Health & Disease

- OTHER -

1998 - 1999
Along with the good that has accompanied South Africa's opening up to the rest of the world, come the bad - an increase in the incidence of diseases not common in the country. Medical experts say the increase in cross-border travel by air and by road, coupled with unusual weather patterns and industrial accidents, is contributing to the spread of diseases such as cholera.

Doctors Steven Toovey and Andrew Jameson say that in the last year, they have seen a dramatic increase in the number of patients being treated for cholera. "The disease is spreading rapidly, and we are seeing cases in parts of the country where it was previously unknown."

Serious flooding and rainy conditions are also contributing to the spread of cholera, says Jameson. "Wet conditions make it easier for the disease to spread." Toovey agrees, adding that cholera is a bacterial disease that spreads through contaminated water and food.

While vaccination against cholera is highly recommended, the availability of vaccines is limited in many countries. "Vaccines are expensive and may not be available in all areas," says Toovey.

To prevent cholera, the experts recommend the following:

- Drink only boiled or treated water.
- Eat cooked or bottled food.
- Avoid raw or undercooked seafood.
- Practice good hygiene, such as washing hands regularly.

Meanwhile, in Hong Kong, two women were admitted to hospital with suspected cholera. Three cases of cholera have already been confirmed in the city.

Chinese health officials have issued confirmation that all three cases of cholera reported in Hong Kong this month are caused by the same strain of bacteria. The disease is spread through contaminated water and food, and it is highly contagious. The infected individuals were tourists from India and Pakistan, and they were visiting shopping areas.

"We have been monitoring the situation closely," said Dr. Jameson. "We urge all tourists to be cautious and follow the guidelines for cholera prevention."
Invasion of the KILLER TICKS

Congo fever fear grips a small town after man dies

BOBBY JORDAN

HUNDREDS of farm-workers in a tick-infested Northern Cape town are living in fear following news that traces of deadly Congo fever — transmitted to humans via ticks — have been found in the body of a local teacher who died last week.

Farm-workers in Steinkopf, about 70 km from the South African border with Namibia, claim they have been besieged by killer ticks and say it is just a matter of time before more residents become infected.

Some fear they may already be infected and are appealing for help to get rid of the ticks.

"This Congo fever is a frightening thing. Somebody must do something," said 84-year-old sheep farmer Bokkie Fisch. "I've never seen so many ticks in the bush before. Everything is covered in them. It's not right,"

Doctors say Congo fever antibodies found in Cloete's body proved only that he'd been infected by the virus at some stage — probably via a tick-bite.

The actual cause of his death was attributed to a serious liver condition.

However, doctors are monitoring at least a dozen people known to have had contact with Cloete before his death, including hospital staff at a clinic in Nababeep, where Cloete was first admitted, and at Cape Town's Libertas Hospital where he died last Wednesday.

Congo fever fear grips a small town after man dies

Although the virus was first recognised in the Crimea region of the Soviet Union at the close of World War Two and had subsequently appeared in eastern Europe, the Middle East, parts of central and east Africa and South Africa.

The virus killed a woman who worked at the Oudtshoorn abattoir in November 1996, setting off a major Congo fever scare.

While bugs are considered the major transmitters of the disease to humans, some cattle and sheep store the disease in their blood.
Mpumalanga on standby for possible cholera outbreak

By Anise Thom
Health Reporter

A field hospital has been put on standby to contain a possible epidemic in a remote Mpumalanga village after a woman contracted cholera from the Lomati River.

The mother of five is making a speedy recovery in hospital after becoming the first person to contract cholera within South Africa's borders during the current southern African outbreak.

The woman, who comes from Phiva village, was admitted to Shongwe Hospital on Friday with profuse watery diarrhoea.

Dr David Durrheim, a consultant in communicable disease control with the Mpumalanga health department, said yesterday that the woman had not travelled outside the village and they suspected she had contracted cholera from contaminated water from the Lomati River.

"She has recovered well and is ready for discharge," said Durrheim, adding that two of her children also had diarrhoea, but tests revealed no evidence of cholera infection.

He said her children, as well as other villagers, were being carefully monitored.

A local clinic had remained open over the weekend with stool specimens continuously being sent through for testing.

A field hospital was on standby, but Durrheim described the present situation as stable. Water Affairs was also ensuring clean water from a nearby water project.

Durrheim said cholera occurred in areas of poor hygiene where domestic water was contaminated with human faeces. Food which was contaminated by infected food handlers, and tainted shellfish, played a secondary role.

He said he most profound symptom was diarrhoea, which, in turn, led to a huge loss of fluid and the person's rapid dehydration.

"The most important thing is to rehydrate the person as soon as possible," Durrheim said, warning that cholera was spread easily in areas where there was poor sanitation.

The woman is the sixth person in the region to be stricken with the life-threatening disease since January.

The other five victims in the province contracted the disease in Mozambique, where about 15,000 people have been infected and more than 300 people have died since an outbreak began in August.

Farmers in the area are being urged to provide adequate ablution facilities for casual labour during the current harvesting season.
SA spearheads African drive to conquer malaria

CAROL CAMPBELL  ARG 6/4/98

Deep concern over the rampant spread of malaria across Africa and the lack of international interest in getting it under control has prompted a team of African scientists to collaborate to map the spread of the disease across the continent for the first time.

Researchers from the South African Medical Research Council are leading the project, called Mapping Malaria Risk in Africa, which will produce a unique database on a plague that has killed millions of Africans.

Researchers from Mali, Cameroon, Tanzania, Kenya, Ghana and the Ivory Coast are partners in the project.

Until now there has been no comprehensive information on the spread of malaria in Africa. Instead, individual countries have been running their own research and control programmes - often inadequately.

Dave le Sueur, a research council scientist and co-ordinator of the project, said malaria killed more people in Africa than AIDS, and that 80% of all people who die from malaria are Africans.

"Coupled with civil war, it is devastating the continent's economies - yet the world and many African governments are doing almost nothing to control it," he said.

Often this was due to the absence of adequate information to plan and focus limited resources.

"Malaria places a massive strain on a country's health service and can devastate productivity, yet little progress has been made against the disease," said Dr Le Sueur.

By operating across international borders, the research team will provide information which will show how important it is for neighbouring countries to work together to stamp out malaria.

