News and Notes

Champa celebrates centenary

What began as an asylum for the abandoned leprosy patients in 1902 by the Reverend Peter Abraham Penner, an American Mennonite, celebrated its centenary in February this year. Champa started in the early 20th century when Reverend Penner spotted two desperate beggars affected by leprosy peeping over the fence of his home seeking some food, assistance and shelter. Leprosy then was considered one of the most dreaded diseases in the orient. Touched by the encounter, he offered them food and shelter for that night, hoping that they will be gone the next day. To his surprise, they were still there. So a temporary shelter was provided, and Champa’s sanctuary began.

In 1903, The Leprosy Mission started giving modest financial support. By 1905 there were already 100 patients receiving treatment and living in the leprosarium. The Zamindar of Champa donated some land in 1907 and houses were built for the inmates, separate for men and women. In the year 1915, a small church was built. In 1920, one Indian doctor joined Reverend Penner and treatment was started in the newly built wards. The number of inmates increased and the system of home gradually gave way to hospital wards. Later, in order to meet the educational needs of the children of the inmates, a primary school was built in the year 1932.

By the 1940s, with dapsone treatment available, the nature of leprosy work was changing, and in 1960 a new hospital was opened on the site. There were still some 500 patients at that time but the need to accommodate them was no longer there.

Today, the physical facilities have been improved with the renovation of the buildings and provision of new medical equipment. With 64 inpatient bed facilities for both leprosy and general patients, the main activities include quality care for the patients, self-care and involvement of community members, especially village women in case detection activities and health education.

Genomics and World Health

WHO has issued a major new report on the impact of genomics. The report, Genomics and World Health, details the latest advances in genome research, and explains how this research could result in medical advances against many diseases, including those pandemic in poor countries. The report also warns about the potential risks of such research, and makes recommendations on how the fruits of this research can be brought to the developing world. It makes a major contribution to the debate on the ethics of genome research, and anticipates how the global community could use genetics to attack the unfinished agenda of infectious diseases such as malaria, TB and HIV/AIDS, helping to narrow the existing unethical inequities in global health. The need for public engagement on issues related to genomics in order to enable society to enter into informed debate on an uncertain, rapidly changing field with enormous potential for improving health.
The 22nd Biennial Conference of the Indian Association of Leprologists, held on 24th November 2001 at Patna, Bihar

The 22nd Biennial Meeting of the Indian Association of Leprologists was held in Hotel Chinikya at Patna during 23rd to 25th November 2001. About 300 members attended the meeting. The meeting was inaugurated by Mr. Ashok Bhatt, Minister of Health and Family Welfare, Government of Gujarat State. The conference had a wide scientific programme consisting of panel discussions, state of the art lectures, free papers and poster presentations. The key note address was delivered by Professor Ji Baohong who spoke on Chemotherapy of Leprosy.

For the panel discussion on ‘Leprosy Elimination’ the moderator was Dr S. K. Noordeen. The speakers were Drs N. S. Dharmshaktu and Jalal Uddin Ahmed, presenting the leprosy scenario of two countries, Drs P. K. B. Patnaik and P. Krishnamoorthy presenting the profile of leprosy in two states and Drs C. R. Revankar and G. Rajan Babu, presenting the views of two pioneer NGOs. The moderator for the panel discussion on ‘Future of Chemotherapy’ was Dr M. D. Gupte and the speakers were Drs Ji Baohong, Vithal Jadhav and Kiran Katoch.

There were two state of the art lectures. Professor Bhushan Kumar spoke on ‘Clinical Problems in Leprosy’ and Dr H. Srinivasan, on ‘Rehabilitation in Leprosy’.

As many as 60 papers were presented as proffered papers grouped under the sessions on Control, Laboratory, Clinical, Rehabilitation and Social Aspects of the disease. The sessions were chaired by Drs R. Ganapathi, V. M. Katoch, D. Porichha, W. van Brackel and P. K. B. Patnaik.

Ninety papers related to different aspects of the disease were displayed as posters for all the 3 days of the conference. Three prizes were awarded to posters judged first, second and third on the merit of presentation and content. The scientific committee under the Chairmanship of Dr S. K. Noordeen functioned at Chennai and took meticulous care of the scientific component in terms of selection of papers, publication of abstracts and floor management. This was matched by the warm hospitality extended to the delegates by the organizing committee under the able stewardship of Professors Mathura Prasad and Amarkant Jha Amar.

