

NEWS and NOTES

This department furnishes information concerning institutions, organizations, and individuals engaged in work on leprosy and other mycobacterial diseases, and makes note of scientific meetings and other matters of interest.

Brazil. *College of Hansenology of the Endemic Countries founded.* On 12–15 November 1980 in Rio de Janeiro, Brazil, the first Congress and Foundation of the College of Hansenology of the Endemic Countries was held. The main subjects discussed in the panels were related to classification, microbiology, clinical, experimental hanseniasis, pathology, therapeutics, immunology, physical rehabilitation, psychosocial rehabilitation, and epidemiology and control. The conclusions and some of the papers presented will be published in HANSENOLOGIA INTERNATIONALIS.

The Congress was attended by representatives of 23 countries who voted on the constitution and by-laws of the college. The purposes will be "the integration of hanseniasis (Hansen's disease) into the mainstream of modern medicine, the research in all scientific fields of the disease and the study of elimination of all cultural barriers which are creating psycho-social problems and hindering preventive efforts."

The association is open to professionals in the fields of medicine, chemistry, biology, psychology, anthropology, history, social sciences, nursing, health education, communication, and others who would wish to cooperate.

The officers and council elected included: President, Rubem David Azulay; Secretary-Treasurer, Célio Paula Motta; Vice Presidents, medical, J. Languillon (Africa), G. Klingmuller (Europe), H. J. Shroff (Asia), R. Hastings (North America), Paul Niemals (Central America), E. Junquiers (South America), M. Mangiaterra (South America); Vice Presidents, non-medical, Thomas Fritz (social sciences); E. Storrs (biology); Councillors, F. G. Urcujo (Nicaragua), K. Nakamura (Japan), Helder M. Goncalves (Portugal), H. Rosen (Uruguay), A. Valencia (Bolivia), F. Durksen (Paraguay), A. Carayon (Senegal).

The next Congress is planned to be held in 1985 at Carville, Louisiana, U.S.A. Other local or sub-regional meetings are being organized. For membership applications or information, write: Rua Nascimento Silva, 16/201-Ipanema, Rio de Janeiro/RJ, Brasil-CEP 22.421.—(Adapted from materials provided by Dr. Rubem David Azulay and Célio Paula Motta)

Burma. *Tenth meeting of THELEP Steering Committee held in Rangoon.* The tenth meeting of the THELEP Steering Committee was held, together with the first meeting of the ad hoc Clinical Trials Subcommittee, in Rangoon, Burma, 16–17 November 1981. Progress in five on-going prevalence surveys of secondary dapsone resistance was reviewed. Applications for the conduct of two field trials in South India were approved, and the protocol was modified to permit comparison of the THELEP field trial regimen with that recommended for multibacillary leprosy by the Study Group on Chemotherapy of Leprosy for Control Programmes. Progress in the two controlled clinical trials was again reviewed. An unexpected finding was that of primary dapsone resistance, with a prevalence of 17.5% in one trial and 40% in the second. Eleven applications for research support were reviewed; all but one were approved, for a total of US\$184,733.—(From the WHO report)

China. *Leprosy in Guangdong Province basically under control.* More than 67,000 cases cured since 1949. During the Second National Leprosy Conference held recently in Canton, the delegate from the province of Guangdong announced that leprosy, which was formerly very prevalent in this province, is now basically under control.

After 1949, effective measures were tak-

en to prevent and treat leprosy cases. Many leprosy control organizations were established within the province and some 2000 professional personnel were trained. After several large-scale mass surveys the epidemiology and distribution of leprosy in this province were clarified and a total of 93,000 patients were identified. At present, 67,000 cases have been cured, leaving only 9090 patients still requiring treatment. Fresh leprosy cases are currently few and mostly non-infectious.

Leprosy can be cured clinically; therefore, it should not be considered as a horrible or frightening disease. At present, many cured patients have resumed work, and quite a number are now married and lead happy lives.

While visiting our hospital in Chao An County in April, 1981, Professor M. Lechat, famous leprologist and President of the International Leprosy Association, said, "The fact that leprosy is still very rampant in many parts of the world, as I have seen after a recent inspection tour, almost makes me lack confidence to say that leprosy can be controlled. I am very much impressed and encouraged by the achievements of your work, which made me feel that control and eradication of leprosy is a possibility. You have set a good example!"—(*Reported in the Guangdong "Southern Daily" of 27 November 1981*)—Ma Haide

National Technical Symposium on Leprosy Control held in Nanjing. Under the direction of the Ministry of Health, a National Technical Symposium was held from 1–6 March in Nanjing, attended by 48 leprologists from 28 provinces, autonomous regions and municipalities in China. Presiding at the symposium was Dr. Ye Gan-yun, Deputy Director of the Institute of Dermatology, C.A.M.S. Among the participants were noted leprologists, Drs. Li Jiageng, Su Junrui, Lu Jianmin, Deng Yunshan, and others. Dr. Ma Haide, Advisor to the Ministry of Health, was absent on business in South China. The highlights of the symposium included discussions of the leprosy control regulations which would put in force further development of the program for a national campaign against leprosy. The drafts of the regulations dealt with

in this study were worked out and nine of them were unanimously adopted, including, "The Regulation for Management of Leprosy Control," "The Regimen of Combined Chemotherapy in Leprosy Control," "Criteria for Clinical Cure of Leprosy," and "The Project of Epidemiological Survey of Leprosy."—Ye Gan-yun

Ethiopia. *All Africa Leprosy & Rehabilitation Training Center (ALERT) international courses program, 1982.* Dr. J. Warndorff, Director of Training, has supplied the following details:

Monday 11 January–Saturday 13 March:

Course for Senior Rural Area Supervisors on Clinical Leprosy and Leprosy Control. The course will include two weeks of field work.

