Lepr Rev (1998) **69,** 314–333

News and Notes

ActionAid Disability News: the Newsletter of the Disability Division of ActionAid in India

ActionAid Disability News is a bi-annual newsletter of the *Disability Division of ActionAid* in India, PO Box 5406, No 3, Rest House Road, Bangalore, 560 001. The Newsletter is meant for private circulation only, for planners, administrators, health professionals, funding organizations and implementing organizations involved in disability and rehabilitation programmes. Its main emphasis is on articles related to policy development, concept clarification, development of methodology in areas of service delivery, training of manpower and programme evaluation and the development of technology related to rehabilitation. Action Aid is interested in exchanging copies of the Newsletter on a reciprocal basis with other rehabilitation publications and in gathering information on programmes and research findings related to disability and rehabilitation. Apart from a series of valuable original articles in the latest issue (Vol 9, No 1, 1998), the pages are full of 'networking' information on meetings, seminars, workshops, publications and training courses.

Researchers create designer antibody

The following appeared in the *British Medical Journal* vol 316, 7/3/98, page 726:

Immunologists have designed an antibody that can specifically suppress just one section of the immune system, rather than having to knock out the whole system. This antibody could revolutionize the lives of people who undergo organ transplantation because the T lymphocytes that cause organ rejection could be selectively 'turned off' by it, leaving the rest of the immune system intact to fight off rejection.

Patients who receive bone marrow and other organs from donors run the risk of organ rejection. To prevent this happening, they are conventionally given chemotherapeutic agents, such as cyclosporin, which effectively suppresses the entire immune system. Although this means that the foreign tissue which the patients have received is not immediately rejected, it also means that they are left with few defences against invasive infections or other diseases. They are often critically immunocompromised.

Now Yan Qi and Uwe Staerz from the National Jewish Medical and Research Centre in Colorado have created a hybrid antibody that will allow helper T cells to recognize a foreign organ but not allow these T cells to become activated and cause organ rejection (*Nature Biotechnology* 1998;16:271–6). Conventional antibody molecules have two identical arms that bind them to a specific target. This designer hybrid antibody has one binding arm, which is directed to cells on the transplanted organ and a second arm, which interferes with the activation of specific helper T cells. The result is that these T cells recognize the organ as foreign but are prevented from being activated. No other T cells are affected.

The binding arm of the hybrid antibody binds to all foreign cells with a specific class II HLA type. Dr Staerz calculates that to cover virtually all donor and recipient combinations of HLA types it will be necessary to make just four or five antibodies. As a result of selective immunosuppression, he believes that 95% of all transplants will need no additional minor antigen matching. A further advantage may be conferred by administering the hybrid antibody: patients may only have to take this treatment in the

short term. Dr Staerz believes that the T cells which are responsible for organ rejection may eventually be destroyed by the antibody activity, thus preventing organ rejection in the future.

So far these hybrid antibodies have been shown to work in tissue culture. Dr Staerz and his colleagues will be testing them in animal models within 6 months, and if all goes well they expect to start clinical trials within 2 years.

WHO Committee Identifies Constraints That Stall Progress Against TB. Statement by Ad Hoc Committee on the Global TB Epidemic, London 17–19 March 1998

The members of the Ad Hoc Committee convened by the World Health Organization call on world leaders to give their urgent attention to the global tuberculosis epidemic. Excellent progress against the global TB epidemic in nearly 100 countries is being overshadowed by the stalled or slow progress in many of the 22 countries which account for the vast majority of the world's TB cases. The Committee notes with deep concern that even where progress has been good, questions of sustainability and expansion pose risks for the near future in places such as China and Bangladesh. Global targets cannot now be met.

Intensified technical efforts will not by themselves bring about the acceleration and expansion needed. This Committee has identified six principle constraints choking action by health authorities. These are financial shortages, human resource problems, organizational factors, lack of a secure supply of quality anti-TB drugs, and public information gaps about TB's danger. The most fundamental constraint is the lack of political will to develop and sustain effective TB programmes.

It is of course primarily the responsibility of the political and health leaders of the countries faced with the epidemic to execute an effective response. But, it is transparently in the world's public interest that the global community help fight the epidemic wherever it exists. Since progress has been too slow overall and is stalled in some key countries, extraordinary measures now are needed to reverse the insufficient political will which underpins the other constraints. The keys to effective global action to do this are in the hands of a small number of political, legislative, financial and health leaders in the endemic countries and in the developed nations and the global institutions.

The Committee believes that many of the world's leaders are unaware of the dimensions and costs of the TB epidemic and the urgency of controlling it. It also believes that most citizens in the affected countries are unaware of the risks they face and the fact that these can be eliminated by concerted use of the DOTS strategy. The world cannot be protected from TB as long as countries with a high burden of TB do not make progress. Because of HIV's impact on TB and emerging drug resistant forms of TB, the dangers of national and global inaction are increasing sharply. This committee has concluded that the insufficient political will to control TB is the greatest single constraint to progress. Political action to make and keep tuberculosis control as a true social and developmental priority would allow progress to be made against the financial, human resource, organizational, drug supply and information constraints. The committee calls on heads of state, parliamentary leaders, and finance, planning and health ministers to exercise their pivotal roles.

The global institutions for a coordinated initiative to support committed national leaders exist and must also exercise their mandate. A coordinated partnership of the WHO, the World Bank, bilateral development assistance agencies, the IUATLD and other NGOs and the global research community is needed urgently. These institutions can help sustain the environment to encourage political will. Then they can methodically and persistently alleviate the other identified constraints through policy and technical collaboration with the endemic countries and by financing and supporting the DOTS strategy, including the research to permit its wider and easier use and to develop new tools.

The Committee will finalize its full report for discussion with WHO leaders within a few days.

Further enquiries: Global Tuberculosis Programme, WHO, 1211 Geneva 27, Switzerland.

India approves leprosy vaccine

The following appeared in the *British Medical Journal*, volume 316, 7/2/98, page 414:

A vaccine against leprosy has been approved by India's drug control agency and is to be incorporated into the national eradication programme. The vaccine is designed to be used as an adjunct to standard multidrug therapy to accelerate healing and reduce the duration and cost of the treatment.

