
- aims to promote policies and practices in health which are appropriate, sustainable and cost-effective;
- provides information on health and disability issues in developing countries, through print and electronic median, and resource centre services;
- provides technical support and training in publications and information management to strengthen human resources and capacities of partner organisations.

AHRTAG (Appropriate Health Resources and Technologies Action Group) is a non-governmental organisation established in 1977.

AHRTAG'S RESOURCE CENTRE

AHRTAG's resource centre houses a unique collection of over 19,000 books, journals, newsletters, training manuals, reports and audiovisual materials focusing on the practical aspects of primary health care and community-based rehabilitation in the South. Subjects include:

- adolescent health
- child health and development
- communicable diseases
- disability issues and community-based rehabilitation
- evaluation
- health education
- health sector reform

- HIV, AIDS and STDs
- information management
- planning and management
- poverty and inequalities in health
- primary health care
- programme implementation
- sexual health and sexuality
- structural adjustment and health
- training
- urban health

Many of the materials in the resource centre are published in the South. Much of the information is not available in academic or medical libraries in the UK.

For more information please contact:

AHRTAG
Farrington Point
29–35 Farringdon Road
London EC1M 3JB, UK

Telephone +44 171 242 0606
Fax +44 171 242 0041
E-mail ahrtag@gn.apc.org
http://www.poptel.org.uk/ahrtag/

Registered charity no. 274260

UNAIDS: 'HIV epidemic is far worse than thought'

The following is extracted from the *British Medical Journal*, Volume *315*, 6 Dec 1997, page 1486.

HIV infection is far more common than previously thought, according to a report from the joint United Nations programme on HIV/AIDS (UNAIDS) and the World Health Organisation. The new figures show that about one third more people are living with HIV worldwide than was estimated in December 1996.

Dr Peter Piot, executive director of UNAIDS, said: 'We are now realising that rates of HIV transmission have been grossly underestimated—particularly in sub-Saharan Africa, where the bulk of infections has been concentrated to date.'

Over 30 million adults and children are now believed to be living with HIV infection—one in every 100 sexually active adults worldwide. And if current transmission rates hold steady, by the year 2000 the number of people living with HIV or AIDS will reach 40 million.

The pattern of infection had been assumed to be similar in different countries in the same region, but as more data became available it became apparent that there were huge differences in the way the epidemic was developing in different countries. In sub-Saharan Africa, for example, very few countries had reliable data on HIV infection and some, notably Nigeria and South Africa, had virtually none. The country with the best surveillance rates was Uganda, and that showed that infection rates were beginning to level off, with new infections dropping in younger age groups. The situation in Uganda was wrongly taken to be typical of the whole region.

Over 90% of people with HIV live in the developing world, where few facilities exist for voluntary testing and counselling and where, according to UNAIDS, 9 out of 10 HIV positive people will have no idea they are infected. The organisation warns that the full impact in terms of mortality from AIDS is

only just beginning. It is estimated that 2·3 million people died of AIDS in 1997—a 50% increase on 1996. Nearly half of those deaths were in women, and 460,000 were in children under 15.

The report states that in very badly affected countries the development gains achieved over the past few decades are being wiped out by the epidemic. In Botswana, for example, life expectancy, which rose from under 43 years in 1955 to 61 years in 1990, has now fallen to levels found in the late 1960s. On current trends, Zimbabwe's infant mortality can be expected to rise by 138% by the year 2010 because of AIDS.

Clare Short, Britain's international development secretary, said that although recent scientific advances were very encouraging, people in developing countries were unlikely to see the benefit: 'The new advances in drug therapies are prohibitively expensive in societies where expenditure on all health needs is often only £3 a day. It is just not feasible for such therapies to be a solution for the vast majority of people affected by HIV today. The search must continue for affordable means of slowing down the progression of HIV to AIDS and to increase protection, especially for young people.'

'PATH', USA: development of self destructing, single-use syringe

A recent publication from PATH (*The Program for Appropriate Technology in Health*, 4 Nickerson Street, Seattle, WA 98109, USA. Fax (206) 285-6619) includes the following.

A critical problem facing immunization programs is reuse of disposable syringes or the use of improperly sterilized syringes and needles because of inadequate supplies or lack of sterilization equipment. These practices can result in cross-infection with HIV, hepatitis B virus, or other pathogens. In collaboration with the WHO/Expanded Programme on Immunization (WHO/EPI) and with support from USAID and other agencies, PATH has designed and evaluated several nonreusable syringes and other injection devices meant to ensure safe injections.

One device developed by PATH, a self-destructing, single-use syringe called SoloShot®, is now being manufactured by Becton Dickinson and Company and distributed by UNICEF.

UniJect® is a prefilled, single-use injection device that makes it possible for frontline health workers to deliver vaccines, contraceptives, or emergency medications in a safe, easy, and consistent manner. UniJect® has been licensed to Becton Dickinson and Company, which is planning to manufacture and market the device widely in developing countries. A field trial to deliver Cyclofem™, a once-a-month injectable contraceptive, in UniJect® in Brazil demonstrated the acceptability and usability of the device for this purpose. A successful field trial of the device filled with tetanus toxoid and delivered by traditional birth attendants has been conducted in Bolivia, while trials with hepatitis B vaccine for infants and tetanus toxoid vaccine for mothers were carried out in Indonesia.

The Program for Appropriate Technology in Health (PATH) is a nonprofit, nongovernmental, international organization. PATH's mission is to improve the health of women and children in developing countries. To achieve these goals, PATH works with public sector agencies and with private companies.

Further information: Glenn Austin at the above address.