Monday 12 April–Saturday 8 May:

Course for Medical Officers with emphasis on Clinical Leprosy and Teaching of Leprosy.

Monday 10 May–Saturday 29 May:

Course on Dermatology in the Tropics for Medical Officers, Medical Assistants, Nurses.

Monday 13 September–Saturday 30 October:

Course for Physiotherapists in conjunction with the:

Monday 27 September–Saturday 30 October:

Course for Medical Officers with emphasis on Clinical Leprosy and Leprosy Control. The course will include one week of field work.

Apply to ALERT, P.O. Box 165, Addis Ababa, Ethiopia.—(*Lepr. Rev.* 52 [1981] 365)

Federal Republic of Germany. *The Deutsche Aussätzigen-Hilfswerke (DAHW) activities in leprosy.* The DAHW reported on 31 October 1981 in "Heilen und Helfen" that in 1980 they assisted 700,000 leprosy patients in 44 nations of Asia, Africa, and Latin America. DAHW also assisted 12 research and health education projects. More than 135,000 of the leprosy patients which were aided had the lepromatous form of the

disease. A total of 66,300 new cases received treatment and 33,600 cases were discharged from treatment as cured or inactive. The project was made possible by receipt of 28.8 million DM in donations in 1980.

DAHW additionally remarked that there is now a general tendency in all participating nations to integrate the leprosy services into general health care and, in particular, with antituberculosis campaigns. DAHW collaborates with the Borstel Institute in the use of combination therapy with rifampin developed at Borstel.—Dr. W. F. Kirchheimer

The German Leprosy Relief Association's 25th Anniversary on the Occasion of World Leprosy Day on 31 January 1982. For 25 years the German Leprosy Relief Association (GLRA) has been able to contribute its share to the world-wide fight against leprosy thanks to the population's readiness to help. About 600 projects in more than 60 countries benefitted from GLRA's assistance in the last quarter of a century. Well over 1 million leprosy patients and their families have been given support during the course of these years.

"Our assistance is their hope" is GLRA's motto for 1982, the 25th year since its founding, with which GLRA wants to draw public attention and to ask for sympathy for its tasks.

All efforts must be directed towards the early diagnosis and treatment of leprosy patients, to spare them the fate of being outcasts and to help them to lead lives befitting a human being. The successes that have been achieved up to now, the numerous successful treatments, the educational work, the open-mindedness of governments, the example of the volunteers and the men and women involved in leprosy work—all this gives rise to hope that the once "miserable leper" will become the "curable leprosy patient" that can count on medical and social assistance in the same way as other patients.—(From "Heilen und Helfen")

India. *ILO/DANIDA Asian Regional Seminar on Vocational Rehabilitation of Leprosy Patients, Bombay, 26 October–6 November 1981.* This seminar was attended

by 26 participants from 12 Asian countries. The final conclusions of the seminar were as follows:

1) The Size and Nature of the Leprosy Problem in Asia

Although accurate statistics are difficult to obtain, it is estimated that Southeast Asia accounts for 5.3 million leprosy sufferers, almost half the estimated world total of 12 million. The prevalence of leprosy in many Asian countries ranges from 5 to 10 per thousand and additional cases are detected each year; 20% to 30% percent are physically handicapped and constitute a major group requiring rehabilitation. There is no substitute for early detection and early, regular multi-drug treatment aimed at restoring the patient's psychological, social, and economic well-being; this is so vital to the successful outcome of rehabilitation, as well as for achieving early control of the disease.

2) Leprosy Control Programs

All governments who have not already done so are urged to establish National Leprosy Control and Rehabilitation Programs with the following aims and provisions:

- reducing progressively the transmission of infection and the prevalence of leprosy through early case-finding of infectious cases and providing for their regular free treatment and rehabilitation, including economic independence and integration;
- reducing disabilities and deformities associated with leprosy;
- ensuring that sufficient numbers of trained staff are available to man the necessary services;
- collating statistical data on a continuing basis, on the prevalence and incidence of leprosy through sample or national surveys;
- coordinating all government and voluntary effort in the field of medical, social, and vocational rehabilitation of leprosy patients;
- removing all barriers so that buildings, transport, jobs, etc., are accessible to leprosy patients;
- developing a widespread and regular public information campaign to convey

scientific facts about the disease in order to remove the irrational fear and the stigma associated with it and thereby ensuring fuller community understanding and active participation in the programs;

- promoting research into diverse aspects of leprosy.

3) Coordination

No leprosy control program will be effective unless and until the problem is tackled on coordinated lines. This can best be achieved through the formation of a Standing Coordinating Committee on Leprosy. Membership would include representatives from all Ministries concerned (Health, Education, Labor, Agriculture, Social Welfare, Information, Community Development, Industry, etc.), employers and trade unions, local authorities, non-governmental organizations and, wherever possible, leprosy patients themselves. The Committee's main task would be to advise government on the development and phased expansion of comprehensive services for prevention and control of leprosy, including rehabilitation of leprosy sufferers, aimed at integrating them to the fullest possible extent into normal socio-economic life.

4) Integration

The preventive, curative, and rehabilitation services for leprosy patients may not be adequately effective if developed in isolation and should, wherever possible, be integrated in the general community health care and rehabilitation services.

5) Legislation

Legislation and regulations dealing with leprosy appear to be outdated in many cases and need to be reviewed and suitably amended.

6) Public Information

In order to counteract the ignorance, irrational fear, prejudice, and superstition associated with leprosy and to stress the need for early and regular treatment, it is imperative that widespread and continuous public information campaigns be launched.