The Biennial General Body meeting of the IAL was held at on 24th November 2001 at the same venue. Dr S. K. Noordeen, the President of IAL, chaired the meeting and extended a warm welcome to the members. All the members stood in silence to pay homage to the departed souls of the following members of the Association and other important personalities who worked in the field of leprosy: Dr J. A. Pomniah, Dr Professor D. K. Dastur, Mr. S. S. Naik, Dr Professor S. C. Sharma, Dr Radha Bai, Dr Chowdappa, Dr Ebenezer Victor, Dr Aschhof, Dr V. Kapoor, Shri. S. P. Tare, Dr Ramalinga Swamy, Dr Shushila Nayar, Dr Jal Mehta and Dr V. Kandasamy.

The Secretary informed the members about the Booklet on the ‘History of IAL’ brought out by the IAL in view of the Golden Jubilee conference. It was resolved to place on record the appreciation of the General Body to Dr S. S. Pandya for her work in writing this booklet with in a short period of time collecting all relevant information.

Keeping in mind the financial position of the IAL, it was further resolved that all the Overseas Members hereafter would subscribe the journal directly from the HKNS after paying necessary mailing charges.

It was brought to the notice of the General Body regarding the decision of the HKNS to enhance the subscription rate of the journal from Rs. 40/- to Rs. 200/-. The matter was discussed at length and members felt that it was impossible for the IAL to meet the 5-fold increase in the subscription rate of the Journal. In the present leprosy scenario in the country, enrollment of new members to the IAL has fallen considerably. It is also not possible to collect additional subscriptions from the existing members to improve the financial position of the Association. As the funds available with the IAL are very limited and there is no other source to generate more funds, it was resolved to request the HKNS to increase only 50% of the existing Annual Subscription rate i.e. Rs. 60/- per year instead of Rs. 40/-.

In view of the existing financial position, to provide the journal to all IAL members, it was resolved to enhance the annual subscription fee. For ordinary members, it was raised from Rs. 100 to Rs. 150/-.
and for life members the one time contribution would be Rs. 1500/- in place of Rs 1000/-. The new rates would come into force from January 2002 onwards.

It was resolved to place on record an appreciation for Dr S. K. Noordeen, the President of IAL, for the efforts he has put in collecting funds for the IAL.

The General Body resolved to place on record its appreciation to Dr Bhushan Kumar the Organising secretary of 21st Biennial conference, Chandigarh and Dr P. V. Dave, Organizing Secretary of the workshop at Varodara, for depositing the unspent amounts of Rs. 15,454.55 and Rs.36,000, respectively.

The following Office Bearers and the members of the Central Council have been declared elected for the period 2001–2003:

President: Dr Bhushan Kumar, Vice Presidents: Dr Sreevatsa and Dr Mathura Prasad, Secretary: Dr D. Porichha, Treasurer: Dr H. K. Kar, Members: Dr N. Manimozhi, Dr Thomas Abraham, Dr S. K. Samanta, Dr V. K. Sharma, Dr V. V. Pai, Dr P. V. Dave, Dr R. S. Misra, Dr M. Mathew and Dr Sabyasachi Majumdar.

The newly elected Central Council met soon after assuming charge and co-opted Drs Amarkant Jha Amar, Suji Suneetha, S. B. Taranekar, V. M. Katosh, P. K. B. Patnaik, P. R. Manglani, G. Rajan Babu and M. A. Arif.

It was decided unanimously after voting to hold the next 23rd Biennial Conference of IAL at Haldia, West Bengal during 2003. Dr Swapna Kumar Samanta has agreed to organize the Conference. The meeting ended with a vote of thanks to the chair.

Princess Royal visits TLM Anandaban, Nepal

The Leprosy Mission was honoured to receive Her Royal Highness The Princess Royal during a visit to their Hospital at Anandaban, Nepal on the morning of Friday 24th November 2000 as part of her week-long tour of Nepal and Bangladesh.

Anandaban Hospital was founded in 1957 at the invitation of the King of Nepal. Since this time, the Leprosy Mission have been working in co-operation with His Majesty’s Government under a renewable agreement. The hospital serves the 19 districts of the Central Development Region, Nepal, covering a population of 7 million. As well as assisting the government leprosy elimination campaigns, the hospital treated 754 people affected by leprosy as inpatients and nearly 400 people were given MDT treatment through the Anandaban outpatients clinic.

Nepal has one of the highest levels of leprosy globally. Last year, the Leprosy Mission took part in HMG’s campaign to reduce the levels of leprosy in Nepal. During the survey 11,600 new patients were detected and put on treatment. Since the introduction of Multidrug therapy to Nepal in 1982, over 61,000 people have already been cured of leprosy. Her Royal Highness made the visit as part of a tour arranged for her by the British Embassy in Kathmandu, Nepal.