The vaccine, developed at the National Institute of Immunology in New Delhi, is said to be the first in the world that stimulates the immune system to kill *Mycobacterium leprae*. The vaccine, administered intradermally, is prepared from a killed non-pathogenic strain of *Mycobacterium*, first isolated in the mid-1970s from the sputum of a patient with tuberculosis in Madras.

'Patients who receive the vaccine and standard anti-leprosy multidrug treatment show faster clinical improvement and more rapid clearance of bacteria than those who receive only drugs,' said Dr Rama Mukherjee, a senior scientist at the Institute. Whereas multidrug therapy using rifampicin and two other drugs takes 12–24 months, the vaccine will help to reduce duration of treatment by at least 6 months in the most severe cases, Dr Mukherjee said.

'We expect this vaccine to provide a big boost to the leprosy eradication programme,' said Dr Manju Sharma, secretary of India's department of biotechnology, which invested about 20 million rupees (£300,000; $480,000) in the project. Leprosy is prevalent across Asia, Africa, and Latin America, but India accounts for 60% of the global pool of patients with leprosy, estimated to be about one million in 1996. A fifth of patients are below the age of 18.

The vaccine is based on the concept of 'cross reacting antigens,' in which the killed *Mycobacterium* strain is used to stimulate the immune system into mounting an attack on *M. leprae*. 'This is possible because the two bacilli have cross reacting antigens,' said Dr Mukherjee. The first commercial batch is expected to be released by June 1998 and will be sold in India at six rupees (10p) a dose.

Health ministry officials, however, have expressed reservations about the impact of the vaccine in the leprosy eradication programme. 'We don't see any real advantage of using this adjunct. Patients who are on standard multidrug therapy are not expected to actually feel any benefit from the faster clearance of the bacteria brought about by the vaccine. Drug treatment alone does lead to complete elimination of bacteria, although the process may be slower,' said a senior official.

Others argue that the vaccine has been known to cure the disease and clear bacteria within 6 months in some patients. 'It will also help prevent reactivation of the disease in the most severe cases,' said Gursaran Talwar, former director of the National Institute of Immunology. India is nowhere near eradicating leprosy with the current treatments available. Last year the health ministry detected 400,000 new cases.

Institute scientists say that the immunoprophylactic role of the vaccine is also under investigation. Over the past 8 years, nearly 23,000 health household contacts of patients with leprosy have received the vaccine, but the results of this study are not expected for another 3 years because of the long gestation period of the leprosy bacillus.

Global research funding for AIDS, malaria and tuberculosis

Writing in the latest issue of *EDIT*, *The University of Edinburgh Magazine*, issue 14, Summer 1998, Bryan Christie describes the present world situation with regard to malaria and the prospects for the development of a vaccine. The final paragraphs include the following: 'Figures which compare global research funding against the annual death toll from particular diseases highlight the plight: HIV/AIDS gets $3274 per death: asthma $789: malaria $65 and tuberculosis $13.' [EDIT, The University of Edinburgh Centre, 7–11 Nicolson Street, Edinburgh].

Scotland as a focus of world electronics industry

The following appeared in the latest edition of EDIT, The University of Edinburgh Magazine, Issue 14, Summer 1998, page 4:

Working closely with Scottish Enterprise, Edinburgh, Glasgow, Heriot Watt and Strathclyde Universities have launched the world's first Institute for System Level Integration. The Institute is being developed through a unique collaboration of the four universities working with an international panel of experts and Scottish Enterprise to create a focus for both research and teaching in this emerging discipline. The Institute, which will make Scotland a world centre for next generation semiconductor research and design, is to be based in a new Design Complex being built at Livingston near Edinburgh which will include the creation of 1,895 highly skilled new jobs by Cadence Design Systems of San Jose, California, the world's leading electronic design automation software and design services company. The Institute is also committed to deliver professional development modules from 1998 and, as soon as possible thereafter, a full-length MSc course targeted at students with a first degree in Electrical Engineering or Computer Science.

Cadence have also announced a University Scholarship programme which will award eight prizes to the top graduates in both Computer Science and Electrical Engineering at Edinburgh, Glasgow, Heriot-Watt and Strathclyde Universities. The prizes will be given either as £1,000 in cash or a 1-year sponsorship of an approved Masters degree in System Level Integration at any of the four universities.

INASP: International Network for the Availability of Scientific Publications

The following items are taken from the latest *INASP Directory* (1997/1998):

Commonwealth Secretariat

Commonwealth Secretariat
Health Department
Marlborough House
Pall Mall
London
SW1Y 5HX
UNITED KINGDOM

Contact: Dr Helen Bicken

Telephone: (44 171) 747 6291 *Fax:* (44 171) 747 6287
The Commonwealth Secretariat, through its Health Department, is involved in technical cooperation. Proposals include:

development of linkages between health institutions in Commonwealth countries for interchange of personnel, information and training opportunities;
development of training materials in response to needs expressed at Commonwealth Health Ministers Meetings;
gathering of information on key health issues from Commonwealth countries and making this available, production of reports on expert group meetings, workshops or specific projects and sharing these with Commonwealth countries.

African Medical and Research Foundation (AMREF)

African Medical and Research Foundation
Publishing Department
Wilson Airport
PO Box 30125
Nairobi
KENYA

Contact: Alice Nabwera

Telephone: (254 2) 501301/3 *Fax:* (254 2) 602495 *E-mail:* 62057276@eln.attmail.com

The African Medical and Research Foundation (AMREF) is an African non-profitmaking non-governmental organization committed to health development and aims to produce health learning materials that are more appropriate and cheaper than the equivalents imported from other countries. The Department has some 40 health manuals on its list and is constantly developing new materials or revising its popular titles.

As a Kenyan-based professional publishing body with its own printshop and an established distribution system, the AMREF Publishing Department is also well placed to produce printed materials for ministries of health, health-related NGOs and international organizations working in the region as well as serving the needs of its own programmes.

An alternative contact is Caroline Agola.

APNET (African Publishers Network)

APNET (African Publishers Network)
PO Box 3773
11th Floor Megawatt House
44 Samora Machel Ave
Harare
ZIMBABWE

Contact: Gillian Nyambura

Telephone: (263 4) 705105 *Fax:* (263 4) 705106 *E-mail:* apnet@mango.zw

The African Publishers Network was established at the Harare conference of the African Publishing Institute on 17th February 1992.

The Network believes that the most viable way in which Africa can solve the current book crisis is through the long term expansion of indigenous publishing activities. This refers to all manufacturing of books in Africa, from research, scholarship and authorship through to printing, marketing and distribution.