The scientists and a small handful of international partners were in Cape Town recently to discuss the progress of their research.
Scientists from Africa join forces to push back malaria

It has claimed more lives in Africa than AIDS and 90% of all those who succumb to the dreaded disease are Africans, researcher reveals.

BY CAROL CAMPBELL
Cape Town

Deep concern over the rampant spread of malaria across Africa and international disinterest in getting it under control has prompted a team of African scientists to collaborate and map the spread of the disease across the continent for the first time.

Researchers from the South African Medical Research Council (SAMRC) are leading the project called Mapping Malaria Risk in Africa (Mara), which will provide a unique database on the plague which has killed millions of Africans.

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“Coupled with civil war, it is devastating the continent’s economies—yet the world and many African governments are doing almost nothing to control it. Malaria places a massive strain on a country’s health service and can devastate productivity, yet little progress has been made against the disease,” he said.

By working across international borders, the scientists will provide information which will show how important it is for neighbouring countries to work together to stamp out malaria. The scientists and a small handful of international partners were in Cape Town recently to discuss the progress of their research, which is now being used by world health authorities as a model on how to chart the severity of other diseases.

Dr le Sueur said the team had battled to win full international financial support for the project, which was eventually funded by a Canadian organisation called the International Development Research Centre (IDRC).

“They believed in the project from the start and put in R7-million seed funding.

“Now we are starting to make people sit up and take notice, but, before, I don’t think the international community was really interested in sorting this problem out. It was seen as just one of those things—in Africa there is malaria.”

The World Health Organisation (WHO) has given the researchers R3.3-million which will enable them to continue building their unique model.

Dr le Sueur said the team had collected the data, already gathered by doctors and scientists over decades, and used it with information about weather patterns and climate, to build the malaria model of Africa.

“The information was all there, in dusty boxes buried in the basements of buildings. We just had to ferret it out and feed it into the computer.”

In remote areas where no statistics have ever been collected, the scientists have used weather patterns and climatic information to predict how bad the malaria levels in these communities are.

Climate is important in the breeding of malaria because the mosquito which carries the parasite can only survive in warm, humid conditions.

By using weather forecasts, the Mara team can predict the onset of malaria in a region and warn health authorities to
Holidaymakers warned against spread of killer mosquitoes

Drug regimes for chloroquine-resistant areas

**mefloquine (Larimar®)**
- Advantages: highly effective, weekly regime
- Disadvantages: certain contra-indications, not yet indicated for long-term use, severe neurological side effects, although rare, relatively expensive

**chloroquine** (eg. Malarone®, Dronabinol® P, Plasmoquine®, Proguanil® (Paludine®))
- Advantages: well tolerated with lower incidence of severe side effects, can be used for long term, available without prescription, relatively inexpensive
- Disadvantages: widespread resistance, especially in SE Asia, poor correlation between dose and response

**doxycycline** (e.g. Vibramycin®)
- Advantages: resistance is rare, highly effective in SE Asia
- Disadvantages: relatively little experience as an antimalarial, short-term use only (≤7 weeks), photosensitivity and candida superinfection, relatively expensive

Malaria is only transmitted by the female *Anopheles arabiensis* mosquito which has fed off a human carrying the malaria parasite. It will not be able to pass malaria to the next human host immediately, but only after the two weeks it takes the parasite to develop in the mosquito's body.

### Three-week period
1. Malaria parasites injected into human body
2. Infected red blood cells develop into young parasites inside the red blood cells
3. Parasites grow and reproduce
4. Insect bites release young parasites into new red blood cells
5. Asexual cycle of development is repeated over and over, destroying red blood cells

### Two-week period
6. Mosquito sucks blood from infected human body
7. Parasites develop in stomach and develop into cysts
8. Cyst develop and develop into oocysts
9.They invade other organs, until injected into new human host

Source: Lee Baker, *Glossary of Malaria*, LifeLine, IPS Drug Information Centre

**Deadly strain rampent in the Amazon**

Brasilia  After the fires which threatened the huge rainforest reservation in the northern Amazon, Brazil's Yanomami Indians are at high risk from the strain of malaria, which is particularly lethal.

COPP says health workers were able to fly into the jungle in recent days after forest fires ground their planes for weeks.

After the fires, the biggest threat in the Amazon, said Joao Zucchi, a member of the Independent Commission for the Creation of the Yanomami Reservation (CIPP), who told the Yanomami community that the worst of the disease was over.

He said 1,000 members of the Yanomami community, who live in communal huts in clearings near the Venezuelan border, were particularly at risk.

About 800 Yanomami there were sick with the falciparum strain of the parasite which, if untreated, quickly leads to coma and death.

COPP health workers were able to fly into the jungle in recent days after forest fires ground their planes for weeks.

Rain this week finally extinguished flames.

Troops and firemen, however, were still fighting fires in the north of Roraima state, near the border. - Reuters
Big guns of G8 to help fight malaria

BY TYRONE SEAL AND MELANIE-ANN FERIS

A n international initiative to eradicate one of Africa’s worst killer diseases, malaria, has been given a half-a-billion-rand boost at the Group of Eight summit.

Health and travel officials in South Africa welcomed the move, which will boost the country’s R67-million battle against the scourge.

Britain has pledged R480 million to help wipe out the mosquito-borne disease which kills more than 2 million people each year and has devastated parts of Africa’s tourist industry.

Prime Minister Tony Blair, who hosted the G8 summit in Birmingham at the weekend, said the funds would be contributed by his government’s Department for International Development to the World Health Organisation’s Roll Back Malaria initiative.

At the summit, the leaders of the G8 countries – Canada, the United States, Germany, the United Kingdom, Italy, France, Japan and Russia – agreed to support the initiative, as part of a larger plan to contain and eradicate infectious and parasitic diseases.

While the WHO estimates that 2 million of the 300 million to 500 million people who contract malaria worldwide die each year, poor record-keeping in Africa means there are no accurate figures on infection rates.

It is estimated that a further half a billion people, 90% of them in Africa, suffer from the disease.

In South Africa, 5500 people are thought to have malaria in KwaZulu Natal, where at least 45 people have died this year.

Eleven people have also died of the disease in Mpumalanga, which has almost 4 000 confirmed cases.

The initiative aims to halve the number of deaths caused by malaria by 2010, and to halve that number again five years later.