7) Recruitment and Training of Staff

There is a serious shortage of qualified staff to service preventive, curative, and re-

habilitation programs for leprosy patients. Urgent steps should be taken by governments to overcome this acute shortage by:

- introducing the subject of leprosy into all regular courses in schools, universities, medical schools, etc., covering not only the medical aspects but also the humane and socio-economic problems associated with the disease. Wherever possible, a Department of Rehabilitation of the Handicapped (including leprosy patients) should be established in medical colleges and in hospitals;
- creating adequate posts and offering financial incentives and a career structure to those who are prepared to work full-time in leprosy services.

8) Vocational Training and Employment

General. It is considered necessary to have a multi-pronged program which will not only have the desired impact on the problem of employment of the leprosy sufferers but also facilitate the economic rehabilitation of as large a number of such persons as possible by government and voluntary organizations.

a) Training as a means of overcoming stigma. Experience has shown conclusively that one of the most effective means of overcoming stigma and irrational fear associated with leprosy is to provide leprosy patients with skills and opportunities for employment. This enables them to compete on equal terms with other workers, thus gaining their respect and that of their employer.

b) Overcoming discrimination in employment. While employers in general are reluctant to employ persons suffering from leprosy, once they are informed and assured that the individual in question is non-infectious and under regular medical supervision, has skill to offer, and needs no more attention and supervision than other workers, prejudice and stigma often become a secondary consideration.

c) Expanding training and employment opportunities. The range of training and employment for which leprosy patients can be considered is very wide indeed.

d) Certification. There appears to be widespread disparity as to the agreed peri-

od of time which should elapse after initial treatment before a certificate is issued permitting a leprosy patient to take up open employment. It is suggested that such certificates be issued after tests have proved negative in three consecutive smear examinations carried out at monthly intervals after an initial negative stage under the existing system of mono-drug therapy. It is suggested that appropriate multi-drug therapy, instead of dapsone treatment alone, could be the criteria of medical fitness.

e) Development of training and employment programs. As evidenced in India and elsewhere, large-scale training and employment programs for leprosy patients, both in urban and rural areas (which apart from initial help in providing capital equipment and maintenance costs) do not necessarily require long-term assistance and can be successfully developed to the stage where they are economically viable.

f) Self-employment. Self-employment is an important avenue of resettlement for many leprosy patients, including work on the land, handicrafts, tailoring and dress-making, private trading, etc.

g) Sheltered employment. Sheltered employment or training cum production workshops should be provided for positive leprosy cases and for those with severe disabilities.

h) Employment in agriculture. As the majority of leprosy patients are to be found in rural areas, their training or retraining in rural rehabilitation centers for work on the land as farmers, small-holders, poultry farmers, horticulturists, etc., should be given the highest priority.

i) Adaptation of tools and machinery. In general, it is found that the majority of leprosy patients can cope well with ordinary tools and machinery. Every effort should be made, however, to encourage employers through a grant scheme to adjust machinery, tools, articles, etc. to facilitate the employment of those with severe deformities. Indigenous prosthetic and orthotic aids should also be developed to facilitate the integration of the leprosy patient into active social and economic life.

9) Social Security

Government and voluntary organizations concerned should assure the social security

of those leprosy patients who fail to achieve or maintain an adequate socio-economic status from the date of their identification as leprosy patients.

10) The Role of Voluntary Organizations

National and international voluntary organizations have played a pioneering role in planning, launching, and developing rehabilitation programs for leprosy patients. They are still the main provider of services and in view of the high expenditure involved in training leprosy patients, their activities should receive every encouragement and the fullest possible financial and material support from governments and the public at large.

11) Directory of Available Services

A National Leprosy Directory for all institutions, associations, services, and programs available for the rehabilitation of the leprosy affected should be compiled (and kept up to date) to facilitate ready availability of all relevant information.

12) Importation of Antileprosy Drugs and Equipment

All governments are urged to authorize the duty-free import of antileprosy drugs, prosthetic, and orthotic aids and training materials (including tools and equipment) required for leprosy control and rehabilitation programs. Every effort should be made to encourage the local manufacture of essential drugs.

13) Inter-Country Cooperation

Inter-country cooperation in transference of technologies in leprosy control and rehabilitation work should be encouraged through exchange and training of technical staff and scientists, and through supply of materials, equipment, and technology to develop agricultural, horticultural, animal husbandry, and cottage industry projects.

14) International Assistance

The International Labour Organization, the World Health Organization, UNICEF, and other international, governmental, and non-governmental organizations are requested to give all possible help and support to governments and non-governmental organizations in implementing the conclusions of this seminar.—(Adapted from the

Seminar report and materials provided by Stanley G. Browne)

Hind Kusht Nivaran Sangh [Indian Leprosy Association] 3 [1981] 12-13)

Workshop on National Leprosy Control Programme of Varanasi Region. A two-day workshop on National Leprosy Control Programme, Varanasi Region, was held on 8-9 February 1982 at the Banaras Hindu University campus. The workshop was inaugurated by Dr. K. C. Gupta, Chief Medical Officer, Varanasi, and was addressed by Dr. C. Vellut, WHO Consultant and Advisor for Eastern U.P. and Bihar. There were five sessions on the following topics: 1) Classification of Leprosy, 2) Treatment of Leprosy, 3) Health Education, 4) National Leprosy Control Programme in Varanasi Zone, and 5) Social Aspects of Leprosy. The workshop was attended by a large number of delegates from U.P.—(From Monthly News Bulletin of the Hind Kusht Nivaran Sangh [Indian Leprosy Association] 4 [1982] 32)

ICMR Awards for 17 scientists. Seventeen biomedical scientists from all over India have been selected by the Indian Council of Medical Research (ICMR) for its national awards for their outstanding contributions in their respective fields of research. Among the scientists honored are four leprologists: Dr. D. K. Dastur of Grant Medical College, Bombay; Dr. Surrinder Kaur of the Institute of Post Graduate Medical Education and Research, Chandigarh; Dr. G. Ramu of Central JALMA Institute for Leprosy, Agra; and Dr. Indira Nath of the All India Institute of Medical Sciences, New Delhi.