The detailed objectives of APNET are:

to address urgently the need for effective communication between African publishers, and between countries and regions; on developments affecting or likely to affect African publishing as a whole, through the medium of a newsletter;
to set up an information-gathering system to bring together information on developments affecting African publishing from its many diverse sources;
to analyse critically trends in African publishing and, where necessary, to produce policy documents reflecting the views and position of indigenous African publishers;
to encourage and assist inter-African trading in books and joint ventures between African publishers;

to assist in the establishment of national publishers associations throughout Africa;
to work towards an association of African publishers as a body genuinely representative of indigenous African publishing throughout the continent; and
to expand and improve the availability and scope of training for publishing and book distribution to Africa.

The project will in practice be based on six inter-related activities:

the creation of a resource centre of documentary material on African publishing which will include information from the major book periodicals, policy statements and conference documents, and essays and articles on African books;
the publication and distribution of a trilingual newsletter (*The African Publishing Review*) six times per year, the basis of which shall be country reports of major publishing developments, regional reports, special features on publishing conditions within a country, and other news affecting or likely to affect African publishers;
the research and publication of occasional documents reflecting policy thinking on indigenous African publishing;
inter-regional contact and networking involving travel by African publishers to attend important events in Africa, to collect information, to hold discussions, to brief publishers on the activities of APNET, to assist in inter-African book trading and to assist in the establishment of national publishers associations;
representation: to ensure indigenous African publishers' participation through APNET at major international conferences and otherwise to meet important multi-lateral agencies involved in support for African publishing;
to engage in the development of an African Publishing Institute for the expansion, improvement and coordination of training facilities available to African publishing.

APNET is both representative of indigenous publishing in Africa and is a democratic organization. The priorities for programmes and activities are determined through meetings and discussions at different levels (e.g. national publishers association to APNET General Council to APNET Administrative Committee for implementation) and through extensive consultation. The single most important factor determining the type of activities APNET supports is how this affects the long-term viability and sustainability of development in indigenous publishing.

APNET is committed above all to the idea that long-term book provision in Africa can only be sustained through the expansion and development of indigenous publishing.

The APNET contacts are: Gillian Nyambura and Tainie Mundondo (APNET Secretariat Committee, Harare). Victor Nwankwo (Nigeria), Henry Chakava (Kenya), Hamidou Konate (Mali), Samuel Matola (Mozambique) and Jane Katjavivi (Zimbabwe) are the regional representatives for West, East, francophone, lusophone and Southern Africa.

ExtraMED

ExtraMED
Informania Ltd
PO Box 40
Petersfield, Hants GU32 2YH
UNITED KINGDOM

Contact: Diana Zielinski

Telephone: (44 1730) 301297 *Fax:* (44 1730) 265398
E-mail: 100060.172@compuserve.com

ExtraMED originated from a project of the World Health Organization. It consists of the publication in CD-ROM format of copies of health and biomedical journals, containing all the text and illustrations of the original journal articles. The text is in page images—printouts look like photocopies of the original articles, catalogued and searchable by keyboard.

Taking its name from the fact that it comprises journals that are 'extra' to *MEDLINE*, *ExtraMED* focuses on journals that are largely excluded from the international indexes. The *ExtraMED* Consortium of Journals now comprises over 290 biomedical journals throughout the world, selected through WHO's various Index Medicus projects. *ExtraMED* is designed to serve the purposes of promoting the literature of developing countries, while subsidising its production and development through subscription revenue. At the same time, it provides a powerful new research and diagnostic tool.

The journals in *ExtraMED* are outside the coverage of the MEDLINE services and are mostly from developing countries. They include many topics that MEDLINE journals don't cover adequately, e.g. tropical diseases, traditional medicine and biodiversity, cholera and other waste-borne diseases, etc. Printed copies of the articles can be made from the disc.

The main advantage of *ExtraMED* is that it gives the most important medical journals of the non-MEDLINE world in one source. It should be of great interest to developing countries in view of the subject matter and coverage of the journals contained in the disc.

The CD-ROM is published every month and contains the equivalent of 8000 pages.

Tropical Medicine Resource (TMR)

Tropical Medicine Resource
Wellcome Centre for Medical Science
The Wellcome Trust
210 Euston Road
London NW1 2BE
UNITED KINGDOM

Contact: Head, Tropical Medicine Resource

Telephone: (44 171) 611 8603 *Fax:* (44 171) 611 8270 *E-mail:* tmr@wellcome.ac.uk

The Tropical Medicine Resource is funded by The Wellcome Trust. It is targeted at early postgraduate or senior undergraduate medical and life sciences students and their tutors, based in centres of higher learning throughout the world. It has two component parts, both delivered on CD-ROM:

the Visual Archive is a searchable, electronic database of images illustrating a wide range of aspects of tropical medicine from clinical features to the environment. Each image presented is catalogued, described and copyright-cleared. A loan service for obtaining copies of the images is planned but is not yet fully operational;

the Computer-Interactive Tutorials provide an introduction to key topics in tropical medicine or a means of quick revision. They are highly visual learning materials that allow user interaction and provide learning objectives and self-assessment

The materials are designed for ease of use but support materials are provided as a backup. These include on-screen help, an on-screen glossary of medical and scientific terms, a printed program manual, a printed glossary and quick reference screen guides. The materials are also designed to be reliable, and all information presented is checked by external subject experts.

At present the TMR CD-ROM is available for appraisal by any centre of higher education that has the appropriate hardware and is willing to agree to fulfil the appraisal requirements.

TMR CD-ROM currently covers the following six topics: anaemia in pregnancy, malaria, schistosomiasis, sexually transmitted diseases, sickle cell disorder and trachoma. The TMR is working to extend the resource to cover additional topics; immediate priorities are tuberculosis and diarrhoeal diseases.

Instituto de Investigação Cientifica Tropical (IICT)

Instituto de Investigação Cientifica Tropical
Rua da Junqueira 86
1300 Lisbon
PORTUGAL

Contact: Joaquim Alberto da Cruz e Silva, President

Telephone: (351 1) 364 5071 *Fax:* (351 1) 363 1460

The Institute for Tropical Sciences Research (IICT) dates from 1883 with the aim of developing scientific research in tropics. In order to achieve its objectives IICT has a number of programmes:

to coordinate activities resulting from scientific relations between Portugal and tropical countries (mainly those countries with the Portuguese language, but also 40 other countries);
to plan scientific and technical cooperation activities with these countries;
to implement collaborative scientific assistance and exchange programmes as well as training programmes through scholarship schemes;
to support university teaching and research in areas of its scientific activities.