Dr Andrew Jamieson, from the British Airways Travel Clinic in Johannesburg, said last night that any attempt to eradicate malaria would be welcomed in the country.

“Firstly, malaria causes major economic problems. A lot of people choose not to go to resorts like the Kruger National Park because of the risk of picking up malaria.

“Secondly, if we can stop deaths due to malaria, it will make a major difference to many people’s lives.”

Vincent Hoongwane, spokesman for the minister of health, welcomed the announcement as a “refreshing piece of news”, especially since provinces like Mpumalanga and KwaZulu Natal were battling the disease.

South Africa will have to collaborate with neighbouring countries, which are battling with a higher incidence of malaria cases.

“Disease knows no boundaries and effort to eradicate malaria can only be succeed if we work together,” he said.

The Government spends more than R67 million each year to combat malaria.

The WHO initiative will promote, among other strategies, improved treatment of the disease through proper diagnosis and treatment; better protection, such as the use of insecticide-treated mosquito nets; the control of mosquito breeding; and improved surveillance.

“Every 30 seconds, a child somewhere dies of malaria,” said Clare Short, who heads Britain’s Department for International Development.

“It kills indiscriminately; it puts an enormous strain on health services, and prevents the developing world from escaping from grinding poverty. The Roll Back Malaria initiative presents a huge opportunity to make a difference.”

The initiative will co-ordinate a coalition which will include leaders from malaria-ridden countries, the WHO, United Nations agencies, the World Bank, scientific institutions, private sector bodies, and others.

Report, picture.

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UK puts up R480m for malaria battle

OWN CORRESPONDENT

JOHANNESBURG: Britain has committed R480 million to efforts to wipe out malaria, which claims more than a million lives each year. Prime Minister Tony Blair, who hosted the G8 summit of world leaders in Birmingham at the weekend, said the funds would be contributed by his government's Department for International Development to the World Health Organisation's new "Roll Back Malaria Initiative", known as the RBM.

The leaders of Canada, the US, Germany; Britain, Italy, France and Russia agreed at the summit to support the initiative as part of wider efforts to contain and eradicate infectious diseases.

The World Health Organisation estimates that, of the 300 to 500 million people who contract malaria worldwide each year, about two million die. It is estimated that a further half a billion people, 90% of them in Africa, have the disease.

In South Africa, it is estimated that 5,000 people have malaria in KwaZulu-Natal, where at least 45 people have died this year alone. Eleven people have died of the disease in Mpumalanga, which has almost 4,000 confirmed cases.

The RBM intends to halve the number of malaria deaths by the year 2010. Health ministry spokesperson Mr Vincent Hlongwane, welcomed the announcement, but said any efforts to tackle the disease in the country would have to be initiated in collaboration with South Africa's neighbours, who had a higher incidence of malaria.

"Disease knows no boundaries and efforts to eradicate malaria can succeed only if we work together," he said.

The government spends more than R67m a year in combating malaria.
Scientists study SAs silent killer

THE Medical Research Council and the Cancer Association of SA have pooled more than R1m to re-launch the silent killer and search for esophageal cancer.

At yesterday's project launching at Umtata, the council said black SA men had one of the world's highest rates of this cancer. One in 33, or 430,000 of today's population, risked getting the disease. But Transkei had SA's highest rate.

Council president Dr Walter Froese said the council had been involved in researching esophageal cancer in Transkei since 1965, and had found a toxin-producing fungus in home-grown maize, which could be linked to esophageal cancer.

Four principal investigators and 14 leaders would set up projects to obtain information on cancer incidence, magnitude and survival; start a registry in Umtata; explore early detection methods, look at how diet might influence the disease's onset or prevention, and analyse genetic involvement.

The multidisciplinary research team involved the universities of Cape Town, Stellenbosch and Cape Transkei and the council's mycology toxins and experimental carcinogens project. The project would be co-ordinated mostly by the University of Transkei. Cape Town's biochemistry professor Iqbalas Parker would be project director.
Major drive to reduce oesophageal cancer - a big killer in Transkei.

The disease dying from black men risk 490 000

By ANDREW THOMAS

Major drive to reduce oesophageal cancer - a big killer in Transkei.

The disease dying from black men risk 490 000

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Campaign on to combat polio

By Jimmy Tloti

THE Greater Germiston health department has arranged a "mop up" anti-polio campaign in informal and squatter settlements in the city.

The venture will place emphasis on the immunisation of children below the age of five. The settlements are regarded as high risk areas for the spread of polio.

The drive will also help to "catch up" with children who missed being immunised in earlier campaigns.

Polio causes paralyisis and permanent deformity. However, it is prevented by immunisation.

Parents are asked to bring their children for the first dose of immunisation at health centres in the settlements from August 17 to 21.

The second phase of immunisation will follow from September 14 to 18. All patients will be issued with health cards, the health department said.

Also on health, Mokgadi Pela writes that a workshop with key South African players and members of the HIV research fraternity is to take place in Durban on September 1 and 2.

The event will focus on ethical issues in the conducting of HIV trials in the country.

Among issues to be discussed are informed consent and the role of researchers in caring for vaccine trial participants with HIV infection.

Organisers believe there should be wide consultation about the ethical issues, given the interplay between politics and science and the nature of the Aids pandemic in South Africa.

This will ensure that future decisions made about vaccine trials are informed and based on ethically and scientifically sound information.

The workshop is being organised before the International Aids Conference in Durban in 2000.

For more details contact Ms Qurraza Abdoor Karim on (031) 251-481 during working hours.
Coit in bid to wipe out cervical cancer
4 000 South Africans suffer from leprosy

Bhungani ka Mzoto
Health Reporter

NEARLY 4 000 people in South Africa suffer from leprosy, a chronic disease affecting mainly the nerves, skin, nose and eyes.

This is according to the Leprosy Mission Southern Africa, which celebrated World Leprosy Day on Sunday.

The mission said though affecting people of all races and social levels, 90 percent of leprosy cases occur in the developing countries of Asia, Africa and South America – India, Bangladesh, Burma, Indonesia, Nigeria and Brazil.

The latest statistics released by the World Health Organisation indicate that an estimated five million people suffer from leprosy.

According to executive director of the Leprosy Mission in South Africa, Mr Peter Laubscher, many victims live in remote or war-torn areas while some are too afraid to come for treatment because of the stigma in their community.