Dr. Dastur has been awarded the Basanti Devi Amin Chand Prize for his outstanding contributions in the field of neuro-tuberculosis and neuro-muscular disorders in leprosy and malnutrition. Dr. Kaur has been awarded the Kshanika Oration Award reserved for women scientists for her work on leprosy. Dr. Ramu and Dr. Indira Nath have been awarded the JALMA Trust Fund Oration Award—Dr. Ramu for his therapeutic studies in leprosy and Dr. Indira Nath for her studies on suppressor cells and development of an *in vitro* method of investigating certain characteristics of *M. leprae*.—(From Monthly News Bulletin of the

Birla Smarak Kosh Award for Professor Talwar. Professor G. P. Talwar, Professor and Head of the Department of Biochemistry, All India Institute of Medical Sciences, and Director of the National Institute of Immunology, New Delhi, has been given an award of Rs.1 lakh by the Rameshwardas Birla Smarak Kosh (of the Bombay Hospital Trust) for outstanding research in the medical field. Prof. Talwar and his team are involved in the high technology research program concerning the immunology of leprosy.

The press release says, "In recent years, Prof. Talwar has been involved with two major national health programs, that of fertility and leprosy. He pioneered a conceptually new approach of mobilizing the body's immune system to counteract important hormones and protein for the control of fertility. Prof. Talwar's outstanding contributions in endocrinology, reproductive biology, and immunology have received widespread recognition for their originality and significance. He is the recipient of many international and national awards."—(From Monthly News Bulletin of the Hind Kusht Nivaran Sangh [Indian Leprosy Association] 4 [1982] 31-32)

Padma Bhushan Honor to Dr. J. M. Mehta. Dr. J. M. Mehta, Honorary President of the Poona District Leprosy Committee, has been honored with "Padma Bhushan" in recognition of his selfless work in leprosy. The award was conferred on him on the occasion of the Republic Day celebration held on 26 January 1982.

The Poona District Leprosy Committee, of which Dr. Mehta is the Honorary President, is the administrator of Dr. Bandorawalla Leprosy Hospital, Kondawa, near Poona. It is a voluntary social welfare organization of Poona. Under his presidency, the Committee has organized several leprosy activities in and around Poona. The two main projects of the Committee are the Pune Urban Leprosy Investigation Centre and the Solapur Comprehensive Leprosy Project. Dr. Mehta, besides being the Honorary President of the Poona District Lep-

rosy Committee, is also the Honorary Chief Executive and Head of the Department of General, Plastic and Reconstructive Surgery of the Dr. Bendorawalla Leprosy Hospital. Under his guidance, a vocational training center for imparting vocational training to leprosy patients was set up at the Dr. Bendorawalla Leprosy Hospital. He is a member of the National Leprosy Advisory Committee of the Government of India. At the X International Leprosy Congress, held at Bergen in 1973, Dr. Mehta was invited to serve as a member of the Rehabilitation Committee.—(*From Monthly News Bulletin of the Hind Kusht Nivaran Sangh [Indian Leprosy Association] 4 [1982] 26*)

Dr. B. C. Roy National Award to Dr. A. J. Selvapandian. Dr. A. J. Selvapandian, Professor of Orthopaedics and Head of the Department of Orthopaedics and Leprosy Reconstructive Surgery of the Christian Medical College and Hospital, Vellore, is among the 23 recipients of the Dr. B. C. Roy National Award for 1981 awarded by the Medical Council of India. He has been honored in recognition of his merit as an eminent medical teacher. The Award carries a cash value of Rs. 5000/- and a medal.

Dr. Selvapandian is a distinguished leprologist and orthopedic surgeon of India. He followed Dr. Paul Brand (a British national born in India) who became interested in orthopedic surgery, specialized in hand surgery, and devoted his life to preventing and correcting disabilities in leprosy patients in India. He joined the Christian Medical College and Hospital, Vellore, as Registrar in General Surgery in 1952, and became the head of the Department of Reconstructive Surgery in 1962. A Hand Research Unit was organized and developed by him in this department. Under his able leadership, the department is actively involved in the Reconstructive Surgery Programme and in training surgeons within and outside the country for taking care of leprosy deformities in their areas. The Leprosy Physiotherapy Training Courses conducted by the Hind Kusht Nivaran Sangh for medical officers and technicians are run under his charge. This training program was sponsored by the Sangh in 1958, and to date

nearly 500 candidates have been trained in physiotherapy. He is also in-charge of the "Shanti Illam" maintained by the Sangh for providing free board and lodging accommodations (during preoperative and post-operative periods) to indigent leprosy patients undergoing surgery at this hospital. The First All India Workshop on "Deformities in Leprosy, Implications, Prevention and Management" was organized by him at the Christian Medical College and Hospital, Vellore. He was the second recipient of Dr. K. C. Sahu Gold Medal awarded by the Hind Kusht Nivaran Sangh in 1976. He is one of the past presidents of the Indian Association of Leprologists.—(*Adapted from Monthly News Bulletin of the Hind Kusht Nivaran Sangh [Indian Leprosy Association] 4 [1982] 26*)

Multi-drug regimen pilot project at Oragadam Village. A pilot project for multi-drug therapy at Oragadam Village in Chengalpattu District was inaugurated by Dr. H. V. Hande, Health Minister of Tamil Nadu, on 26 January 1982 to study the implications of multi-drug regimen under field conditions. Nearly 3000 cases of leprosy detected in the village have been put on multi-drug regimens, and their bacteriological status is being watched. Each patient received drugs costing Rs. 25/- to Rs. 30/- per month from the government of Tamil Nadu.—(*From Monthly News Bulletin of the Hind Kusht Nivaran Sangh [Indian Leprosy Association] 4 [1982] 31*)