During her visit to Anandaban Hospital, the Princess was met by Mr Pradeep Faiibus, Administrative Superintendent, and Dr C Ruth Bullin, Medical Superintendent, Dr Manesh Shah, head of Physiotherapy, Dr Mark Macdonald, Surgeon and Dr Rachel Hawksworth as well as some of the many inpatients currently receiving care at Anandaban.

Stressing the importance to people affected by leprosy of the visit, Dr Mark Macdonald said: ‘The visit of a royal princess, strengthens the good working relationships with both Government and community leaders, and raises the profile of Anandaban hospital and the Leprosy mission, as providing first class care to those affected by leprosy in Nepal. In a society where the label of leprosy often leads to social ostracizing, Princess Anne’s visit and her willingness to accept the people she meets, goes a long way towards creating a world, where those affected by leprosy are totally accepted and participate in normal society.’
Immunotherapy: relevance in HIV and drug resistant tuberculosis

The following abstract is taken from the proceedings of the Indo-French Symposium on Tuberculosis and AIDS, and was presented by V. M. Katoch, of the Central JALMA Institute for Leprosy in Agra, India.

Management of tuberculosis faces a big challenge when multi-drug resistant (MDR) tuberculosis is encountered. This becomes more complicated when such MDR is present along with HIV/AIDS. Several alternate drug regimens for the treatment of MDR tuberculosis have been proposed, tried and are being used. These are, however toxic and very expensive. Immunotherapy can be another attractive option, which can be used as adjunct to therapy. Though immunotherapy with tuberculins, killed Mycobacterium tuberculosis and even live M. tuberculosi was tried before the advent of anti-tubercular drugs, this approach was abandoned. Good results with chemotherapy and not so encouraging results with these immunotherapeutic approaches were the possible reasons for this decline in interest. Now immunotherapy perhaps needs to be considered once again because of increase in multi-drug resistance. Though the experience is extremely limited quite encouraging results of use of immunotherapy in HIV-MDR tuberculosis cases have been reported. Trials using recombinant IL-2 have been reported in MDR tuberculosis.

Chemotherapy of leprosy has usually followed successful trends in the chemotherapy of tuberculosis. Perhaps now, the reverse may become true. Immunotherapy as adjunct to chemotherapy of leprosy has shown to be quite promising. Different agents which have been observed to have good immunomodulatory effects are drugs, mycobacteria (live BCG or dead ICRC, Mw, M. habana, M. vaccae) and cytokines such as interleukin 2 and gamma-interferon. Beneficial effects include enhanced bacterial killing and clearance and enhanced granuloma clearance, which effectively result in reduction in the time period required for therapy. While there are apparent risks in the use of live mycobacteria in cases of HIV/AIDS, dead mycobacteria and IL-2/gamma interferon need to be considered for trials in cases of MDR cases with or without HIV/AIDS. Some of these mycobacteria have been shown to be inhibitory against M. tuberculosis in animal experiments.

BCG vaccine

Why is the BCG vaccine for tuberculosis so ineffective in some populations? Evidence in mice indicates that it may be due to prior exposure to free-living mycobacteria, found in soil, water or food. This exposure produces some immunity to mycobacteria, including to the BCG vaccine itself, preventing it from multiplying enough to produce immunity to TB.

Best feet forward for LEPRO

LEPRA will be holding an on-line celebrity footwear auction commencing on 8th November at www.ebay.co.uk. To date, over 40 pairs of shoes have been donated from celebrities including Liz Hurley, Tony Blair and Des Lynam. As leprosy caused disabilities often affect the feet, staging a footwear auction is particularly appropriate and the partnership with Ebay will help LEPRO raise both awareness and funds. To view the latest list of celebrity footwear donors visit the LEPRO website at www.lepra.org.uk.

WHO launches global strategy on traditional and alternative medicine

The World Health Organization (WHO) has released a global framework for policy to assist countries to regulate traditional or complementary/alternative medicine (TM/CAM) to make its use safer, more accessible to their populations and sustainable.
‘About 80% of the people in Africa use traditional medicine. It is for this reason that we must act quickly to evaluate its safety, efficacy, quality and standardization—to protect our heritage and to preserve our traditional knowledge. We must also institutionalize and integrate it into our national health systems,’ says Ebrahim Samba, WHO’s Regional Director for Africa.