"Therefore the challenge of bringing leprosy under control worldwide by the next century presents a huge challenge but one we believe is possible." Laubscher said if leprosy is untreated, it can lead to loss of feeling in the hands, feet and face, making sufferers vulnerable to injury because of the absence of pain.

"Neglected injuries can cause permanent damage and deformity while facial paralysis can lead to blindness," he said.

Laubscher said leprosy was caused by bacteria and is probably spread through droplet infection such as sneezing or coughing, but in most cases the disease is not highly infectious. "It is not hereditary, cannot be caught by a handshake, and most people have a natural immunity to the disease," he said.

2/2/99
MALARIA

STING OF DEATH

Transafrica businessmen beware: a full-blown malaria epidemic is raging across the sub-Saharan region, and if you haven’t taken your antimalarial tablets, a trip to Zimbabwe or Ghana could mean your death warrant.

Consider this cautionary tale. Last September a 54-year-old Johannesburg businessman, who travelled frequently to other African countries, went to Nairobi, Kenya. As it’s considered a largely nonmalarial city, he took no preventive medication.

However, he squeezed in a weekend at a high-risk Kenyan game park. Ten days after returning to SA he developed fever and diarrhoea. He self-diagnosed a travel-related tummy bug and dosed himself with imodium (an anti-diarrhoeal) and paracetamol.

During the third night of fever he complained of a severe headache. He was found in a coma the following morning, rushed to hospital and placed in intensive care where cerebral malaria was diagnosed. He died the following day. Large areas of sub-Saharan Africa are now considered “high risk” malaria areas (see chart).

Parts of SA are now high-risk too. There were 14575 cases recorded in KwaZulu-Natal last year, and 112 deaths, compared with 4117 cases and 20 deaths in 1995. Nationwide 25 841 cases and 182 deaths were reported last year, against 8 750 cases and 44 deaths in 1995.

There’s an ambivalent attitude to prophylactics. A young man in his late 20s, who worked in Natal’s Mkuze game park was advised by fellow workers and a local doctor not to take antimalarial medication as it “masks the disease and makes diagnosis difficult”.

Last December, after the start of the rainy season, he developed a fever. Two days later he became delirious and was rushed to hospital. Despite vigorous and intensive treatment, including replacement blood transfusion, he died of severe malaria four days later.

Dr Andrew Jamieson, medical director of British Airways Travel Clinics, points out local citizens are the hardest hit by malaria. He adds that the most tragic statistic is the disease kills a child in sub-Saharan Africa every 15 to 20 seconds.
Myths About Leprosy Dispelled

By CLAUDIA MIRTA

Good news is that the bacterial disease can be cured with modern medication.
Simple diet of homegrown brew and samp linked to high incidence of gullet cancer

This way after all: Doctor urges jazz fans to moderate their appetites to avoid gout.
Silent Killer that Affects Young and Old

Osteoporosis decreases bone density in young women who exercise too much and eat too little.
Africa unites to beat malaria

Scientists at the largest malaria conference ever held in Africa, which took place in Durban last week, were upbeat about forming alliances to fight malaria on the continent.

From humble beginnings in Dakar two years ago, the Multinational Initiative against Malaria (MIM) has burgeoned into a global movement aimed at controlling the disease that kills at least one million Africans — many of them younger than five — and infects up to 500 million people every year.

The MIM conference showed that malaria cannot be treated as a country-specific problem and scientists and control staff committed themselves to working together to find solutions to the public-health problem the disease posed.

KwaZulu-Natal MEC for Health Zweli Mkhize announced a tripartite programme involving the governments of South Africa, Mozambique and Swaziland to fight malaria in the region.

Many new approaches and breakthroughs came out of the conference. One particularly effective method of preventing malaria is the use of old-fashioned bed nets. Researchers showed that bed nets cost less than residual spraying of houses with insecticides and may be as effective.

Scientists were optimistic that a vaccine against malaria will be a reality in the next 10 years. However, they stressed there had to be an understanding of the parasite at its most fundamental level.

"The life cycle of Plasmodium falciparum is one of the great mysteries of biology, and understanding its genetic blueprint will help solve one of the most fascinating problems," said Professor Harold Varmus, director of the United States National Institutes of Health. A vaccine which covers all the stages of the parasite's life is already being tested.

An African-centred project aimed at pinpointing where malaria occurs on the continent is being steered by the Medical Research Council's Durban office. The final product of this data collection will be an atlas that will help policymakers and malaria control managers to plan effectively and direct resources appropriately.

The cost of drugs and the lack of commitment from pharmaceutical companies to develop new anti-malarials was highlighted. It was pointed out that because malaria affects the poor, there is little incentive to invest in drug development. While there are more than 100 antibiotics on the market, there are only 10 anti-malarial drugs, and the threat of multi-drug resistance looms ever closer.

"Drug resistance has complicated an already dangerous disease, and we need to educate rural people about drug compliance. We also need to empower African scientists to develop new drugs, so we need to keep capacity in Africa. Collaborative work will bring down the cost of clinical trials, and it's easier to get help from South Africa than Europe," said Professor Ayo Oduola of the University of Ife and in Nigeria.

A major breakthrough has been the discovery of a herb that has excellent cure rates. The herb is known as quinina — common wormwood — but the active ingredient, artemisinin, appears only in certain species of the weed found in China and parts of Africa. When taken in conjunction with other anti-malarial treatment, artemisinin derivatives produce better cure rates and are the faster acting than other anti-malarial agents. The drug is effective against multi-drug resistance.

WHO is working on an artemisinin derivative, artesunate, in suppressive form, which is useful for seriously ill patients in rural areas who have no access to injectable anti-malarials, and who can use it as emergency medication while they get to hospital.

Artemisinin derivatives are not freely available in South Africa, but can be released on a named patient basis through the Medicines Control Council. However, this may prove to be extremely expensive for the individual.

Greer van Zyl is head of media liaison at the Medical Research Council.
MORE than six million people in
South Africa suffer from arthritis – a
chronic disease affecting body
joints, the Arthritis Foundation said.

To highlight Arthritis Awareness
Day tomorrow, the foundation has
planned information sessions where
people will be educated about the
treatment and how to cope with the
disease.