IICT has a staff of 426 of whom 157 are research fellows and collaborating university professors. It has 23 specialized research centres which cover areas such as: Agrarian Sciences, Geographic Engineers, Biological Sciences, Earth Sciences, Historical, Economic and Sociological Sciences, and Ethnological and Ethno-Museological Sciences. It also possesses a substantial Documentation and Information Centre.

IICT is Portugal's major scientific publisher, having published more than 8000 scientific works, over 1600 books and review numbers, and nearly 1600 geographical, hydrographical and geological maps. The Institute has a large exchange programme with other institutions working in similar areas.

IICT is a member of the ECART (European Consortium for Agricultural Research in the Tropics) jointly with CIRAD (France), NRI (UK), KIT (Netherlands), ATSAF and GTZ (Germany). Together, these organizations represent a European capacity of over 2500 professional staff and several research centres in the tropical regions.

Book Aid International

Book Aid International
39–41 Coldharbour Lane
London
SE5 9NR
UNITED KINGDOM

Contact: Sara Harrity, Director

Telephone: (44 171) 733 3577 *Fax* (44 171) 978 8006 *E-mail:* rls@gn.apc.org

Book Aid International, formerly Ranfurly Library Service, was founded in 1954 and is a voluntary

organization with 30 members of staff supported by many volunteers. Its core programme meets requests for books from developing countries at all levels and in all subjects by supplying new and used donated books.

The rest of the books are purchased to fill gaps in donated supplies. Book Aid International buys essential titles in very high demand and low supply, for example atlases and dictionaries for learners of English as a second language. It also buys books for children and adults published within Africa to strengthen the cultural relevance of its ongoing programmes and support the development of local publishing.

Currently, Book Aid International sends over half a million books each year to support literacy, education, training and publishing in over 60 developing countries. Eighty percent of the books support projects in 13 countries in sub-Saharan Africa.

The organization works in partnership with organizations which are able to distribute books most effectively in their country. All requests are assessed according to Book Aid International's recently revised criteria for book aid. Books are sent via an established distributor, often the public library service in the country concerned, which then allocates the books according to local needs and priorities. Or they are sent direct to the requesting institution.

An alternative contact is David Membrey, the Deputy Director.

World Health Organization (WHO)

World Health Organization
Office of Library and Health Literature Services
20 Avenue Appia
CH-1211 Geneva 27
SWITZERLAND

Contact: Yvonne Grandbois, Acting Chief

Telephone: (41 22) 791 2071 *Fax:* (41 22) 791 4150 *E-mail:* hlt@who.ch
Web site: http://www.who.ch

The Office of Library and Health Literature Services, also known as the WHO Library, operates an international exchange of health science books and periodicals. Membership in the exchange simply entails sending in the name of the library to the WHO Library. Participating libraries send their lists of offers and needs to the WHO Library which duplicates the lists and sends them to the member libraries. These libraries then contact each other to request specific items. Libraries in the developed world are asked to pay the postage for material going to the developing world.

WHO Library's products *WHODOC*, *Liaison* and the *Library Digest for Africa* are available on the WHO gopher on the internet, or in printed form for libraries without Internet access.

A project with which WHO is associated is the *African Index Medicus* (AIM) launched in 1993. This is produced under the leadership of the Association for Health Information and Libraries in Africa (AHILA). AIM seeks to improve access to the contents of African health and biomedical journals. Requests for more information on the AIM Project should be addressed to Lucilda Hunter at the Library and Documentation Centre, WHO Regional Officer for Africa, PO Box 6, Brazzaville, CONGO (*tel:* (242) 839111; *fax:* (242) 839400).

A new project entitled *Les Bibliotèques bleues* (Blue trunk libraries) is being launched for francophone Africa. It is a collection of books and manuals suitable for district health centres.

International Union of Pharmacology (IUPHAR)

International Union of Pharmacology
Department of Pharmacology
Faculty of Medicine, University of Montreal

Case Postale 6128
Montreal, Quebec H3C 3J7
CANADA

Contact: Prof Paul du Souich, Secretary, Clinical Pharmacology Division

Telephone: (1 514) 343 6335 *Fax:* (1 514) 343 2204
E-mail dusovic@ere.umontreal.ca
Web-site: http://iuphar.pharmacology.unimelb.edu.au/

The object of the International Union of Pharmacology (IUPHAR) is to foster international cooperation in pharmacology by:

promoting cooperation between societies representing pharmacology and related disciplines throughout the world;
sponsoring international and regional congresses and meetings and helping in their organization by establishing advisory committees;
encouraging international cooperation and free exchange of scientists and of ideas in research;
acting as a body through which pharmacologists can participate with scientists from other disciplines in international activities

IUPHAR has provided, since 1980, monthly copies of *Trends in Pharmacological Sciences* to various developing country institutions, upon the recommendation of its Executive Officers. The 1994 value of these subscriptions was estimated at about £4500. A survey of recipients is made every 3 years.

An alternative contact is Professor W C Bowman, Department of Physiology and Pharmacology, University of Strathclyde, Glasgow G1 1XU, UK.

Commonwealth Pharmaceutical Association (CPA)

Commonwealth Pharmaceutical Association
1 Lambeth High Street
London
SE1 7JN
UNITED KINGDOM

Contact: Philip E. Green, Secretary

Telephone: (44 171) 735 9141 *Fax:* (44 171) 735 7629

The Commonwealth Pharmaceutical Association (CPA) makes recent issues of the *British National Formulary* available on an annual basis to pharmacy departments, pharmacists and other health professionals. The CPA arranges collection within the UK; Book Aid International provides shipment to its distributors in developing countries in the Commonwealth and the local CPA representative is responsible for collection of the books and decides upon the nature and extent of distribution.

American Society of Clinical Pharmacology and Therapeutics (ASCPT)

American Society of Clinical Pharmacology and Therapeutics
c/o Dept of Pharmacology
Cornell University Medical College
1300 York Avenue—Box 70
New York
NY 10021
U.S.A.

