NEWS

CHILDREN COULD BE WORST HIT BY FLU THIS SEASON

The expected flu epidemic will be particularly severe this year, if events from the northern hemisphere are any indication. The sudden deaths in November of three children in Scotland and two in England have been ascribed to Fujian flu (influenza A virus H3N2). High infection rates among children and adolescents have been reported from France, Spain, Norway, Portugal and the south-western USA.

Most of today's children and adolescents have little or no history of exposure to flu viruses (especially influenza A variants); they therefore have limited protective immunity and are extremely susceptible to infection. Children older than 2 years are generally not regarded as high-risk candidates for flu and are therefore not catered for in current flu prevention strategies.

Although vaccination with this year's flu vaccine, which contains the influenza A Panama virus (a close relative of the Fujian virus), could offer adequate protection, most countries do not include otherwise healthy children in their vaccine requirements and also do not stockpile flu vaccines. In consequence, current stocks of the vaccine will be inadequate to cover the needs of the pre-adult population.

Dr Steven Toovey, medical director at MedInfo, says the situation is mirrored in South Africa. We have not experienced a type A flu epidemic for several years, and people living here may not have been exposed to the virus and may have little natural immunity. The risk will be particularly high among children, many of whom were born subsequent to the last major outbreak. He believes that children need to be included in vaccination programmes as a matter of priority — especially given the growing incidence of HIV among children, who will likely be more susceptible to flu infection.

DEPARTMENT OF HEALTH RECOMMENDATIONS PERTAINING TO THE USE OF VIRAL VACCINES — INFLUENZA, 2004

Recommended vaccine formulation

The following strains have been recommended by the World Health Organisation for the 2004 southern hemisphere influenza season:

- A/Fujian/411/2002 (H3N2)-like strain
- A/New Caledonia/20/99 (H1N1)-like strain
- B/Hong Kong/330/2001-like strain.

The actual viral strains recommended for the vaccine for each component are as follows:

- A/Wyoming/3/2003 for the A/Fujian/411/2002-like strain
- A/New Caledonia/20/99 (IVR-116) for the A/New Caledonia/20/99-like strain
- B/Brisbane/32/2002 or B/Shangdong/7/97 for the B/Hong Kong/330/2001-like strain.

Vaccines should contain 15 µg of each haemagglutinin antigen in each 0.5 ml dose.

Indications

1. Persons (adults or children) who are at high risk for influenza and its complications because of underlying medical conditions and who are receiving regular medical care for conditions such as chronic pulmonary and cardiac disease, chronic renal diseases, diabetes mellitus and similar metabolic disorders, and individuals who are immunosuppressed (including HIV-infected persons with CD4 counts above 200/ml).

2. Residents of old-age homes, chronic care and rehabilitation institutions.

3. Children on long-term aspirin therapy.

4. Medical and nursing staff responsible for the care of high-risk cases.

5. Adults and children who are family contacts of high-risk cases.

6. All persons over the age of 65 years.

7. Women who would be in the second or third trimester of pregnancy during the influenza season. Pregnant women with medical conditions placing them at risk for influenza complications should be immunised at any stage of pregnancy.

8. Any persons wishing to protect themselves from the risk of contracting influenza, especially in industrial settings, where large-scale absenteeism could cause significant economic losses.

Dosage

Adults — whole or split-product or subunit vaccine: 1 dose IM.

Children < 12 years — split-product or subunit vaccine: 1 dose IM.

Children < 9 years who have never been vaccinated should receive 2 doses 1 month apart.

Children < 3 years should receive half the adult dose on 2 occasions separated 1 month apart.

Contraindications

1. Persons with a history of severe hypersensitivity to eggs.

2. Persons with acute febrile illnesses should preferably be immunised after symptoms have disappeared.

3. The vaccine should be avoided in the first trimester of pregnancy unless there are specific medical indications — see above indication no. 7.

Timing

Vaccines should be given sufficiently early to provide protection for the winter. A protective antibody response takes about 2 weeks to develop.

Chemoprophylaxis

In cases where vaccine has not been administered, consideration should be given to the use of supplementary chemoprophylaxis with amantadine in certain high-risk individuals, e.g. patients with chronic lung and heart diseases. Amantadine should be administered in a dosage of 200 mg daily in 2 divided doses for the duration of the epidemic activity, i.e. approximately 6 - 12 weeks. The dosage should be reduced in persons with renal disease and persons over the age of 65 years.