There are more than 100 differ-
ent types of arthritis, although the
main types are osteoarthritis,
rheumatoid arthritis and gout.

The foundation said although
there is no cure yet, early diagnosis
and treatment go a long way to help
prevent further deterioration which
could result in severe damage to the
joints.

Ms Helen David, a physiothera-
pist, said X-rays and blood tests
allow the doctors to determine
which type of arthritis a patient is
suffering from.

Osteoarthritis is the result of
general wear and tear or trauma.
Rheumatoid arthritis is the inflam-
mmatory disease of the tissues sur-
rrounding the joints.

"With osteoarthritis, the carti-
lage between two joint surfaces
becomes worn and the soft tissue
around the joint becomes swollen,
painful and eventually shortened,
causing stiffness or lack of
mobility," David said.

She said beside the knees, hips
and spine, other joints may also be
affected, particularly after trauma
such as sports injuries and motor
vehicle accidents.

Physiotherapy and medical care
are the key to management of
arthritis.

The Arthritis Foundation can
be contacted at (011) 647-2346 or
(012) 425-4738.

The South African Society of
Physiotherapy (SASP) at (011)
435-1467
Traditional healers join forces with science to fight malarias
Take a deep breath...

Call the asthma helpline 89 (9)

Thousands of parents have suffered the agony of watching their children gasp for breath – and doing the long wait to get to the nearest hospital as another asthma attack ensues.

Many other people have watched their loved ones die from asthma, in spite of this chronic condition being easily controlled with proper medication.

Cape Town is in fact one of the most allergic cities in the world, and there are few who escape. Pollens and colds frustrate the number of asthmatics – with the prevalence of asthma increasing dramatically here in the past 10 to 20 years.

Better news, though, is that while asthma is becoming much more common, aggressive preventative treatment is resulting in a drop in the number of asthma deaths.

Dr Gill Alwis, associate professor at Groote Schuur Hospital's respiratory clinic and Western Cape head of the National Asthma Education Programme, says deaths from asthma remain a major concern because most are preventable with the proper treatment.

A Cape Town study of fatal and near-fatal asthma between 1980 and 1991 found marked differences in the asthma incidence in different racial groups for white patients was 1.9 per 100,000 people, for coloureds 7.4 per 100,000 people and for Africans 10.6 per 100,000 people.

Between 1980 and 1985 there were 82 deaths a year: from 1986 to 1991, 84 deaths a year; and between 1992 and 1997, 77 deaths a year.

"During these years the Cape Town population grew dramatically but there has been a decrease in the number of asthma deaths. The reality is that our death rate is still three times higher than in the United Kingdom," says Professor Alwis.

He is the national vice president and Western Cape head of the National Asthma Education Programme, which was established in 1994 to help improve the quality of care and quality of life of asthmatics.

Together with Cipla-Medpro pharma-corals, the helpline also hired a 24-hour Asthma Helpline for Cape Town at the beginning of the year, aimed at providing additional support, information and assistance for sufferers and their families.

There are so many myths and so much ignorance about asthma. People often believe asthma is a disease only for other people – they think asthma is infectious, they think the pumps are additive, and many think it's a nervous condition.

"Through both the programming and the helpline we hope to dispel some of these myths and get across the correct information so people recognise the condition and get the correct treatment," says Dr Alwis.

The helpline is run by clinical technologist Letla Jansen, who herself has two asthmatic children. She is literally on the phone all day, answering calls and advising, and if she cannot answer questions she can call back from Dr Alwis and other thoracic clinic specialists.

The education programme, on the other hand, facilitates asthma support groups at grassroots level. Leaders of these groups go through training in all aspects of asthma, including triggers and treatments.

Asthma affects about 20% of children and 10% of adults worldwide, but occurs mostly in the Southern Hemisphere – and particularly in urban areas. Only a small percentage of sufferers have severe asthma.

It is a nervous condition but results from inflammation of the airways, which causes the airways to narrow, resulting in coughing, wheezing, a tight chest, a whistling sound when breathing and shortness of breath. It comes and goes and is often at its worst in the mornings and evenings.

Some of the asthma triggers, as opposed to the causes, include pets, foods, exercise, viruses and climate. The causes can be genetic, or as a result of allergens or pollutants.

Dr Alwis says inhaler pumps are the best treatment because they are not dangerous or addictive, and deliver the dose straight into the lungs without any side-effects.

She also encourages asthma patients to use peak flow meters, which measure the state of their condition. Patients blow into the meter and record their best "flow".

Then if they start blowing below three-quarters of their best level, they know they must double their medication. If it drops below half their condition does not improve, they need to see a doctor and get a course of corticosteroids.

Breathing easy: patient John Roman of Mitchell's Flat blows into a peak flow meter to check the state of his asthma. With him is Gill Alwis, associate professor in the respiratory clinic at Groote Schuur Hospital.

Dr Alwis encourages asthma sufferers to:

- Get regular treatment.
- Get their inhaler technique checked.
- Monitor their lung function with a peak flow meter.
- Avoid asthma triggers as far as possible.

She says asthmatics must get to hospital as soon as they find their inhaler pumps don't work – because the narrowing of the airways means the medication is not getting into the lungs.

Patients are then given medication via a drip, get oxygen treatment and are put on pills and introduced to other therapies.

People can die of asthma if it is not properly recognized and treated. Mostly they have waited too long to seek medical attention.

"Asthma deaths are always a tragedy because they are usually preventable," says Dr Alwis.

The 24-hour Asthma Helpline number is (021) 956-1673.

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So what exactly is the disease?

- The key features of asthma are the three 'Ss':
  - Spasm of the airways
  - Sensitisation of the airways
  - Subsequent over-reaction of the airways
- If symptoms last for 20 minutes or longer:
  - Take regular medication
- Triggers include:
  - Pets and foods
  - Exercise
  - Colds and upper respiratory infections
  - Smog
  - Flowers
- Causes include:
  - Genetic
  - Environmental
  - Workplace
  - Exercise
  - Seasonal
- Allergens:
  - Pollens
  - House dust mites
  - Animal hairs
  - Fungi
  - Food proteins

Asthmatic recalls the 'night I nearly died'

DI CAELERS

If your asthma medication is not working, get medical attention as soon as possible - because so much can go wrong quickly.

