

TB prevalence down 30% in China after DOTS

A decade after introducing the WHO-recommended tuberculosis (TB) control strategy across half of China, a recent study showed that prevalence of the deadly bacterial disease that affects the lungs has fallen by about one-third.

WHO and the Chinese Ministry of Health published a joint report in the *Lancet* on 30 July based on the findings of a survey conducted in 2000 among 376 000 people in all 31 provinces, autonomous regions and municipalities on the Chinese mainland.

In the report, researchers compared TB prevalence in regions where the DOTS control strategy had been implemented with those in the rest of the country.

Researchers concluded that — as a direct result of the project — there were 382 000 fewer cases of TB in 2000 than 10 years earlier, a 30% decline in

prevalence, taking into consideration a larger and more aged population.

WHO said TB remains a significant public health problem in China with 1.4 million new cases each year, where the most recent WHO data suggests that only four or five cases out of every 10 receive treatment through the DOTS programme.

Routinely collected data show that in 2000 only 30% of new TB cases had been referred to TB dispensaries known as DOTS clinics. The remaining cases were treated in general hospitals, by private practitioners or received no treatment at all, WHO said.

“These people should be referred to DOTS clinics, but it doesn’t always happen,” said Catherine Watt, an epidemiologist from WHO’s Stop TB department.

“In order to improve the detection rate China needs to improve access to DOTS, improve referral from hospitals and ensure that people know where to

go for free diagnosis and treatment,” she said.

WHO officials said they hoped the study would spur China to honour its commitment to implement DOTS across parts of the country that have not yet adopted the control strategy.

Some experts argued that DOTS was introduced in Chinese regions with the best health infrastructure. Dr Watt said that whether this was the case or not, the study demonstrated that DOTS had a clear impact on TB in China and added that funding played a vital role in making the programme effective.

“It is clear that DOTS will only be as effective in the rest of the country if it is properly implemented and properly funded,” Dr Watt said.

DOTS relies on a regular supply of essential anti-TB drugs as well as sustained political commitment to fighting TB, a diagnosis method known as “smear microscopy”, standardized treatment practices and a standardized recording and reporting system. ■



A patient takes his anti-TB drugs at a Beijing DOTS clinic.

WHO/VIOT

Two countries re-infected with polio, as Nigerian state resumes vaccinations

Polio has spread from Nigeria to two more African countries, Guinea and Mali, three weeks after the Nigerian state of Kano which suspended immunization in August last year resumed polio vaccinations, WHO said.

WHO confirmed on 24 August that there were two new cases of children paralysed by polio in Mali and one in Guinea. Both countries had been polio-free for four years. WHO also confirmed three more cases of polio in Sudan's Dafur region, which is facing a severe humanitarian crisis, in addition to a case reported in June.

Nigeria's northern state of Kano became the last of several to resume vaccinations on 31 July, marking an important step towards global efforts to halt transmission of the virus by the end of 2004, WHO said.

But WHO renewed a recent warning, following the news of the six latest polio cases, that Africa could be on the brink of the largest polio epidemic in recent history if efforts are not stepped up to bring the spread of the disease under control.

These six latest cases bring the tally of African countries that have been re-infected with polio to 12 and the number of children paralysed to 94 — not including Niger and Nigeria — since Kano and several other northern Nigerian states suspended a polio immunization campaign in August last year.

Since leaders in some of Nigeria's northern Moslem states suspended immunization over unfounded concerns about the oral vaccine's safety, the number of cases in Nigeria has also shot up, with 476 by 24 August, compared with 107 a year before.

Over the last 12 months, the virus has spread to Benin, Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Ghana and Togo, which had also been polio-free for several years.

Twenty-two countries in western central Africa are preparing to carry out synchronized immunization campaigns in October and November targeting 74 million children under five years old.

Since the global eradication campaign was launched in 1988, the polio virus has been reduced from 125 to six

countries where the virus is endemic, or present and circulating: Afghanistan, Egypt, India, Niger, Nigeria and Pakistan.

