

In this month's *Bulletin*

Tracking thalassaemia

About 7% of the British population is at risk of β thalassaemia or one of the other inherited haemoglobin disorders. National register data show that the annual number of babies born with one of these disorders has been falling steadily since the late 1970s, when prenatal diagnosis of these congenital haemoglobinopathies was introduced. However, given the acceptability of prenatal diagnosis, the proportion of babies born with these disorders is 50% higher than expected. The problem, as Modell et al. point out (pp. 1006–1013), could be a “widespread failure to deliver timely screening and counselling”. What’s more, national register figures also show that mortality from these disorders has been rising, despite the availability of effective treatment. This finding prompted a study, which showed poor compliance with iron chelation therapy among adolescents and young adults. The UK experience, the authors note, underscores the value of a national diagnosis register to track rapidly changing epidemiological patterns and pinpoint problem areas.

DALYs vs the people

The 1990 global burden of disease study found that reproductive ill-health accounted for just over a quarter of the burden of disease suffered by Indian women, as measured in disability-adjusted life years (DALYs). A survey, however, conducted in India’s Karnataka State and reported by Bhatia & Cleland (pp. 1065–1069), in which a sample population of 421 young married women were questioned every month for a year about their health problems, found that reproductive disorders accounted for half of the total days of illness experienced by these women over the year. Health planners take note, say the authors: don’t neglect the subjective view.

User fees: a grassroots experiment

Most cost-recovery, or user-fee, schemes are begun and run by health authorities. Unsurprisingly, many of these schemes have led to a general drop in the use of health services. Uganda’s Kabarole District used a bottom-up approach that involved members of the community at all stages of the process, from the initial decisions about setting up the scheme and about the amounts users would have to pay to the way in which the revenue would be spent. After two years, Kipp et al. report (pp. 1032–1037), overall use of outpatient services fell by 21% in the 11 health facilities participating in the exercise. But the drop was confined almost exclusively to the four urban or semi-urban health centres, where use of services fell by an average of 41%. In the seven rural centres, use had risen by 21%. Among the reasons for the difference could be the fact that the rural communities felt greater ownership of the schemes than the urban or semi-urban communities. This, say the authors, is a rare example of a user-fee scheme leading to an increase in utilization of health services, at least in a section of the community.

Responding to measles vaccine

Vaccination of children against measles has not been as uniformly successful in developing as in industrialized countries. A difference in the immune response elicited by the vaccine could be one reason for the difference. To find out, Bautista-López et al. (pp. 1038–1046) studied the immune responses of 55 Peruvian children who were administered the standard Schwarz measles vaccine at about nine months of age. Antibody responses in these children were as strong as those recorded in industrialized countries: 93% had high,

protective antibody levels three months after vaccination. By contrast, only 23% of the Peruvian children had cellular (lymphoproliferative) immune responses to the measles antigens in the vaccine, compared with 55–67% of children in developed countries. The finding suggests, say the authors, the need for an in-depth study of the immune response to measles vaccination in children in developing countries.

Responding to yellow fever vaccine

In West Africa, more than 70% of deaths from yellow fever occur in children under six months of age, who tend to be disproportionately prone to contracting the disease during outbreaks. The problem is that children under six months of age run the risk of developing viral encephalitis following yellow fever vaccination. Nine months is therefore the earliest recommended age for vaccination. A study described by Osei-Kwasi et al. (pp. 1056–1059) in 420 Ghanaian infants found no difference in either immune response or frequency of adverse effects (of which none was severe) between the 200 infants of the study vaccinated at six months and the 220 infants vaccinated at nine months. Moreover, maternal yellow fever antibodies were no longer present in the children participating in the study, who were thus at risk of infection and in need of early protection. These findings suggest, in the authors’ view, that the yellow fever vaccine could be given safely to infants at six months and *should* be given at this age during yellow fever outbreaks or in areas where the infection is endemic. ■