This is the advice of asthmatic Cheryl Zimri of Noordhoek, who has experienced first-hand the terrors of asthma - she lost her sister to asthma, and four years ago very nearly died herself.

Ms Zimri, 44, who has two asthmatic children, has lived with asthma her entire life.

Three of her eight siblings are also asthmatics, including her sister, Gaynor Stoffels, who died 12 years ago at the age of 22.

Ms Zimri doesn't hesitate to recall her worst asthma experience, the night four years ago that she nearly lost her life.

Doctors, she says, told her they did not save her from death, but "had to go to the other side to fetch me back".

She was not feeling well that night and, after her children Candice, now 23, and Heath, now 16, had gone to bed, she increased her medication and used her nebuliser.

That is the last thing she remembers of that night.

Her husband Steve returned home at 10 pm to find her in a coma.

"He apparently picked me up, left the kids in their beds, and rushed me to Groote Schuur. By the time we got there - from Montana near Bishop Lavis, where we lived at the time - the doctors declared me dead."

"My husband thought it was over," Ms Zimri says.

Later, when doctors stabilised her and then transferred her to Somerset Hospital, her husband was told to gather the family members because she was not expected to live.

They predicted that even if she did, she would have brain damage.

But after seven days in the intensive care unit, Ms Zimri was on the road to recovery.

Since then her medication has been changed and she says her asthma is under control.

"But I'm very careful. In winter I get my flu injections, make sure I look after myself, and take all my medication as directed. That is very important."

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 Advances in treatment

DI CAELERS

South African asthmatics can now benefit from a breakthrough, with "once-a-day" treatment already being taken by about a million patients in 45 countries.

Called Singulair, the Merck Sharp & Dohme pharmaceutical company product is a long-term controller, rather than a preventative medication and should not be used for the immediate relief of asthma attacks, nor to prevent or treat asthma attacks brought on by exercise.

It is also the first and so far the only Leukotriene blocker approved by the Medicines Control Council for prescription in South Africa.

Leukotriene blockers are the first new therapeutic approach to asthma treatment in more than 20 years and are recommended for use in conjunction with steroid-based treatment, the cornerstone of traditional asthma therapy.

"They may even help reduce the use of this treatment,"
Expensive Hib vaccine for free at public clinics

On Caelters
Health Writer

South African children are to be vaccinated free of charge against the Haemophilus influenzae type B – or Hib – bacteria that can result in pneumonia, meningitis and septicemia.

The national health department announced that from July 1 the Hib vaccine would be included in the South African Childhood Immunisation schedule.

Previously, this expensive vaccine that prevents deadly disease was available only from private practitioners. It will now be available at all public clinics.

The Hib bacterium lives in people’s noses and throats, according to the department. While it does not usually cause disease in those with a normal immune system, it can result in severe disease and even permanent damage or death in children younger than five who have not been vaccinated.

It is spread in droplet form from one child to another when an infected child coughs or sneezes, or shares toys which he or she have put in their mouths.

Creches, day care centres and other places where young children come in close contact provide ideal conditions for the bacteria to spread.

The department says that Hib infection can also infect the joints, bones, tissue under the skin, the membrane surrounding the heart, and the larynx and pharynx.

Death or permanent damage occurs especially in infants who are malnourished and those under a year old. Some who survive Hib meningitis end up with permanent brain damage.
Leading nations must help to beat malaria

Drug companies spend more money on finding cures for diseases prevalent in rich countries as their markets are more lucrative, write Jeffrey Sachs and Michael Kremer of the Financial Times

The world has a rare opportunity to roll back the scourge of malaria, a disease that has haunted humankind for centuries and has widened its death grip in recent years.

Nobody knows the exact extent of malaria, which may reach 500-million cases and 2.7-million deaths a year, but all agree that the toll on human welfare and economic development is profound.

Advances in science have now made it possible for us to seek to eliminate the disease. We believe the key to success lies in harnessing the world's biotechnology industry in the struggle.

Great strides in vaccine research and in the science of malariology offer real hope. Many believe that an effective anti-malarial vaccine may be developed in a decade. Sequencing of the 140,000 genes in the genome will soon be complete and promising potential vaccines have been identified. The critical problem is to find money for research, development and distribution. But there is simply not enough money in malaria research for-profit companies to worry about.

- Malaria is a tropical disease in which a parasite is spread between humans by the bite of an infected mosquito. Since the mosquitoes only transmits the disease only in warm temperatures and it is highly concentrated in tropical climates.
- There is simply not enough money in malaria research for-profit companies to worry about.

As a result malaria vaccine research is carried out mainly in government research institutions, all suffering from underfunding and competing claims on scarce budgets. The Wellcome Trust estimates that the world's malaria research programs amount to $84m a year or perhaps $42 a malaria fatality.

This expenditure is tiny relative to that on diseases affecting rich and more temperate areas. For example, research funding for asthma is about $60bn a year or $500 a fatality. In short, the 2.7-billion people in the tropics who are vulnerable to malaria provoke remarkably little research effort.

In an important meeting in Washington in 1995 some of the world's leading scientists in malarology recognised that "a malaria vaccine is feasible" but that a "coordinated strategy for vaccine development ... is essential".

We believe that these scientists should be supported in part of the solution by calling for increased support for public malaria research. A strategic planning group, or board, should be created to mobilise global science. However, we think an additional step is needed. The key is to bring the private sector into the development process.

Governments and research institutions support much basic scientific research on malaria.

Indeed basic research has produced fundamental and much-needed breakthroughs in our understanding of malaria and vaccines over the past decade. It is costly and time consuming to move from the basic science such as the mapping of the malaria genome, to development of an effective vaccine.

Governments in rich countries are reluctant to commit these funds without a guarantee that a vaccine will be effective.

Pharmaceuticals are developed by profit-oriented companies. It costs about $300m to develop, test and bring to market a new medicine. A malaria vaccine may cost several times as much, given the scientific challenges involved. Such development costs are a critical barrier to developing an effective vaccine. Without a sizeable market at the end of the process, no private company will undertake the risky and costly path of vaccine development.

That market is nowhere in view. Not only are malaria victims poor but existing international agencies that might buy the vaccines on their behalf are strapped for cash.

They would also seek to negotiate a very low price for the vaccine once it was developed. This price would cover the marginal production cost of a vaccine but not the cost of development.

