

In this month's *Bulletin*

Reproductive tract infections in Bangladesh (pp. 180–188)

A survey in Matlab, a rural area 60 km south-east of Dhaka, Bangladesh, finds bacterial and viral reproductive tract infection to be low to moderate; fewer than 1% of the women have cervical infection; no cases of HIV infection are found. On the other hand, the men report high levels of unsafe sexual activity. The authors believe these data, provided by 804 women and 969 men, suggest an unusual opportunity to prevent a potential epidemic in a low-income, disadvantaged community.

Growth of affluent Indian children (pp. 189–195)

The growth performance of 395 children aged 12–23 months in an affluent suburb of Delhi was found to be similar to that in rich countries. The children belonging to the subpopulation with high parental education (i.e. at least one parent with 17 years or more of education) appear to have achieved their genetic growth potential. This population will be included in WHO's Multicentre Growth Reference Study for the construction of a new growth reference for the world's children.

Infectious disease surveillance in Africa (pp. 196–203)

Epidemiologists from WHO and the US Centers for Disease Control and Prevention assessed the disease surveillance systems used in the United Republic of Tanzania. Of the five systems in use, the Health Management Information System appeared to be the most suitable for the country, and for integration with those of the 45 other African states of the region. Personnel using it need standardized case definitions, access to laboratories to confirm disease diagnoses, simplified forms and reports, improved methods of reporting, regular supervision and feedback, and more resources.

Age preference in Zimbabwe (pp. 204–209)

Does being alive and well have the same value at any age? Residents of Harare, Zimbabwe, thought the value of averting a year of ill-health was greatest for 15 year-

olds and equal for people aged 1, 30 and 45 years. As one might expect, the mean age of the 67 people questioned was quite low: 27.69 years. They saw the value of averting death increasing with the number of years of life saved. Although their age-weighting did not correspond exactly to the Global Burden of Disease age-weights, these young Zimbabweans did show a preference for saving the lives of young people.

Vaccine-associated polio in India (pp. 210–216)

The estimated risk of vaccine-associated paralytic poliomyelitis (VAPP) in India was found to be lower than in other countries: one case per 4.1 to 4.6 million doses of oral polio vaccine (OPV) administered. In England and Wales the risk has been estimated at one case per 1.4 million doses, in the USA at one case per 2.5 million, and in Latin America at one case per 1.5 to 2.2 million doses. This confirms the view that mass immunization campaigns using OPV can safely be continued and intensified with a view to achieving polio eradication by the end of 2002.

Reducing TB mortality in developing countries (pp. 217–227)

Of the various interventions aimed at controlling tuberculosis, the directly-observed treatment, short course (DOTS) is found to have by far the highest impact. It is also the most cost-effective, at US\$ 5–50 per disability-adjusted life year (DALY) gained. The main obstacle to reducing mortality and prevalence significantly by scaling up the use of DOTS is lack of support for it, resulting in shortages of funding and staff. Meanwhile, technical innovation is highly desirable, especially for a vaccine providing protection for adults, simpler and shorter regimens for treatment, and improved diagnostics.

Finding and tackling the causes of maternal death (pp. 228–234)

Verbal autopsies, medical records and extensive discussions were used to review 130 maternal deaths occurring over a five-year period in South Kalimantan, Indonesia. Most of the deaths were caused by haemorrhage and hypertensive diseases.

Delays in decision-making and poor quality of care in health facilities were major contributory factors. The audit led to improvements in obstetric care in the district through better accountability and working relations.

Rapid assessment of schistosomiasis prevalence (pp. 235–242)

Of the 200 million people infected with schistosomiasis, 85% live in subSaharan Africa. Since the host snails cannot be controlled cost-effectively and there is no vaccine for this disease, control relies largely on chemotherapy, with praziquantel as the drug of choice. However, schistosomiasis is not distributed evenly, and treatment has to be targeted. School questionnaires are found to be an effective way of providing the information needed, being well accepted, reliable and inexpensive. They will be a valuable resource for large-scale control activities, as a first step towards defining the magnitude and distribution of this disease.

Good news in 1980: compression of morbidity (pp. 243–244)

James Fries's article entitled "Aging, natural death, and the compression of morbidity" appeared in the *New England Journal of Medicine* in 1980. With the implications of dramatic reduction of infectious diseases in industrialized countries evident by the 1970s came the emergence of non-communicable diseases later in life as the main causes of death. Fries predicted that just as mortality had been compressed into the older age groups, morbidity could be as well, raising the average age of first disability or major infirmity to very near the end of life. Taking the average maximum lifespan to be 85 years, he thus rejected the conventional expectation of an ever more feeble elderly population. Kalache and colleagues show us around this cheering landmark paper.

Perspective: essential ingredient for rolling back malaria (pp. 251–252)

Members of the Partnership for Social Sciences in Malaria Control explain why physicians, laboratory scientists and epidemiologists can't do it on their own. ■