In wealthy countries, growing numbers of patients rely on alternative medicine for preventive or palliative care. In France, 75% of the population has used complementary medicine at least once; in Germany, 77% of pain clinics provide acupuncture; and in the United Kingdom, expenditure on complementary or alternative medicine stands at US$2300 million per year.

But problems may arise out of incorrect use of traditional therapies. For instance, the herb Ma Huang (ephedra) is traditionally used in China to treat short-term respiratory congestion. In the United States, the herb was marketed as a dietary aid, whose long-term use led to at least a dozen deaths, heart attacks and strokes. In Belgium, at least 70 people required renal transplant or dialysis for interstitial fibrosis of the kidney after taking the wrong herb from the Aristolochiaceae family, again as a dietary aid.

In developing countries, where more than one-third of the population lacks access to essential medicines, the provision of safe and effective TM/CAM therapies could become a critical tool to increase access to health care. But while traditional medicine has been fully integrated into the health systems of China, North and South Korea and Viet Nam, many countries have not collected and standardized evidence on this type of health care.

The global market for traditional therapies stands at US $60 billion a year and is steadily growing. In addition to the patient safety issue and the threat to knowledge and biodiversity, there is also the risk that further commercialization through unregulated use will make these therapies unaffordable to many who rely on them as their primary source of health care. For this reason policies on the protection of indigenous or traditional knowledge are necessary.

About 25% of modern medicines are descended from plants first used traditionally. The efficacy of acupuncture in relieving pain and nausea has been well established. Randomized controlled trials also offer convincing evidence that therapies such as hypnosis and relaxation techniques can alleviate anxiety, panic disorders and insomnia. Other studies have shown that yoga can reduce asthma attacks while tai ji techniques can help the elderly reduce their fear of falls.

As well as addressing chronic conditions, TM can also impact on infectious diseases. In Africa, North America and Europe, three out of four people living with HIV/AIDS use some form of traditional or complementary treatment for various symptoms and conditions. In South Africa, the Medical Research Council is conducting studies on the plant Sutherlandia fruticosa’s efficacy in treating AIDS patients. Traditionally used as a tonic, this plant may increase energy, appetite and body mass in people living with HIV.

The Chinese herbal remedy Artemisia annua, used for almost 2000 years, has recently been found to be effective against resistant malaria and could give hope of preventing many of the 800,000 deaths among children from severe malaria each year.

The strategy, a working document for adaptation and regional implementation, and more information on TM/CAM can be accessed on: http://www.who.int/medicines/organization/trm/orgtrmmain.shtml.

**Expert advice**

Tremendous progress has been made in leprosy control since multi-drug therapy was adopted as standard treatment. Since 1985, over 11 million people have been cured of the disease and a number of countries have managed to eliminate the disease. However, despite this dramatic success, the number of newly detected cases of leprosy is still worryingly high. The International Leprosy Association (ILA) recently organized a Technical Forum with 16 experts in leprosy from 11 countries to review the future of leprosy control. Their main conclusion was that significant numbers of new patients will continue to be found for many years, so it is essential that leprosy control activities be sustained even in countries
Three million HIV/AIDS sufferers could receive anti-retroviral therapy by 2005: new hope for those in developing world

Barcelona, July 9 2002

In response to the urgent need to scale up access to HIV/AIDS treatment, the World Health Organization (WHO) is joined by the International AIDS Society at the XIVth International AIDS Conference to formally launch new international guidelines for a public health response to the treatment of AIDS in resource-poor settings.

The guidelines represent a major breakthrough. For the first time, highly complex anti-retroviral (ARV) therapy has been simplified so that it can be used in settings that don’t have highly trained medical staff and sophisticated laboratories available to initiate and supervise treatment. The move lowers the technical barriers to HIV/AIDS treatment, potentially benefiting millions of people currently unable to access it.

WHO estimates that today nearly 6 million people living with HIV/AIDS need equitable access to care and support, including anti-retrovirals (ARVs). Currently, fewer than 5% of those who require treatment in developing countries can access these medicines, with an estimated 230,000 people currently receiving ARV therapy in the developing world. Half of these people live in only one country, Brazil. Africa, the continent that has been hardest hit by the HIV/AIDS pandemic, is even less well served, with fewer than 50,000 people estimated to be currently receiving ARV therapy. This coverage represents less than 2% of the people that need access to this life saving therapy.

WHO believes that potentially, at least three million people needing care could get ARVs by 2005—a more than ten-fold increase in the developing world.