On 30 June, WHO advised international travellers to Nigeria that they should be up to date with their polio vaccinations.

WHO guidelines recommend a booster dose four to six years after primary series of vaccinations and that anyone intending to visit Nigeria should have completed a full course of polio vaccination as recommended by their national governments.

The eradication campaign is being led by WHO in cooperation with United Nations children's fund UNICEF, Rotary International and Centers for Disease Control and Prevention in Atlanta, the United States. ■

WHO Regional Director dismisses "bleak picture" of his work in Africa

The director of WHO's Regional Office for Africa, Ebrahim Samba, dismissed a scathing critique published in the *Lancet* on 7 August of his work.

Dr Samba, who has been regional director for 10 years, argued that despite widespread poverty and instability in the region his office had achieved unprecedented success.

In a response published on 11 August, Dr Samba rejected the *Lancet's* central charge that appointments of WHO country representatives and senior staff were "often paybacks for political or other favours", or that his successor would be selected on a political basis.

He said that to suggest as much was a misunderstanding of WHO's role and that as an international organization it was inevitably close to the 192 governments it represents.

"The *Lancet* painted a bleak picture of the work of WHO in the African Region, giving the impression that WHO is not recording any successes there. In fact, despite the challenges and ongoing instability, the opposite is true," Dr Samba said.

He gave polio eradication, as well as fighting leprosy and guinea worm, and helping to rebuild health systems in post-conflict Liberia and Sierra Leone as examples of those successes.

In an editorial (2004;364;9433) entitled: WHO's African regional office

must evolve or die, the *Lancet* called for more transparency from WHO and public debate over the nomination of a successor to Dr Samba, who retires in January.

The *Lancet* said WHO's African office had an "ineffective and self-serving central management" leaving staff "demoralized and unsupported", and that the root cause was mistakenly acting like a "political rather than technical agency".

The weekly journal said that despite having the world's highest disease burden and lowest level of economic development, and the constraints of "corruption, poor governance, political instability, and civil strife" in Africa, WHO's Regional Office for Africa could do better.

"Indeed many commentators are privately and scathingly critical of its composition and working practices", the *Lancet* said.

Dr Samba said that all staff were recruited "strictly on the basis of qualification, experience, proven track record and competence" and that a current review of WHO policy on selection, placement and rotation of WHO representatives would address some of the *Lancet's* concerns as well as other issues.

On 1 September, each of the five candidates for the post was due to be interviewed for an hour by the African Regional Committee which comprises health ministers from 46 countries that belong to the African Region. Then they will vote on the nomination.

The candidates are Dr Deogratias Barakamfitiye of Burundi, Dr Phetsile Kholekile Dlamini of Swaziland, Dr Evaristo Njelesani of Zambia, Dr Francis Gervase Omaswa of Uganda and Dr Luis Gomes Sambo of Angola. The result of the vote will be announced on 2 September.

Dr Samba, who comes from the Gambia, accepted the *Lancet's* concerns that some programmes were driven by donors. He said this was true of "some important programmes" and had been the subject of considerable internal discussion.

Dr Samba added that far from being "limited" extra-budgetary resources had grown from a combined budget of 90 million dollars for 1994 and 1995, when he first took office, to 350 million dollars for 2002 and 2003, which he viewed as a "vote of confidence".

The *Lancet* recommended that WHO should loosen political ties between its Regional Office for Africa

and African governments, re-orient its core function toward technical expertise and make appointments based on competence and qualification.

It said the African office should decentralize into four or five sub-regions — a scheme Dr Samba said had been tried before without success. ■

WHO to develop new child growth standards

WHO received a US\$ 6.5 million grant from the Bill and Melinda Gates Foundation over the next six years to develop a new and more effective set of growth standards to help identify early signs of conditions like under-nutrition or obesity in children.

The project announced on 4 August will be carried out jointly with the United Nations University's Food and Nutrition Program.

At present, 99 countries are using the traditional growth standards, but the project aims to encourage these to switch to the new set by 2010.

Traditional growth references were established through studies of representative children from selected populations.