We propose that public policies should be organised to provide an adequate market at the end of the development process. Leading governments should pledge today that they will help purchase in mass distribution an effective malaria vaccine when such a vaccine is developed and pay a realistic price that covers development and production.

No public money would have to be spent until an effective vaccine is found. No large bureaucracy would be needed to choose among scientific approaches or subsidise development efforts although government support for basic research would continue.

Nor would any government agency have to decide in advance who is worthy to lead the anti-malaria campaign. We believe in a decentralised approach, in which the smallest to the largest private biotechnology and pharmaceutical companies are given an incentive to search for an effective vaccine.

Market forces rather than unwieldy public agencies would be harnessed to tackle the key steps in vaccine development.

Such a programme need not be prohibitively costly. About 90% of malaria cases, including almost all of the worst variety, are in sub-Saharan Africa. About $250m a year would be sufficient to buy vaccine for the 25-million children born in Africa each year at $10 for a course of treatment.

Even at $40 a child—a large amount for a vaccine widely distributed in developing countries—the cost would be only $1bn to produce a vaccine worth many times that amount.

A committee of experts could establish criteria for eligible vaccines and determine procedures for purchasing vaccines.

Foreign aid to Africa now totals about $16bn a year so that at $10 a child the antimalaria effort would amount to 1.5% of total aid.

Unlike aid programs of uncertain effectiveness, the vaccine funds would only be spent when a proven vaccine was developed.

Spending such sums each year would be a very small price to help protect Africa against a disease that kills 2-million or more people a year and that cripples economic development.

With the financial backing of the richest countries mobilising the world's biotechnology and pharmaceutical companies, we could realistically hope for a breakthrough in malaria that could give new hope for billions of people in the developing world. Indeed, once such a breakthrough is made possible, it is hard to imagine that the opportunity will not be grasped.

Sachs is professor of economics and director of the Centre for International Development at Harvard University. Kremer is professor of economics and the Massachusetts Institute of Technology.
Final lap in race for polio-free world

Outbreaks spark new urgency before 2000 deadline
The hangover that lasts a lifetime

From page 1

They are vulnerable to co-option by criminal gangs.

Frustrated by the lack of public awareness, Mrs Lourens and other concerned parents of "booze babies" around the world decided to take action today.

"We decided on the idea of ringing bells in cities across the globe at 9.09 am on the 9th day of the 9th month of the year in 1999 for a 'magic minute' to remind women not to drink while planning to conceive, during their nine months of pregnancy or while breastfeeding."

Mrs Lourens said that Tisha was supposed to be in her care for six months. "We fell in love with her and could not send her to a children's home and so she stayed."

Tisha is small for her age and she will face developmental difficulties, but being at the receiving end of one of her spontaneous hugs and watching her giggle as she plays with her siblings shows there is hope.

In the Western Cape, health professionals estimate that the cost to the provincial government for the "hangover that lasts a lifetime" is about R14 billion a year.

Colleen Adams, a developmental paediatrician at the University of Cape Town's Child Health Unit, who is researching the syndrome, said there was no cure and sufferers would always need the support of their communities.

"Those who are (seriously affected) are protected in that they are recognised early and services are provided for them," she said. But many slipped through the net, landed on the streets and were most likely to be manipulated by others.

A single binge could result in a child being born with the syndrome, but genetic susceptibility varied, she said. "The bottom line is that no one knows who is susceptible and who is not. It's best not to take a risk."

Professor Denis Viljoen, head of genetics at the University of the Western Cape and director of the Foundation for Alcohol Related Research, is investigating the prevalence of the syndrome in the Eastern Cape and GEUTING. He said it was erroneous to believe sufferers were concentrated in the wine lands of the Western Cape with their culture of drinking.
Against malaria
South Africa on the warpath
with a difference. Harry Mchunu investigates
South Africa is planning cross-border raids.
Malaria: north should buzz off and let south use cost-effective DDT

Chemical is not a human carcinogen and it works, writes Richard Tren

DDT is recognized by nearly all scientists and researchers involved with malaria to be the most effective pesticide in malaria control.

Donald Roberts of the Uniformed University of Health Sciences in the US has studied the relationship between malarias and DDT use and found a strong negative relationship: the more DDT is used, the lower are malarias.

In South America it showed that all malarial countries experienced sharply rising rates of malaria since they reduced DDT use. Ecuador, which increased its use of DDT, experienced a 60% decline in malaria cases. Bolivia, Paraguay and Peru, on the other hand, stopped DDT spraying altogether in 1993 and subsequently saw new cases rise by more than 90%.

In 1993 Rachel Carson published her book Silent Spring, and launched the attack against DDT, which resulted in its banning for agricultural use in the US.

In any event, no one is proposing that DDT be widely sprayed over large parts of the world. Agricultural spraying is only one of the tools in the war against malaria.

Many of the studies against DDT were, however, scientifically flawed and have subsequently been related to DDT, for example, is not a Human carcinogen. Bird species actually rose during the period that DDT was used in the US.

The use of DDT has ensured that 5A's malaria-free areas are now possible in the countries they were before the Second World War. The disease, however, has been on the rise in SA and throughout the region. This is partly because of a reduction in DDT use, as well as a higher rainfall in recent years and increased migration of people between 5A and other highly malarious countries such as Mozambique.

This has led to a 50% increase in malaria cases in SA in recent years. Malaria kills 57 million people worldwide and leaves another 200 million chronically ill every year.

DDT is recognized by nearly all scientists and researchers involved with malaria to be the most effective pesticide in malaria control.

The World Health Organization has recommended that DDT be used in areas where malaria is still prevalent. In addition, because profits in fighting malaria are limited, private sector research is minimal. This limits the development of new drugs and vaccines.

Efforts to develop a vaccine and new drugs are woefully underfunded. In addition, because profits in fighting malaria are limited, private sector research is minimal. This limits the development of new drugs and vaccines.

The DDT debate merely illustrates how the environmental ideals of so-called civilized countries are pursued at the expense of developing nations that have little or no resources.

One can only hope that the recent report that two 11-year old boys in Long Island, New York, contracted malaria at a scouting camp will bring some of the moral hazards behind the question of DDT to the forefront of the debate that malaria imposes on the south.