Japan. *Sasakawa Memorial Health Foundation (SMHF), Japan. Reference and Health Learning Materials for Leprosy, May 1981.* Dr. Yo Yuasa, Executive Director of SMHF, has kindly supplied information about the following list of materials, some of which may be available free of charge to bona fide applications from individuals and institutions in East and Southeast Asian countries with which SMHF has working relationships—namely Korea, Taiwan, Philippines, Indonesia, Malaysia, Thailand, Burma, and Nepal. It is important to note the geographic restriction of this offer. Applicants in the countries listed should apply to the Executive Director, Sasakawa Memorial Health Foundation, Sabokaikan

Building, 2-7-5 Hirakawa-Cho, Chiyoda-Ku, Tokyo 102, Japan, for full details.

Reference materials available (free)

Periodicals:

P-1 INTERNATIONAL JOURNAL OF Leprosy. International Leprosy Association. Quarterly

P-2 LEPROSY IN INDIA, Indian Leprosy Association. Quarterly

P-3 EXCERPTA MEDICA: LEPROSY AND RELATED SUBJECTS. Excerpta Medica on behalf of the Leprosy Documentation Service. 10 issues/year

P-4 LEPROSY REVIEW, British Leprosy Relief Association. Quarterly

P-5 WHO CHRONICLE, WHO, Geneva. Monthly

WHO Publications (except periodicals):

WHO-1 *A Guide to Leprosy Control*, WHO/Geneva, 1980, pp. 96, Sw.fr. 15.00

WHO-2 *Leprosy in Children*, WHO/Geneva, 1976, pp. 28, Sw.fr. 9.00

WHO-3 *WHO Expert Committee on Leprosy*, WHO/Geneva, 1977, pp. 48, Sw.fr. 6.00

Audiovisual materials available

Health Education Films:

HEF-1 *The Net*, The Leprosy Mission, 25 min, color, location India, (English) £170 (approx.)

HEF-2 *Leprosy*, Lepa (British Leprosy Relief Association), 36 min, color, (English) £330 (approx.)

HEF-3 *Morbus Hansen*, NSL (Netherlands Leprosy Relief Association), 25 min, color, location Indonesia and Kenya, (English) HFL2,100 (approx.)

HEF-4 *Kusta*, NSL, 27 min, color, location Indonesia, (English) HFL2,100 (approx.)

HEF-5 *Kariçu*, NSL, 31 min, color, location Kenya, (English) HFL21,100 (approx.)

HEF-6 *Siku Moja*, NSL, 27 min, color, location Kenya, (Swahili) HFL2,100 (approx.)

HEF-7 *Helping Hands*, NSL, 30 min, col-

or, location Ethiopia, (English) HFL2,100 (approx.)

HEF-8 *Sarva Mangalam*, NSL, 28 min, color, location Nepal, (English) HFL2,100 (approx.)

HEF-9 *Armauer Hansen—Discoverer of the Leprosy Bacillus*, Svekon Film, 40 min, color, (English) US\$680 (approx.)

HEF-10 *Toward Eradication of Hansen's Disease*, Sasakawa Memorial Health Foundation, 36 min, color, location Philippines, Thailand, Korea, (English & Japanese)

Scientific Films:

SCF-1 *Leprosy*, Science Service Berlin, 30 min, color, location Ethiopia etc., (English, German, French, Spanish) DM2,200 (approx.)

SCF-2 *Leprosy—Therapy*, Science Service Berlin, 24 min, color, location Ethiopia etc., (English, German, French, Spanish) DM1,650 (approx.)

SCF-3 *Leprosy—Rehabilitation*, Science Service Berlin, 24 min, color, (English, German, French, Spanish) DM1,650 (approx.)

—(Adapted from *Lepr. Rev.* 52 [1981] 365–366)

Malawi. *Field experience for doctors.* Any doctor taking up an appointment in leprosy control in Africa and willing to gain practical field experience will be welcome to spend a few weeks in Malawi with Dr. Gjalit Boerrigter.

As this arrangement can be made for only one doctor at a time, applications in the first instance should be sent to: LEPRO, Fairfax House, Causton Road, Colchester, CO1 1PU, Great Britain.—(From ILEP "Flash" December 1981)

New Zealand. *Pan Pacific Leprosy Symposium.* The Pan Pacific Leprosy Symposium was held in Christchurch, New Zealand from 17–20 February 1982. Among those attending the meeting were individuals from Australia, Fiji, India, Japan, Malaysia, and Taiwan, in addition to those from New Zealand.—Dr. J. C. Hargrave

The Philippines. The PHILIPPINE JOURNAL OF DERMATOLOGY AND LEPROSY. The former PHILIPPINE JOURNAL OF LEPROSY has been revived with the modified title PHILIPPINE JOURNAL OF DERMATOLOGY AND LEPROSY to meet the demands of progress in other skin diseases.—Perpetua D. Reyes-Javier

Switzerland. Annual Report of IMMLEP and THELEP, 1980–1981. One Scientific Working Group, IMMLEP, deals with the immunology of leprosy and the other, THELEP, with chemotherapy and drug development.

Work on the development of the anti-leprosy vaccine continues to make good progress. Experiments in mice confirm the protective effect of four different preparations of killed *Mycobacterium leprae*. The preferred procedure (protocol 1/79) produces a high yield, with minimal damage to bacteria and minimal contamination. It is proposed to undertake the testing of the immunogenic potential of this preparation with and without BCG in human beings as the first step in the vaccine trials.