SEVEN MAJOR COMPANIES COMMIT TO CO-INVESTMENT TO EXPAND COMMUNITY HIV/AIDS PROGRAMMES

Seven global companies with operations in developing countries — AngloAmerican, Chevron Texaco, DaimlerChrysler, Eskom, Heineken, Lafarge and Tata Steel — announced that they will use their facilities, employees and other infrastructure to expand workplace HIV/AIDS prevention and treatment programmes into communities where they operate. By using infrastructure that was created to serve their employees, this corporate contribution will reduce the start-up and running costs of public programmes. Such capacity will be critical to the achievement of such global targets as 3 million people on antiretrovirals by 2005 ('3 by 5'), for which WHO and UNAIDS are mobilising focused technical support.

In South Africa, AngloAmerican and Eskom will pool resources such as clinics and skilled personnel in the 'coal or power belt', a region stretching over 500 km where both companies have mines and power plants. DaimlerChrysler's operation in East London has existing clinics, and they already share their health care staff with public sector services.

Other pilot projects will be undertaken with the companies in Cameroon, Ghana, India and Nigeria.

The Global Business Coalition on HIV/AIDS is a rapidly expanding alliance of almost 130 international businesses — with over 4 million employees in 178 countries — dedicated to combating the AIDS epidemic through the business sector's unique skills and expertise. For more information, visit the GBC website at **www.businessfightsaids.org**.

WHO CALLS FOR GOVERNMENT INVOLVEMENT IN REHABILITATION PROGRAMMES FOR DISABLED

On the International Day of Disabled Persons (12 December 2003), the World Health Organisation (WHO) urged governments at all levels to make a stronger commitment to the implementation of the rights of people with disabilities. About 600 million people in the world experience disabilities and the day-to-day life of 25% of the world's population is affected by disability. Eighty per cent of the world's disabled people live in low-income countries; the majority of them are poor and cannot access basic services, including rehabilitation facilities. The global disabled population is increasing as a result of malnutrition, war, chronic conditions, HIV/AIDS, road injuries and land mines, as well as population growth and medical advances that preserve and prolong life.

Experts who met last year at an international WHO consultation hosted by the government of Finland in Helsinki, reviewed the impact of community-based rehabilitation (CBR), an approach designed to empower people with disabilities. CBR was introduced by WHO some 20 years ago and has been adopted in 80 principally low-income countries. It shifts the emphasis from institutions or hospitals only offering medical rehabilitation, to the community in order to work with people with disabilities in achieving equal opportunities, equal rights and dignity.

CBR needs multi-sector collaboration with the involvement of all ministries, especially health, education, social welfare, labour, development and finance. CBR should be a part of strategies to reduce poverty and programmes must include people with disabilities, their families and disabled people's organisations at every level, reflecting the slogan for disabled people's organisations: 'Nothing about us without us'.

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IMPROVED MALARIA CONTROL BOOSTS TOURISM

The Lebombo Spatial Development Initiative (LSDI) — a collaboration between governments and academic institutions in Mozambique, South Africa and Swaziland — has recently achieved huge successes in decreasing the risk of malaria in the Lebombo area. This should minimise international and local tourists' fears of contracting malaria. Concerns about malaria have deterred international and local tourists from visiting the many beautiful attractions surrounding the Lebombo mountain range in southern Mozambique, north-eastern KwaZulu-Natal, eastern Mpumalanga and eastern Swaziland.

The dual approach employed by LSDI includes effective spray programmes to reduce the mosquito population and the use of new, more effective combination treatments to cure the disease in patients. The artemisinin-based combination treatments (ACT) have been recommended as the preferred first-line malaria treatment by the World Health Organisation (WHO) as they have been shown internationally to improve cure rates, decrease malaria transmission and slow the spread of drug-resistant malaria parasites.

Dr Karen Barnes, of the University of Cape Town Division of Pharmacology, reports that 'from 2000 to 2001 this dual strategy resulted in an 85% reduction in cases and an 89% reduction in malaria deaths in KZN'. Impressive cost savings to the province have resulted. Mpumalanga similarly added ACT to its effective spraying programme in January 2003, and the number of malaria cases have halved compared with last year.

In neighbouring states, e.g. Swaziland, malaria cases have decreased by 65% without any changes in the Swazi malaria control programme. This is in stark contrast to the increase in malaria across most of Africa, mainly due to the widespread use of ineffective malaria treatments such as chloroquine.