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MALARIA

THE TOTAL ONSLAUGHT GETS UNDER WAY

Regional co-operation provides hope for tourism and investment

In an historic first for the region, the governments of SA, Swaziland and Mozambique are co-operating in a R40m joint offensive to wipe out malaria.

In addition to the inter-governmental malaria protocol signed last week, a conservation area agreement and protocol has also been finalised, laying the foundation for the creation of cross-border nature reserves and major resort developments that straddle the three countries.

They include investment opportunities for major resort developments at Ponta do Ouro on the Mozambican border and Kosi Bay in northern KwaZulu-Natal as well as game parks, joining the Ndumu Game Reserve and Tembe Elephant Park in northern KwaZulu-Natal, with the Phinda corridor in Mozambique, and one combining Swaziland's Hlane Royal National Park with the Mwaulua Nature Sanctuary in Mozambique.

Other tri-national projects allow for improved border management and access control, regional destination and investment marketing, and a harmonised approach to terrestrial and marine resource management.

This regional co-operation stems from the Lubombo Spatial Development Initiative (LSDI), an inter-governmental programme launched a year ago to unblock the impediments to the development of northern KwaZulu-Natal, southern Mozambique and eastern Swaziland.

This beautiful subtropical region, which is bounded by the St Lucia wetlands in the east and Swaziland's Lubombo mountains in the west, is marked by poverty and neglect and ravaged by one of Africa's biggest killers — malaria. Until this scourge is beaten, investors and tourists will continue to stay away.

SA is in the midst of the worst malaria outbreak since the Eighties. Malaria is usually a seasonal phenomenon that peaks after the summer rains, but in September there were almost 2 000 cases reported at the Ndumu clinic, compared to only 74 last September. This is even higher than the 1 496 cases reported by the clinic in the peak month of March this year.

Scientists at the SA National Malaria Research Programme blame the upsurge on the warm, wet season, multidrug resistance, and an influx of people from Mozambique, where there are no control measures, who are carrying the disease. Surveys of the uncontrolled malaria areas of Mozambique indicate that 40%-70% of people are infected and random border checks reveal that six out of every ten Mozambicans entering SA are infected.

Scientists have been calling for a regional approach to malaria control for the past six years, arguing that controlling the disease in Mozambique will reduce its incidence in the high-risk border areas of SA and Swaziland, and thus in these countries as a whole.

"Since we've become a democracy in SA it's enabled us to start moving forward on projects like this," says National Malaria control project after experiencing 3 500 cases of malaria among its 9 000 workers and six deaths over the past 18 months.

The SA Business Trust is donating R1m, with the remainder coming from the three countries and SA's Medical Research Council.

The project will be spearheaded by a Regional Malaria Control Commission, which pulls together experienced scientists, public health officials and malaria-control programme managers from the three countries.

Already up and running, the commission aims to reduce the incidence of malaria infection from 400 people to fewer than 20 in 1 000 people in southern Mozambique and from 250 people to fewer than five in 1 000 people in the high-risk parts of SA and Swaziland.

It aims to achieve this by expanding the control measures that have worked in SA since the Fifites. The main thrust will be to spray the inside of houses with a pesticide that kills mosquitoes on contact.

The introduction of mosquito nets is also being investigated.

The programme will also beef up primary health-care services so that more malaria cases are identified and treated.

It includes a five-year regional study into malarial drug resistance to determine which drug combinations are most effective against the disease, with the aim of standardising treatment methods in the region.

Scientists and health officials are confident that these measures will reduce malaria in the region, but there is an untested theory that may bedevil the operation — a possible correlation between malaria and Aids.

The latest malaria figures are so startling that scientists are beginning to give this some consideration.

Research Programme leader Brian Sharp says, "Historically, health has been viewed from a country-specific and not a regional perspective. The initiative and success of such a joint control initiative offers a unique opportunity to demonstrate the value of such a regional approach to donors and governments in other parts of the continent."

The Mozal aluminium smelter near Maputo is contributing R2,8m to the malaria-control project.

Their fears are fuelled by a recent Kenyan study that found a link between malaria and the Aids virus in pregnant women.

"There is absolutely no evidence (of such a link) apart from the circumstantial, but based on the Kenyan study it really behoves us to look at it," says Sharp.

This aside, the project is a possible step for the region and given the commitment and expertise of all involved, should be a resounding success.

Claire Blaauw
Impotence outstrips malaria in profitability stakes

David Pilling of the Financial Times says tropical disease curbs are dying of market failure

"We've got to find ways of creating that market"
Worrying diabetic figures released

Sowetan Reporter

AT LEAST two-million South Africans have been diagnosed as diabetics, while an equal number are believed to suffer from the disease.

The South African Diabetes Association released these statistics yesterday to coincide with Diabetic Awareness Week, which began on Monday. The association said between eight and 10 percent of all South African blacks had been diagnosed as diabetics, while four to five percent of whites and 13 percent of Indians suffered from the condition.

Chairman of the association's Soweto branch Mr. Lebogang Kgaye said yesterday the intention was to present an awareness programme tomorrow.

Experts would be on hand to explain how to care for sufferers.

Working with staff at several Soweto clinics, the association had trained a number of volunteers to test blood for sugar. "If the blood of the person shows a high sugar content, the person is advised to see a doctor or visit a clinic," Kgaye said.

World Diabetes Day is on Sunday and its theme is: "Prevention means intervention now."

For more information Kgaye can be contacted on (011) 984-6525.
**False remedy fools consumers**

**Paul Kirk**

South Africans are increasingly using false or misleading claims about anti-malarial drugs and home remedies to treat or prevent malaria. The practice is widespread and it is not uncommon to see advertisements for these products in local newspapers.

"The problem is that people are desperate to find a solution to the malaria problem and they will believe anything," said Dr. Andrew Lewandowski, a specialist in tropical medicine at the University of Cape Town. "But they need to be aware that these remedies may not work and could even harm them.

It is estimated that at least 50% of the population in malaria-endemic areas use false remedies, according to a recent study by the World Health Organization. The problem is particularly severe in rural areas where access to正规的医疗 care is limited. People often turn to traditional healers or use untested remedies that they believe will cure their symptoms.

"We need to educate people about the risks of using false remedies," said Dr. Lewandowski. "We must also work with local communities to provide them with access to正规的医疗 care and treatment."