Immunodiagnostic tests are being further developed. An ELISA test of comparable sensitivity to the radio-immunoassay test to *M. leprae* has been established. A method has also been developed for early detection of systemic infection in armadillos, and monoclonal antibodies are being evaluated for their specificity for *M. leprae*.

Clinical trials of drug combinations continue under the auspices of THELEP. At one center, several cases of jaundice led to the suspension of one regime but investigations suggest that drug toxicity was not the cause of the jaundice. Detailed protocols for field trials of chemotherapy of lepromatous leprosy were drafted and two trials are expected to start soon. With regard to drug development, analogs of thalidomide and of rifampin failed to yield promising leads, but work continues on analogs of ethionamide and prothionamide. Work continues on the development of prolonged-release preparations of dapsone. Surveys are being carried out on the frequency of primary dapsone resistance in endemic countries. One report from The Philippines showed a prevalence of 2.1% of new cases

of lepromatous leprosy. Results from other geographical areas are expected soon.—(From UNDP/World Bank/WHO Annual Report, Ch. 1, pp. 8–9)

United Kingdom. *Lady Richardson named Chairman of The Leprosy Mission.* For the first time in its history, The Leprosy Mission England and Wales has a lady chairman. Life-long supporter of the Mission, and wife of the International Chairman, Sir Eric Richardson, C.B.E., Ph.D., Lady Richardson was unanimously elected to the position. Sir Eric, an engineer and distinguished college principal, and Lady Richardson have travelled widely, visiting a number of African countries, India, Nepal, Indonesia, Korea, Australia, and New Zealand. The new Chairman's missionary activity experience has been much sought after in many organizations and within her own church, and The Leprosy Mission is honored to have her as Chairman.—(Adapted from New Day (Magazine of The Leprosy Mission) no. 328 [1981] 9)

ILEP. Information on side-effects from clofazimine (Lamprene; B663). Dr. Harold Wheate, Secretary to the Medical Commission, has passed the following notice:

The Medical Commission of ILEP would be grateful to receive information concerning the frequency and severity of the side effects of the drug clofazimine (Lamprene). It is generally agreed that severe gastro-intestinal disturbances are encountered only when large doses (300 mg per day or more) are given for periods exceeding three months. It is not yet certain whether minor disturbances are dose-related or time-related or both. May we ask readers who are interested to send information concerning:

- 1) Numbers of cases treated with Lamprene during the past 12 months.
- 2) Number and nature of gastro-intestinal side effects and the dose and duration of therapy in each case.
- 3) Number and nature of any other side effects of note and the dose and duration of therapy in each case.

Although an attempt has already been made to obtain similar information through a

questionnaire devised by CIBA-GEIGY, the response was far from satisfactory. *All those with experience of this important drug are earnestly requested to send in information as requested above* to Dr. Harold Wheate, Secretary to the Medical Commission, ILEP, 234 Blythe Road, London W14 0HJ, England.—(*Adapted from Lepr. Rev.* 52 [1981] 190)

U.S.A. Closing of Public Health Service Hospitals. Most of the Public Health Service hospitals and clinics in the United States are being closed as a result of the current drive for reduction of federal spending. One of the disturbing aspects of this action is dispersal of the tropical disease specialists formerly concentrated in these facilities. Because the PHS hospitals were among the few medical centers offering sophisticated care for victims of Hansen's disease (leprosy), the PHS is making special provisions for the Hansen's patients under treatment at PHS facilities that are closing. The main PHS treatment center at Carville, Louisiana, will stay open; patients in other places will be referred to local specialists or, if they require hospitalization, will be transferred to the Carville facility. The PHS has set aside \$2.5 million to pay patients' costs not covered by health insurance.—(*From Trop. Med. Hygiene News* 30 [1981] 27)

Details announced on leprosy seminar. The 27th International Seminar on Leprosy will be held from 12–18 September 1982 and the Workshop on Training from 20–24 September 1982 at the National Hansen's Disease Center, Carville, Louisiana, U.S.A., under the joint sponsorship of the American Leprosy Missions, Inc., and the National Hansen's Disease Center.

The purpose of the International Seminar on Leprosy is to provide an up-to-date review of clinical leprology and leprosy control. It is open to physicians, nurses, and other paramedicals planning to work or already working in countries where leprosy is endemic.

The Workshop on Training is designed to introduce participants to a modern, systematic approach to training to enable them to make their own training programs more ef-

fective and enjoyable. It will be led by Dr. W. F. Ross, who has wide experience in this field in Africa and Asia. The workshop is open to anyone who participates in the seminar and expects to be actively engaged in training others.

There are no fees for participating in the seminar or workshop, and room and meals are provided without charge. The only cost to the participant is transportation to and from New Orleans, Louisiana. Participants will meet at the New Orleans International Airport on 12 September 1982.

Applications must be received no later than 1 August 1982 and should be sent to Dr. W. F. Ross, American Leprosy Missions, Inc., 1262 Broad Street, Bloomfield, New Jersey 07003, U.S.A.—(*Adapted from seminar advertisement*)

Fellowships provide mission experience. Medical Assistance Programs (MAP) has awarded fellowships to 41 medical students from the United States and Canada, enabling them to have a 7 to 10 week experience assisting mission doctors in developing countries. Selected from 120 applicants, the fellowship recipients were chosen by a committee chaired by Dr. C. Everett Koop, confirmed by the Senate recently as the new Surgeon General of the United States.

Made possible by a grant from the founder of *Reader's Digest*, the fellowship program began in 1971, and has enabled more than 700 medical students to assist mission doctors in 53 Third World countries. Prompting careers in health missions for many of the recipients, the program offers both surgical and diagnostic experience.