Contact: June Reidenberg, Managing Editor

The American Society of Clinical Pharmacology and Therapeutics (ASCPT) subsidises jointly with the publishers of its journal *Clinical Pharmacology and Therapeutics*, Mosby-Year Book Inc., a number of gift subscriptions to *Clinical Pharmacology and Therapeutics* for selected libraries in Third World medical schools and Ministries of Health in 27 countries. It has provided advice to other US medical societies in developing their own programmes.

Further information: INASP, 27 Park End Street, Oxford OX1 1MU, United Kingdom.

Partners: Magazine for Paramedical Workers: The Leprosy Mission International

The Leprosy Mission International (TLMI) has recently issued Numbers 31, 32 and 33 (volumes 1 and 2, 1996/97, focussing on eye care in leprosy, with important contributions from experts in ophthalmology in the Netherlands, India, Singapore and the United Kingdom. They include numerous colour plates and diagrams on diagnosis, differential diagnosis and treatment. Recommended teaching and learning material includes the following:

Community Eye Health is an excellent magazine dealing with general issues about eye health. For more information contact

Journal of Community Eye Health,
International Centre for Eye Health,
Institute of Ophthalmology,
11–43 Bath Street,
LONDON,
EC1V 9EL, UK

Dr Paul Courtright's book, *Prevention of Blindness in Leprosy:* is also available from the above address.

Essentials of Leprosy: Dr Leo Yoder: New edition of this informative booklet now includes colour plates – original author, Dr Pearson. New eye chapter by Dr Elspeth Zijp. *English.*

Guide to ocular leprosy for health workers: Paul Courtright and Susan Lewallen. Simple, effective measures to prevent blindness in leprosy patients. *English.*

Training health workers in Ocular leprosy: Paul Courtright and Lewallen. For trainers of health workers using the Guide to ocular leprosy. *English.*

Care of the eye in Hansen's Disease: Dr Margaret Brand: Book for Ophthalmologist treating leprosy patients. *English.*

Prevention of Disabilities – Guidelines for leprosy control programmes: ILEP 1995. Eye contributions by Margreet Hogeweg. *English and French.*

PLA Notes (Notes on Participatory Learning and Action) is published three times each year in February, June and October. PLA Notes enables practitioners of participatory methodologies from around the world to share their field experiences, conceptual reflections and methodological innovations. To receive further information about PLA Notes subscriptions please contact

Hilary Pickford,
IIED
3 Endsleigh Street
London
WC1H ODD, UK

Tel +44 (0)171 388 2117
Fax +44 (0) 171 388 2826
email sustag@iied.org

The Nepal Participatory Action Network came into being in January 1995. NEPAN exists to promote and advocate the need, importance and skills of participation and skills of participation for empowering the people who are the subject of development.

Nepan has a resource center which can be used by members and non-members. For more information contact Kamal Phuyal, Co-ordinator, Nepal Participatory Action Network, GPO Box 890, Batule Ghar, Dilli Bazar, Kathmandu, Nepal.

Tel +977 1 421617
Fax +977 1 419718
email nepan@mos.com.np

TALC (Teaching Aids at Low Cost) has a new catalogue out for 1998, which includes new and revised materials for 1998. To obtain a catalogue and price list please write to
TALC
P O Box 49
St Albans
Hertfordshire
AL1 4AX
UK
Tel: +44 (0) 17278 53869
Fax: +44 (0) 17278 46852

Translations of *Partners* may be obtained by contacting the following:

For *India*, *Sri Lanka* and *Myanmar*, the address is The Leprosy Mission, CNI Bhavan, Pandit Pant Marg, New Delhi, India.

For copies of the *Bengali* edition write to: Dr Chaudhury, Grecaltes Training Centre, 23 Market Street, Calcutta 700 087, India.

For copies of the *Hindi* edition write to: Mr P K Roy, Leprosy Mission, CNI Bhavan, Pandit Pant Marg, New Delhi, India.

For copies of the *French* edition, Associés, write to: La Mission Evangélique Contré la Lépre, Chemin de Réchoz, 1027 Lonay, VD Switzerland.

For copies of Partners in *Chinese* please write to Dr Zhao Xiding, Vice-Editor, China Leprosy Journal, 402, 87 Hengfu Road, Guangzhou, 510095, China.

Partners is printed and despatched in Singapore on behalf of: The Leprosy Mission S.E. Asia, 6001 Beach Road, #08-06, Golden Mile Tower, Singapore 199589.

The Leprosy Mission International, 80 Windmill Road, Brentford, Middlesex, TW8 OQH, U.K. E-mail: junen@tlmint.org

Letter to the British Medical Journal: 'Dominant gene probably caused some of the defects ascribed to thalidomide'

Following a series of alarmist and potentially misleading articles in the lay press recently, the following letter from Professor Dick Smithells was published in the *British Medical Journal*, volume 316, 10th January 1998:

EDITOR—The Journal *Teratogenesis, Carcinogenesis and Mutagenesis* published a highly controversial paper by Huang and McBride purporting to show experimental evidence which might 'explain' second generation defects in the offspring of people accepted as having been damaged by thalidomide. Bower

asks why the journal should publish this paper alongside a devastating critique by Neubert, a member of the journal's editorial board, saying that 'the paper... contains so many inadequacies that it is impossible to draw any conclusions.

I wish to put the record straight. Dr McBride's work was not 'presented to the European Toxicology Society in Dublin five years ago.' According to Professor Neubert's paper, Dr McBride's data were presented in Dublin at the time of the European Teratology Society's meeting but outside the regular programme and were therefore not included in the abstracts of that meeting. The data were 'released by the authors (without knowledge of the organisers) to the press as highlight of this meeting.' There is therefore no valid experimental evidence to support the 'second generation' hypothesis.

The second strand to the media story is that a small number of people who were accepted as having been damaged by thalidomide have become parents of similarly affected children. The only reasonable conclusion is that a dominant gene is responsible in both generations. When decisions were being made in the 1960s and 1970s about who had and who had not been damaged by thalidomide, a number of difficult cases were given the benefit of the doubt (that is, attributed to thalidomide), and some decisions were made by doctors who lacked the necessary experience. It was inevitable that some of these people had not, in fact, been damaged by thalidomide.