‘For the first time we now have the chance to apply a simplified, easy-to-follow public health approach to AIDS treatment rather than complex individual treatment regimes,’ says Dr Gro Harlem Brundtland, WHO Director-General. ‘This, combined with the falling costs of medicines, means it should be possible to extend the life-span of those living with HIV in resource-limited settings.’

WHO sees wider access to safe and practical treatment as an important element of an overall strategy to fight HIV/AIDS, bringing together prevention, improved diagnostics and effective treatment so that these elements mutually reinforce each other.

The new guidelines resulted from a year long process with input from over 120 scientists, researchers, clinicians as well as representatives of civil society and people living with HIV/AIDS from over 60 countries. The guidelines take advantage of the dramatic progress in the medical management of HIV/AIDS that has taken place over the last few years in the developed world and apply the latest evidence and experience to develop simplified, standardized, easier-to-use treatment regimens. In a move to enable wider use of ARV treatment, WHO also included 12 ARV drugs in its Model List of Essential Medicines in April 2002.

‘By simplifying and limiting the number of combination ARV regimens and laboratory monitoring we have been able to reduce the complexity of ARV treatment’, said Dr Tomris Türmen, Executive Director of WHO’s Family and Community Health cluster. ‘But this technical progress must be translated into scaled-up action. There is an urgent need for funds to build up the human resources and infrastructure to deliver the treatments. Moreover, mobilization of the health sector for HIV/AIDS
care will not be enough. More than ever, we need a broad-based partnership to achieve greater equity between rich and poor countries in terms of the quality of care offered.

In high-income countries, an estimated 1.5 million people live with HIV, many of them productively because they receive highly active ARV therapy. In the USA, the introduction of triple combination ARV therapy in 1996 led to a decline of 70% in deaths attributable to HIV/AIDS. In developing countries with access to ARV therapy the same profound effects have been documented: in Brazil, AIDS deaths have decreased by 73% since the introduction of highly active ARV therapy.

Engineered mosquitoes

Computer models indicate that introducing two copies of two genes into just 3% of a mosquito population would be enough to drive the gene through the population. Selection pressure would be created because, when only one of the genes is inherited, the mosquito dies, but when both genes are inherited, the mosquito survives. Only the offspring of some of the crosses between hybrids and wild population mosquitoes will inherit one gene (crosses between hybrids and engineered flies will inherit both genes), so the offspring of wild flies will die more often than those of engineered or hybrid flies.

Does inequality matter?

The following article is taken from TDRnews, October 2001.

This question—does inequality matter?—was posed a few months ago on the front page of The Economist, a leading international news magazine. The magazine further devoted its main editorial to discussing the topic. It argued: in good economic times, even the poor feel better off. In bad ones, the rich may lose the most money, but the poor lose their jobs, their houses, even their families. The editorial goes on to state that helping the truly poor is a much worthier goal than merely narrowing the inequalities. If the rich get poorer, some people may feel pleased, but few are better off. If the poor get richer, the whole country will benefit. It concludes by saying that helping the poor is not just something to do simply on humanitarian grounds but is also something that should be done to ensure stability and continued economic growth of the society. Here there is a shared interest with the humanists, who use the ethical concept of equity as a synonym for social justice and fairness. Inequities are inequalities that are judged to be unfair, i.e. both unacceptable and avoidable. Equity in health care means that health care resources are allocated according to need, health services are received according to need, and payment for health services is made according to ability to pay. It implies a commitment to ensuring high standards of real (not only theoretical) access, quality, and acceptability in health services for all.

During the 1990s, there was growing concern that the efficiency-driven health reforms being implemented in many poor countries, using instruments such as direct user-payments, exemption mechanisms, various insurance schemes, privatization, decentralization, might lead to decreased social justice and fairness as well as add to instability and eventual slow down of economic growth in the poorest countries. In a recent article, Davidson R Gwatkin of the World Bank calls for a new wave of health sector reforms, that are equity-oriented, and conceived and executed with even more passion and determination than the efficiency-directed reforms of the 1990s. He presents three arguments to support his call:

- Significant reforms will require changes that are far deeper than commonly recognized in policy circles.
- Current movement toward debt relief in poor countries is creating a climate that is potentially more favourable to deeper change than was the climate of the recent past.
- Epidemiologists and health systems researchers can best help equity-oriented health policy-makers
take advantage of the present climate by developing an evidence base concerning intervention options for reaching the poor effectively.

Gwatkin further states that, although researchers have contributed valuable conceptual frameworks for approaching these issues, they have not yet reached the heart of the matter, namely the identification of measures that can deal effectively with the inequalities that have been uncovered.