For further information on the program, contact MAP International, P.O. Box 50, Wheaton, Illinois 60187, U.S.A.—(*From National Council for International Health [NCIH] Newsletter* 2 [1981] 1)

International Notes. *Increase in prevalence of leprosy caused by dapsone-resistant Mycobacterium leprae.* The prevalence of secondary resistance of *M. leprae* to dapsone (among lepromatous leprosy patients treated for a minimum of five years) has been estimated, from surveys conducted before 1976, to be 2.5/100 patients at risk

in Malaysia, 3/100 in Israel, 7/100 in Costa Rica, and at least 10/100 in Ethiopia. Apparent primary resistance to dapsone (among patients not known to have had treatment) was first observed in the mid-1970s in 16 of 24 patients studied in Ethiopia. Because some of these estimates may have been biased and because treatment practices in Ethiopia may not have been representative, the THELEP Program (Chemotherapy of Leprosy component of UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases) decided, at its inception in 1976, to sponsor carefully conducted surveys of the prevalence of primary and secondary dapsone-resistant lepromatous leprosy in various countries.

In November 1981, at a Scientific Meeting on Leprosy in Rangoon, Burma (sponsored by WHO Western Pacific and South-east Asia Regional Offices and the THELEP and IMMLEP [Immunology of Leprosy] Programs), estimates of the prevalence of secondary dapsone resistance were reported as 6.4/100 in Gudiyatham Taluk, South India, 4.1/100 in Trivellore Taluk, South India, and 3.6/100 in Shanghai Municipality, China. The surveys are still in progress, and these estimates are thought to be minimal.

Estimates of the prevalence of primary resistance to dapsone showed a marked change: 2/62 (3%) in Cebu, Philippines, 7/40 (18%) in Chingleput, South India, and 12/30 (40%) in Bamako, Mali. Cases of primary resistance were also reported from Guidyatham Taluk, India, and Jakarta, Indonesia. This high prevalence of primary dapsone resistance probably results from transmission of *M. leprae* by patients whose relapses due to secondary drug resistance were not recognized and who therefore had not been treated with effective drugs.

Because of this prevalence of primary and secondary dapsone resistance, it is now necessary to give combined therapy to all new leprosy patients—both lepromatous and tuberculoid. Lepromatous patients who have thus far been treated only with dapsone should probably also be given combined therapy. Dapsone, which has been the standard drug for control of leprosy, may eventually be of little use, even in combination with more expensive and less-well-

tolerated drugs. Earlier recommendations for combined chemotherapy have not been implemented in many countries because of expense and feasibility problems. The WHO Study Group on Chemotherapy of Leprosy for Control Programmes has recently studied relevant problems and has recommended combined-drug regimens based primarily on the intermittent administration of rifampin.

Editorial note from "Morbidity and Mortality Weekly Report": The three drugs used most frequently for leprosy are dapsone, rifampin (rifampicin), and clofazimine. In addition, ethionamide (or prothionamide) has shown promise, but data supporting its efficacy are still inadequate. Dapsone is relatively inexpensive, and the side effects are minimal. Rifampin is much more expensive and has important side effects with irregular administration (Girling, D. J. and Hitze, K. L. Adverse reactions to rifampicin. *Bull. WHO* 57 [1979] 45–49). Clofazimine is also expensive and causes skin pigmentation so that patients with light skin often object to taking it.

Dapsone was first used widely in countries with endemic leprosy in the 1950s, and secondary resistance was not reported until 1964 (Pettit, J. H. and Rees, R. J. Sulphone resistance in leprosy. An experimental and clinical study. *Lancet* 2 [1964] 673–674). Relapse due to secondary drug resistance has appeared after 5 to 20 years of dapsone use, but after only 1 to 2 years of rifampin use, when each was used as single-drug therapy. Drug resistance can be documented by mouse foot pad inoculation after the drug has been mixed in the mouse diet (in three dosages in the case of dapsone). Most of the primary dapsone resistance now being reported occurs at the lowest dosage, and it is still possible that patients with such resistant strains can benefit from full-dosage dapsone as part of a combination regimen.

Consequences of the new findings are quite serious and will become increasingly so as infections now in the incubation period reach the clinical stage. Often purchases of rifampin and clofazimine require foreign exchange, which is limited in many countries with endemic leprosy. The potentially serious side effects will require more

careful supervision during drug administration. Thus, until the problem of drug-resistant *M. leprae* is controlled, the incidence of leprosy can be expected to increase worldwide, and the disease will be more difficult to treat.

These discouraging findings call attention

to the urgent need for development of new antileprosy drugs and an effective antileprosy vaccine. THELEP, IMMLEP, and other organizations are currently sponsoring research in these areas.—(*From Mortality and Morbidity Weekly Report* 30 [1982] 637–638)

NEWS FROM NATIONAL LEPROSY ORGANIZATIONS

India. *Anti-Leprosy Day, 1982.* Anti-Leprosy Day was observed throughout India on 30 January 1982 to coincide with the martyrdom of Mahatma Gandhi. The Hind Kusht Nivaran Sangh, being the premier voluntary organization engaged in antileprosy work, took a lead in the observance of this day. Messages were obtained from various dignitaries and communicated by the Sangh to all concerned for reading them out at public meetings and functions organized on this occasion. A poster calendar bearing the slogan "Early detection and regular treatment cures leprosy" was brought out by the Sangh in collaboration with the Leprosy Mission and the Central Health Education Bureau. Twenty thousand copies of the poster calendar were printed and distributed free. Antileprosy slogans were advertised in the leading newspapers of Delhi. Radio and television network gave full coverage to the function.