So long as the media are prepared to perpetuate the myth of second generation defects due to thalidomide, medical scientists must spend time refuting it. The myth raises hopes of additional compensation for the few but, more importantly, it raises fears among people with defects due to thalidomide that their future children are at serious risk of being born with similar defects. Even those who have completed their families and whose children are healthy may fear third generation defects in their grandchildren.

Zambia: visibly crippled by debt burden

The following extract is from the *Guardian* newspaper of Thursday 14th May, 1998:

'Non-governmental organisations such as Cafod and Oxfam say that, of all African countries, Zambia is most visibly crippled by its debt burden—now $7.2 billion (£4.3 billion)—and by the structural adjustment targets tied to World Bank cheques.

The United Nations Children's Fund (Unicef) estimates that two-thirds of Zambians live in poverty, and there is no sign of improvement on the horizon.

The human consequences are clear. Literacy is declining because families need their children to work and cannot afford school fees. Life expectancy is down from 54·4 years in 1991 to 42·6 years in 1997. As a direct result of hospitals becoming more expensive, there are now 203 infant deaths per 1,000 births, compared to 125 in 1991. Almost uniquely in Africa, access to clean water is declining.'

The St Francis Leprosy Guild, United Kingdom

The St Francis Leprosy Guild (founded 1895), 26 Inglis Road, Ealing, London W5 3RL, held its Annual General Meeting in London on May 6th, 1998. Accumulated funds were approved for leprosy centres in Africa, Bolivia, Egypt, Brazil, Indonesia, Jamaica, Madagascar, Myanmar, Pakistan, Papua New Guinea, Philippines, Thailand, Vietnam and Sri Lanka (total £283,900). The Guild aims '... to help cure people who suffer from Leprosy (Hansen's Disease), to rehabilitate into the community those who have been cured wherever possible, and when necessary to give residential support to those whose disabilities require it.' The 1997 Report to Benefactors has been issued to all members of the *International Federation of Anti-Leprosy Associations* (ILEP) and is available to others on application to the above address.

Journals, electronic publishing and the internet

Under the heading 'Electronic, international and ready for anything', the 'Editor's choice' in the *British Medical Journal*, volume 316, 11th April 1998, ran as follows:

Today we launch the *eBMJ*, an electronic version of the journal that includes not only the full text of everything published in the paper version but also begins to use the remarkable capabilities of the internet.

Eventually, the *eBMJ* is likely to be the primary version of the journal, with the paper journal being one of its manifestations. This transformation is well under way with physics and chemistry journals, and some medical journals—for example, *Pediatrics*—are already including reports on studies (we can't call them papers any more) in their electronic version that are not included in the paper versions. Some journals are also posting reports on studies on their websites the minute they are accepted, meaning they appear electronically months before they appear on paper. This vision of an electronic future will excite some and appal others, but those who love paper and hate computers need not fear. The ease of reading and handling paper and its transportability and familiarity make it most unlikely that it will ever disappear.

But where electronic journals will go is far from clear. They might disappear altogether as authors of studies find other ways to reach readers, or we might move to a few megajournals with all the small ones disappearing. The editor of *Circulation*, the world's primary cardiology journal, thinks, for instance, that one cardiology journal is enough. To survive, journals will have to learn to use the full benefits of the web—speed, worldwide reach, infinite capacity, searchability, interactivity, the ability to link, and so on. Paper people must become web people.

One of the most obvious benefits of an electronic journal is that new material can be accessed immediately anywhere in the world. It wasn't much more than a 100 years ago that it took 18 months for a letter sent from Britain to get a reply from New Zealand. The paper version of the *BMJ* still takes well over a week to get there. The immediacy and reach of electronic publishing means that an international journal like the *BMJ* can become truly global. Already about three quarters of the roughly 20,000 people who access the *eBMJ* each week come from outside Britain, and about 40% have never seen the paper version. This issue of the journal includes information from India, France, the United States, Bangladesh, Canada, the four countries of Britain, South Africa, Norway, Poland, Thailand, Nicaragua and Cuba, Australia, and New Zealand, but perhaps an issue five years from now will be still more international. If, of course, there is one.

Blister pack for 'ROM' treatment of single-lesion, paucibacillary leprosy

A ROM blister pack is available as a free supply from WHO, made possible by a gift from the Nippon Foundation, Japan. The single-dose combination of drugs (rifampicin, ofloxacin and minocycline) is for the treatment of single-lesion, paucibacillary leprosy only. Furthermore, WHO recommends (see *MDT: Questions and Answers*, revised 1997, *Action programme for the Elimination of Leprosy*, WHO Geneva) that this regimen may be used only by programmes detecting a large number (1000 or more) such cases annually. The relevant section on ROM from the *Seventh Report of the WHO Expert Committee on Leprosy*, *WHO Technical Report Series 874*, 1998, reads as follows:

Regimen for single-lesion paucibacillary leprosy

There is some evidence to suggest that single-lesion leprosy is a clinical entity and may be cured by a limited amount of chemotherapy, so a separate regimen for these patients will be useful. The efficacy of a single dose of a drug combination consisting of 600 mg of rifampicin, 400 mg of ofloxacin and 100 mg

of minocycline (ROM) for the treatment of single-lesion paucibacillary leprosy has been proved in a multicentre, double-blind field trial in India. The trial involved 1483 patients with single-lesion paucibacillary leprosy, who were randomly allocated to two groups (study and control), both of which received 6 monthly doses of drug or placebo. The first group was treated with a single dose of ROM and 6 monthly doses of placebo, while the second received 6 monthly doses of WHO MDT for paucibacillary leprosy and a single dose of placebo. At follow-up, 12 months after the 6-month treatment, the treatment failure rate was identical (0·9%) in both groups; adverse effects and leprosy reactions were mild and rare in patients treated with a single dose of ROM and who did not differ significantly from those treated with the standard WHO MDT regimen. Although a single dose of ROM was marginally less effective, in terms of clinical improvement, than the standard MDT regimen, the operational advantages of single-dose treatment are enormous, especially when it is taken into account that, in some countries such as India, more than 50% of newly detected cases are classified as having single-lesion paucibacillary leprosy. The Committee considered that a single dose of ROM is an acceptable and cost-effective alternative regimen for the treatment of patients belonging to this category.

Seventh Report of the WHO Export Committee on Leprosy, WHO Technical Report Series 874

The above Report has recently been circulated and should be studied in the original by all involved in control programmes and the treatment of individual patients. We reproduce below some extracts of pages of particular interest, including a brief summary of the remarkable achievements with multiple drug therapy (MDT) to date.