The new standards set will be based on children who fulfilled a number of criteria. For example, they must have been breastfed by non-smoker mothers, and they must receive a high standard of health care.

"This way they can reach their best growth potential because they have followed health recommendations known to be associated with the best health outcomes," said Dr Denise Costa Coitinho, Director of WHO's Nutrition for Health and Development unit.

Growth standards are the most commonly used tools for assessing the general well-being of children as well as the measuring the health of the communities in which they live.

"The new standards are important for WHO's work across the entire spectrum of nutritional health problems, from malnutrition to obesity," said Dr Catherine Le Galès-Camus, WHO's Assistant Director-General, Noncommunicable Diseases and Mental Health.

The project's first phase began 14 years ago with an evaluation of the current international growth reference.

The second phase, which ended in December 2003, focused on collection

of growth and related data and followed growth and development of some 8500 children in Brazil, Ghana, India, Norway, Oman, and the United States.

The new project to design the growth standards represents the third and final phase. ■

WHO removes 3 more AIDS drugs from approved list

WHO withdrew three more generic drugs from its list of approved AIDS medicines in August after an inspection showed that bioequivalence studies, which demonstrate whether the product has the same therapeutic benefit as the patented original, had not been carried out correctly.

Two other antiretroviral (ARV) medicines were de-listed in May for the same reason, pending new bioequivalence studies.

WHO said the de-listed drugs fulfilled all other requirements on quality, specifications for active ingredients, impurity profile and manufacturing but said lack of bioequivalence could mean the generic copies are not as effective as their patented equivalents.

Peter Graaff from WHO's AIDS Medicines and Diagnostics Service said that switching from the de-listed medicines to alternative products that have not been registered in a country with a strict regulatory system could be risky.

"Although we are not 100% sure yet whether these drugs are bioequivalent — at least we know they are of good quality and safe," said Mr Graaff, referring to the de-listed drugs.

The suspension of the five AIDS medicines could slow efforts to get life-saving ARV treatment to millions of people in the world's poorest countries, while the new bioequivalence studies get underway.

The procurement of cheap generic copies of patented drugs that fulfil quality, safety and efficacy requirements is central to global efforts to scale up treatment for millions of AIDS patients in developing countries.

WHO requires proof of bioequivalence for products it recommends for serious diseases like AIDS, malaria and tuberculosis, however, some government regulatory bodies do not require proof of bioequivalence to license generic drugs.

WHO said it was considering introducing more stringent checks before such products are recommended on its so-called prequalification list in future.

Some generic AIDS drugs which are currently on the market have not passed WHO compliance tests, but WHO officials say they cannot publish a list of these because this might conflict with less stringent regulatory authorities who have approved the drugs.

The three latest drugs to be de-listed are products of Indian generics company, Ranbaxy. One is a two-in-one pill combining 150 mg lamivudine and 300 mg zidovudine, a three-in-pill combining 150 mg lamivudine, 30 mg stavudine and 200 mg nevirapine and a another three-in-one pill containing 150 mg lamivudine, 40 mg stavudine and 200 mg nevirapine.

The two ARV drugs that were de-listed in June were products of Indian generics manufacturer, Cipla. ■

Call for papers on Maternal and Child Health

The *Bulletin of the World Health Organization* is seeking Research and Policy and Practice papers dealing with maternal and child health for a projected issue on this topic to be published in the first half of 2005. We are particularly interested in papers that deal with the following topics: why it is important to invest in the health of women and children; how care for women and children has been affected by global policy change; assessment of the public health challenge; how to meet the needs for effective care of women and children; human resources aspects of maternal and child health; economic aspects of maternal and child health; and countries' responsibilities towards the health of mothers and children. We will also consider relevant submissions on this topic to the other sections of the *Bulletin*: Perspectives, Round Tables, and Public Health Reviews. Manuscripts should be submitted to <http://submit.bwho.org> by 1 November 2004, respecting the Guidelines for Contributors, and accompanied with a cover letter mentioning this call for papers.