'Diana's fund fails to satisfy all' *Guardian* Newspaper, UK

The following information on the 'Diana fund' appeared in The *Guardian* Newspaper of 11/3/98.

The Diana, Princess of Wales Memorial Fund is unlikely to give away enough money to make it one of the top 20 grant-making trusts, despite claims that it will transform the charity landscape.

Projections suggest that after yesterday's initial one-off payouts, the fund's annual grants will total

about £5 million. That would place it 24th in the Charities Aid Foundation list of grant-making trusts, just behind the Variety Club Children's Charity and 10 places behind the Prince's Trust.

The first grants are worth £13 million. Future grants will be made from the income of the fund, the capital of which is expected to reach £100 million. For the fund to continue indefinitely, as is intended, annual grants will be limited to a small proportion of that.

The foundation said that 5 per cent was considered a safe return on investment, giving the Diana fund £5 million to distribute each year.

Yesterday, Vivienne Parry, one of its trustees, said: 'I think the fund will become the most important grant-giving body in the country, and a lifeline to an enormous number of charities.'

In 1995 the Wellcome Trust gave grants worth £218·6 million, followed by the National Lottery Charities Board (£158 million), the British Academy (£22·5 million), the Royal Society (£21·3 million) and the Garfield Weston Foundation (£19 million). The Diane fund could become one of the most important grant-giving bodies only by using up its capital, which would run out within 10 years and betray its remit to keep the princess's name alive.

Alternatively, it could hit the big league if contributions continued pouring in, but there is a belief that they had probably levelled off.

A spokeswoman for the fund said £40 million was in the bank and another £60 million was due later this year, including the money from Elton John's single, Candle in the Wind. Reaction to the first round of grants was mixed.

Eight causes will share £8 million, and £5 million is to be allocated among 100 more bodies, once they apply for funds.

The favoured eight causes are: the homeless charity Centrepoint; the English National Ballet; Great Ormond Street children's hospital; the Leprosy Mission; the National Aids Trust; the Royal Marsden NHS Trust; the Osteopathic Centre for Children; and various organisations dedicated to the eradication of land mines. Vivienne Parry said: 'There will be so many grant announcements that in the end people will take no notice, even though some of them will be for large sums of money. The Diana, Princess of Wales Memorial Fund will become part and parcel of everyday life in Britain.'

Several charities, including Headway, which helps head injury victims, expressed disappointment that they would have to jostle with more than 100 rival organisations for a share of the £5 million.

Forum for health information providers: steering group meeting, British Medical Association, London, UK, 30th March, 1998

A meeting of potentially far-reaching importance, chaired by Professor K. G. M. M. Alberti, President of the Royal College of Physicians of London, was held in the headquarters of the British Medical Association on 30th March, 1998. This was organised mainly by '*INASP-Health*', a specific programme within the *International Network for the Availability of Scientific Publications (INASP)*, dedicated to the coordination and support of activities of health information providers in developing countries, including universal access to reliable information for health professionals.

A full account of the development and aims of *INASP-Health* has been published in 1) previous issues of this journal, 2) *The British Medical Journal*, volume 314, 11th January, 1997 and 3) the most recent issue of *WHO Liaison*, volume 8, numbers 2–3, August–November, 1997.

Thirty people involved in the provision of health information for developing countries were invited, including representatives of the *British Medical Journal*, *Leprosy Review*, *Africa Health*, *Medicine Digest*, Action in International Medicine (AIM), African Medical and Research Foundation (AMREF), The British Council, CAB International (CABI), Essential Drugs Project, Appropriate Health Resources and Technologies Action Group (AHRTAG), Authors Licensing and Collecting Society, Book Aid International, Department of Information Studies, Sheffield University, Footsteps/Tear Fund, International Health Exchange, London School of Hygiene and Tropical Medicine, Nigerian Medical Forum, Practical Pharmacy, SatelLife, Teaching Aids at Low Cost (TALC), Liverpool School of Tropical

Medicine, Neurology International Partnership Programme, South Thames Library and Information Services, Tropical Health and Education Trust, Tropical Health Technology and The Wellcome Trust.

The main objective of this first meeting was to discuss the advisability (or otherwise) of establishing a group or forum of health providers, essentially from the UK, but with the option of inviting participants from outside, to a) improve the knowledge and understanding of participants on the needs of health information users and the most effective ways of meeting those needs, b) exchange ideas, contacts, information, avoid duplication, c) lobby international organizations and others for more resources to be devoted to health information provision and argue the case for health information needs to be given due consideration in the planning and implementation of healthcare programmes, d) facilitate partnerships between participants and/or the organizations they represent.

The initial round of 'self-introductions' at the meeting revealed a vast pool of experience from many parts of the world in the origination, assembly, publication, distribution and assessment of health information/material, whilst at the same time underlining the need for health information providers in the UK to liaise more closely in order to avoid duplication and ensure that the main activities of all agencies working in this field are mutually well known.

Professor Alberti guided the discussions toward the main question to be addressed at this first meeting, namely the possible justification for the creation of a forum in the UK, with meetings (in London) on a regular basis. This was accepted and the next meeting will be held within a few months to discuss the practical steps to be taken to '.. assist health information providers towards the achievement of a common goal: universal access to reliable health information'.

This may well be the first meeting of its kind held in the UK. It clearly has considerable potential for the identification of appropriate and sustainable channels for the provision of reliable health information to health workers at all levels in developing countries. *INASP-Health* is supported by the *Department for International Development* (UK), the *British Medical Association* (UK) and *Danida* (Denmark).