Introduction

The WHO Expert Committee on Leprosy met in Geneva from 26 May to 3 June 1997. Opening the meeting on behalf of the Director-General, Dr R. H. Henderson, Assistant Director-General, noted that more progress had been made in the fight against leprosy during the past decade, since the last meeting of the Committee in 1987, than during any other period in the history of leprosy control. He also noted the reputation of the Committee in finding the right balance between scientific findings, the needs of individual patients and their communities, and the concerns for public health. He expected the Committee to address important issues relating to leprosy chemotherapy, the prevention of leprosy-related disabilities and impairments and the need to simplify approaches in order to reach all patients, including those living in remote areas.

In May 1991, the Forty-fourth World Health Assembly adopted resolution WHA44.9 declaring the commitment to promote the use of all control measures, including multidrug therapy (MDT) together with case-finding, in order to attain the global elimination of leprosy as a public health problem (reducing the prevalence to below 1 per 10,000 population) by the year 2000.

The resolution urged Member States in which leprosy is endemic:

- to further increase or maintain their political commitment and give high priority to leprosy control so that the global elimination of leprosy as a public health problem is achieved by the year 2000;
- to strengthen managerial capabilities within leprosy programmes, particularly at the intermediate level, and to improve training in leprosy for health workers at all levels, including medical students and student nurses;
- to ensure that coverage of MDT is maintained at the highest level possible and that patients comply with treatment;
- to strengthen case-finding activities through various approaches, including health education, community participation and training of health workers;

- to integrate leprosy control within general health services and provide appropriate social and economic rehabilitation measures as soon as possible in accordance with local realities;
- to improve national information systems in order to facilitate monitoring and evaluation of the elimination of leprosy;
- to coordinate the technical and financial resources made available for leprosy control by international and nongovernmental organizations so that they are utilized in the best way.

The establishment of the goal of eliminating leprosy as a public health problem has enabled countries where leprosy is endemic to increase their political commitment and priority for leprosy and to organize and intensify antileprosy activities, which in turn has resulted in a major reduction in the prevalence of the disease. The two international conferences on the elimination of leprosy organized by WHO in Hanoi, Viet Nam, in July 1994 and New Delhi, India, in October 1996 consolidated political commitment towards leprosy elimination by the countries most affected by the disease. Support for leprosy work from various participating agencies, including both national and international nongovernmental organizations, bilateral agencies and other international organizations, has also greatly contributed to the progress towards global elimination of the disease.

The purpose of this meeting of the Expert Committee on Leprosy was:

- to review the global leprosy situation and the technology available for eliminating the disease;
- to identify the remaining obstacles to reaching the goal of eliminating leprosy as a public health problem;
- to make appropriate recommendations for the future on technical and operational matters.

There have been dramatic changes in the epidemiology of leprosy following the widespread implementation of MDT, particularly in the prevalence of the disease. The problem of reaching patients living under difficult conditions and in remote areas has become a priority, and approaches are needed to address this through greater community participation and special initiatives. A WHO Study Group on Chemotherapy of Leprosy met in 1993 and made important recommendations on fixed duration MDT, which made integration of leprosy services into general health services more feasible. Since then, research on leprosy chemotherapy has increased the possibility of further simplifying approaches which would support integration. The remaining issues beyond elimination that need to be addressed include the prevention of leprosy-related disabilities and impairments, community-based rehabilitation, and sustainability of leprosy services. This calls for mobilization and improved coordination of all relevant agencies, including non-governmental organizations, to further reduce the burden of leprosy and its consequences.

Global leprosy situation in 1997

Major changes have taken place in the global leprosy situation since the Expert Committee last met in 1987.

ESTIMATED CASES

Estimates of the number of cases of leprosy in the world are useful for setting priorities and for planning elimination activities. The estimates presented here are based on information from national programmes and derived from registered figures, taking into account the levels of coverage by health services and of MDT.

Estimates for 1997 indicate that there are currently about 1·15 million cases of leprosy in the world, compared with 10–12 million cases in the mid-1980s. The gap between the numbers of estimated and registered cases indicates that over 260,000 leprosy cases remained undetected in 1996; of those, about 60% were living in south-east Asia.

REGISTERED CASES

During the past 12 years, the number of registered cases in the world has fallen by about 85% in almost all countries and regions where leprosy is endemic. About 890,000 leprosy patients were registered at the beginning of 1997.

Leprosy remains a public health problem in 55 countries or areas, but 16 countries account for over 91% of the total number of registered cases, and five of them (Brazil, India, Indonesia, Myanmar and Nigeria) account for about 82%.

DETECTION OF CASES

About 567,000 new cases of leprosy were detected in 1996. This figure has remained more or less constant over the past decade. Several factors appear to have contributed to the steady level of annual number of cases detected, including:

- increased case-finding activities as a result of intensified efforts and expanded geographical coverage, leading to identification of a high proportion of previously undetected cases;
- improved reporting systems; and
- decreased specificity of diagnosis of leprosy (by general health workers rather than specialized staff).

Intensified case-finding efforts and earlier detection of cases as a result of improved control programmes have masked the underlying global trend resulting from MDT. Because the annual detection rates are still very high in some countries or in some regions within countries, such countries may have difficulty in reaching the elimination goal and will need special attention.

Although the number of cases detected each year has remained constant, the characteristics of such cases have changed significantly. Over the past decade the proportion of new cases in children below 15 years and of patients with multibacillary leprosy have increased, while the proportion of newly detected cases with grade 2 disabilities (see section 6.2) has decreased.

ACHIEVEMENTS WITH MDT

By the beginning of 1997, more than 8·4 million leprosy patients had been cured by MDT. Currently more than 97% of registered cases are receiving MDT. The increase in MDT coverage is a result of the efficacy and acceptability of MDT, which is fully standardized and of fixed duration. The numbers of relapses remain low, below 1 per 1000 patients per year, and drug resistance following MDT has not been reported.

However, taking into consideration that treatment is still of long duration (6 or 24 months), which is not always easy to monitor, data on MDT coverage should be interpreted with caution and, whenever possible, the coverage rate should be presented along with the completion rate of treatment by cohorts of patients starting treatment during the same year. Current data suggest that completion rates in most countries vary between 60% and 90%.