This year the Anti-Leprosy Day celebrations gained momentum throughout India, especially because of the two important steps taken by our Prime Minister, Smt. Indira Gandhi—first, in setting up a Working Group to evolve a "Strategy to eradicate leprosy from India" by the end of this century and secondly, in identifying "leprosy control" as one of the areas where special thrust is likely to be given under the new 20-point program of the government. As a result, reports about Anti-Leprosy Day functions have been received from all parts of India.—(*From Monthly News Bulletin of the Hind Kusht Nivaran Sangh* [Indian Leprosy Association] 4 [1982] 16)

Prizes for medical students. The Tamil Nadu State Branch of the Hind Kusht Nivaran Sangh has instituted prizes for final

year medical students in the three medical colleges in Madras, in order to encourage the undergraduate medical students to study the subject of leprosy in greater depth. The director of medical education, Tamil Nadu, had been requested to conduct the examinations. On the basis of the results obtained in the examinations, prizes have been awarded by the branch to the following students: 1) Kum. N. Vasanthi, Stanley Medical College, and 2) Shri N. Chezhan, Kilpauk Medical College. The results from the Madras Medical College are awaited.—(*From Monthly News Bulletin of the Hind Kusht Nivaran Sangh* [Indian Leprosy Association] 4 [1982] 32)

Switzerland. *25th Anniversary of Emmaüs-Switzerland.* On Friday 30 October 1981 Emmaüs-Switzerland celebrated its 25th anniversary in Bern with an evening which included a lecture by Abbé Pierre on "The involvement of young people in today's world," a film presentation of the various Emmaüs groups, and an awards ceremony for the best poster designs.

1) History. Emmaüs-Switzerland began in the severe winter of 1956 when a number of individuals came together to help those who were suffering deprivation. Today there are six distinct groups:

- "Amis d'Emmaüs" (Berne, Zürich, Jura)
- "Coopérative de construction Emmaüs"
- "Dessins et parrainages Emmaüs"
- "Aide aux Lépreux Emmaüs-Suisse"

Having as their motto "Serve first those most in need," all these groups work to help the underprivileged and disadvantaged, those who, for whatever reason, have dif-

ficulty coping with life: the poor, the disabled, children, leprosy sufferers, etc. Each group acts independently, concentrating on its own particular area of interest, but they all work together in the "Fédération Emmaüs-Suisse." On an international level, the Swiss Federation is also part of the International Emmaüs Federation.

2) ALES. But even before the first meeting of Emmaüs International, the group "Aide aux Lépreux Emmaüs-Suisse" (ALES) had already taken steps towards increasing international cooperation.

ALES was not only a founder member of ILEP, but their president, Mr. Marcel Farine, was ILEP's first president and in September 1966 ALES organized ILEP's 1st General Assembly.

3) Social Aspects. ALES is actively engaged in all aspects of the campaign against leprosy control, rehabilitation, research, etc., but, in the tradition of Emmaüs, special emphasis is given to the effect of the disease on the personal life of the leprosy sufferer and on his or her place in society. Thus in endemic countries ALES carries out health education campaigns and, within ILEP, ALES chairs the Ad Hoc Working Group No. 3 on "The human and social aspects of the treatment of leprosy."

4) Book. As part of their celebration of this anniversary, Emmaüs-Switzerland are bringing out a book (cost: SF 15) describing the activities of the various groups which make up the Swiss Federation. This will not consist of formal reports and dry statistics, but will be a lively account of how and why Emmaüs works for those in need. Anyone interested in obtaining copies of this publication should write to the following address:

Fédération Emmaüs-Suisse
Spitalgasse 9
CH—3011 Berne
SWITZERLAND

(From ILEP "Flash," December 1981)

New Zealand. *The Leprosy Trust Board.* The Leprosy Trust Board (LTB) is a non-denominational leprosy relief appeal based in Christchurch, New Zealand, with beginnings in the 1920s when the appeal was first started up for some nine leprosy patients

isolated on Quail Island in Lyttelton Harbour. In 1929 these patients were transferred to the Central Leprosy Hospital on Makogai in the Fiji group and the appeal was expanded to cope with this very much larger family of 750 leprosy sufferers.

The Board was first registered in 1939 and re-registered in 1942 as the "Lepers' Trust Board." In 1978 the name was changed to "Leprosy Trust Board" to conform with the world opinion on the word "leper."

The Board has always worked in close collaboration with The Leprosy Mission, with whom there is a gentleman's agreement, with The Leprosy Trust Board working in the South Pacific area, which is defined from Bougainville in the west to Tahiti in the east and Kiribati in the north downwards. There has never been any duplication of interest or funding in this area, since The Leprosy Mission looks after the worldwide problem with the exception of the South Pacific area.

The Board is a lay body but has representatives of the Anglican, Roman Catholic, Methodist, and Presbyterian churches and also Rotary and Lions Service Clubs.

In the early days, the Board worked mainly through the Fiji government for the patients of Makogai and later through the Church Medical Missions of all denominations working in the Solomon Islands and Vanuatu (New Hebrides), but in later years this support has swung more to the various government medical departments as they have improved their health services and found themselves able to concentrate on the leprosy problem in their respective groups.

The Board's main thrust these days is through the Twomey Memorial Hospital in Suva (Fiji), which it helped to build in 1969. It is now a leprosy training center under the aegis of a tripartite agreement between the Fiji government, the World Health Organization, and The Leprosy Trust Board.

Since this center was started, over 100 medical workers have attended the various courses and have gone back to their island groups with a good base knowledge of leprosy. Twomey Hospital is a show-place and well worth visiting. It is a shining example of what can be done for leprosy control.

As a result of the Fiji government's forward-looking policy on leprosy and the aid

that The Leprosy Trust Board has given, the rate of leprosy is at an all-time low of 0.77 per thousand in Fiji.

The Board hopes it can continue its support for other areas of the South Pacific so that they will also largely overcome the problem

The Board allocates approximately \$500,000 to the area each year and all this comes from the people of New Zealand, with no outside government help for its postal appeal.—(*From ILEP "Flash," December 1981*)