Conclusions and recommendations

The major conclusions and recommendations of the Committee are summarized below.

1. The Global Strategy for the Elimination of Leprosy, based on the implementation of MDT with case-finding, is proving to be extremely successful in reducing the prevalence of leprosy and should be continued.
2. There is an important need to detect and treat the remaining undetected cases, for which special approaches, along with the extension of MDT services to all general health facilities, are required.

3. The progressive simplification of diagnostic and treatment techniques has continued to facilitate reaching more leprosy patients.
4. On the basis of a multicentre trial, the Committee considered that a single dose of a combination of rifampicin, ofloxacin and minocycline is an acceptable and cost-effective alternative regimen for the treatment of single-lesion paucibacillary leprosy. Furthermore, based on the available information, it is possible that the duration of the current MDT regimen for multibacillary leprosy could be shortened to 12 months.
5. There is a need for a fresh strategy for disability prevention and rehabilitation that would ensure a practical, community-oriented approach aimed at reaching the largest number of persons in need with cost-effective interventions.
6. The monitoring of elimination through essential indicators (see section 8) should continue. The information reported should be validated and analysed further by independent monitors in order to identify problem situations needing action.
7. In endemic countries, antileprosy activities should become, and should remain beyond the year 2000, an integral part of general health services and should also involve the communities to the fullest extent possible. Coordination between various agencies, including national and international non-governmental organizations, should be consolidated.
8. It is recommended that research in leprosy be continued, especially in improving patient care and in addressing issues after the goal of elimination has been reached.
9. It is important to sustain antileprosy activities beyond the year 2000 in order to deal with the remaining problems, including newly detected cases and persons with leprosy-related disabilities and impairments.

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 KGMM 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 organized by Neil Pakenham-Walsh of '*INASP-Health*', a specific programme within the *International Network for the Availability of Scientific Publications (INASP)* and Paul Chinnock, Editor of *Africa Health*. '*INASP-Health*' is dedicated to the co-ordination 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) *The British Medical Journal*, volume *314*, 11th January 1997, 2) *WHO Liaison*, volume *8*, numbers 2–3, August-November, 1997 and 3) *World Health*, 50th year, number 6, November–December 1997.

Thirty people involved in the provision of health information for developing countries were invited, including representatives of the *British Medical Journal, African Health, Medicine Digest, Practical Pharmacy*, Action in International Medicine (AIM), African Medical and Research Foundation (AMREF), The British Council, CAB International (CABI), Essential Drugs Project, Healthlink (previously AHRTAG), Authors Licensing and Collecting Society, Book Aid International, Department for Information Studies, Sheffield University, Footsteps/Tear Fund, International Health Exchange, London School of Hygiene and Tropical Medicine, Nigerian Medical Forum, Partnerships in Health Information, (previously SatelLife, UK), 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 organisations 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 towards 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 *British Medical Association* (UK), *Danida* (Denmark), and *Reuters*.

Further information: INASP-Health, 27 Park End Street, Oxford, OX1 1HU, United Kingdom. Tel/Fax +44 (0) 1865 249909/251060. Email inasp@gn.apc.org
WWW: http//www.oneworld.org/inasp/

Damien Foundation India Trust: Annual Report 1997

We are indebted to Dr P. Krishnamurthy, Secretary DFIT, India for the annual report of activities, 1997 covering projects in Utta Pradesh, Bihar, Maharashtra, Karnataka, Andhra Pradesh, Pondicherry, Tamil Nadu and Kerala. Extracts from the Introduction read as follows:

Damien Foundation India Trust (DFIT) passed one more year of useful service to the people in different parts of the country. It went through a phase of expansion and consolidation especially in Bihar and potentiation in other areas through a shift in emphasis in operational process. New inroads were made into the leprosy problem in Bihar, new direction was given to the programme through revised strategies, new programmes were initiated, new initiative was taken to give fillip to efforts on health education, new orientation was given to Prevention of Disability (POD) programme and a new dimension was given to interaction with projects.

The prevalence of leprosy in India which was 57 per 10,000 in 1981 has come down to 5·7 per 10,000 in 1997. Total cases on record (December 1997) is 0·48 million. The spectacular fall in prevalence has been mainly due to the systematic implementation of Multi Drug Therapy (MDT) in the endemic districts. There is no state in India with a prevalence of 50 or more per 10,000. While considerable achievement has been made in some states, in others it is far from satisfactory for various reasons. The state of Tamil Nadu which was highly endemic for leprosy witnessed a dramatic fall in prevalence over 10-year period of MDT implementation and has, following intense case detection campaign, integrated leprosy control with general health services. In the meantime efforts are being made by various agencies, national and international, Government and Non-government, in some of the Northern states like Bihar to establish leprosy control programme adapting locally suitable strategies.

Damien Foundation India Trust is one of the premier voluntary agencies devoted to leprosy eradication and is contributing in its own unique way towards the common struggle against leprosy. Of the 23 leprosy eradication projects it supports, two are directly run, two are Government MDT districts and 19 are projects (three in the north) run by voluntary agencies. DFIT has also placed 15 technical

teams, each consisting of a District Leprosy Advisor and a Supervisor, in 15 districts of Bihar. All the projects that are supported are field-based.

The extent of leprosy problem in Bihar becomes apparent when one looks at the figures—22% of the case load of India and 10% of the global case load is contributed by the state. There were 122,046 cases on record with a Prevalence of 12·8 per 10,000 at the end of September 1997. It is believed that there may be twice the number of cases in the community. Of the 39 districts 17 are considered to be endemic and the rest non-endemic. Since the estimates were made years back and since the programme has not shown the expected progress it is safe to assume that differentiation of districts on the basis of endemicity becomes less relevant. In the endemic districts the programme is run vertically with staff meant only for leprosy and in the non-endemic ones it is implemented through mobile leprosy treatment units (MLTU) one for every 1,000,000 population in a district. Case detection is done through various surveys and voluntary reporting. Patients are treated at service delivery points through daily circuits.

Further information: Damien Foundation, India Trust, 27 Venugopal Avenue, Spur Tank Road, Chetpet, Chennai 600 031 India.

Erratum

Uveitis in leprosy patients who got inactive condition in pre-WHO/MDT era, Namisato *et al*. Volume 69, page 82. Authors' names should read: M. Namisato, S. Joko, S. Izumi, K. Murakami and H. Ogawa.

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