Regional co-operation and the LSDI's extensive capacity-building programmes, and methods of ensuring sufficient funding to continue these ambitious programmes in resource-poor settings, are essential. Ministries of Health, public-private partnerships with Business Trust and BHP Billiton and funding from agencies including the WHO have assisted financially. A $22 million grant from the Global Fund for fighting AIDS, Tuberculosis and Malaria, will enable LSDI to be extended to more districts in southern Mozambique.

URGENT WORK NEEDED TO REBUILD HEALTH CARE SYSTEMS

In their *World Health Report 2003 — Shaping the Future*, the World Health Organisation (WHO) says that health care services of most developing countries require urgent investment and international support. The renewed focus on health systems and services involves the '3 by 5' initiative to increase the availability of antiretroviral treatment for HIV/AIDS; a newly refocused drive to reduce maternal mortality; and work on chronic diseases and mental health. All of these initiatives require stronger health systems to succeed.

A baby girl born in Japan can expect to live for about 85 years, while life expectancy for the child in one of Africa's poorest countries is just 36 years. The Japanese girl will receive some of the world's best health care whenever she needs it, but the girl in Sierra Leone may never see a doctor, nurse or health worker. The report points out that even without the impact of HIV/AIDS, millions of children born in African countries today are at greater risk of dying before their fifth birthday than they were a decade ago.

Health for all remains the goal

Lessons learned from tackling major health challenges including SARS, HIV/AIDS, polio eradication and tobacco use demonstrate that millions of people could be saved from premature death and years of disability through a combination of financial aid and targeted improvements in health services, says the report. Today only 5% of all those people living in the developing world who require antiretroviral treatment for HIV/AIDS actually receive it.

In developing countries, communicable diseases still represent seven out of the ten major causes of child deaths. The gap between developed and developing countries is also made starkly clear in the shocking statistics on maternal mortality. The risk for women of dying in childbirth is 250 times higher in poor countries than in rich ones.

The continuing HIV/AIDS epidemic, deadly outbreaks of diseases such as SARS and the challenge of completing the eradication of polio are all symptoms of a failure to invest in health systems. This failure can have rapid and devastating international consequences, the report says. The lessons learnt from such health emergencies are helping to shape strategies for an urgent health system response to the prevention and care of HIV/AIDS. This will involve complex health interventions that WHO recognises as being not only feasible in resource-poor settings, but precisely what is needed.

The report suggests ways in which international support can counter some of the main health care systems' weaknesses, including critical shortages of health workers, inadequate

health information, a lack of financial resources and the need for more government leadership aimed at improving the health of the poorest members of society. The report calls for rapid increases in training and employment of health care workforces, and stronger government-community relationships.

The *World Health Report 2003 — Shaping the Future* can be ordered form the HMPG book department at a cost of R120. SAMA members will receive their usual discount.

PRACTICE MANAGEMENT

BUSINESS PLANNING, PART IV

Product/service portfolio analysis

The product portfolio of your practice includes all the separate services or products that the practice provides to its customers.

Although practices have traditionally been viewed as a one-stop shop that provides an integrated service, it is important to dissect this integrated service into separate service or product lines in order to:

- Determine the profitability of each service or product. Such an analysis facilitates logical decisions on resource allocation and the future of each product or service.
- Determine the life-cycle stage of each product or service. It is essential to maintain a spread of services across the various life-cycle stages to ensure that product lines in a declining phase are compensated for by new products or services in the development phase.
- Prioritise internal resource allocation.

Practice product portfolio

A practice product portfolio could include the following service or products:

Consultation services

- General
- Obesity
- Aviation medicine
- Insurance medical
- After-hour consultations.

Contractual appointments

- District surgeon
- Private sector occupational health services.

Diagnostic services

- Stress ECG
- Lung functions.

Surgical services

- Surgical procedures
- Assistant fees during surgical procedures.

Obstetric services

- Antenatal services
- Sonars
- Deliveries.

Dispensing services

Research services

- Clinical trials for pharmaceutical companies.

Product life cycle

Five phases have been described in the life cycle of any product/service. These are:

- **Development phase**

Typically services in this stage have few users but also few competitors.

- **Growth phase**

In this phase demand for the service increases, competitors start emerging and a fight for market share develops.

- **Shake-out phase**

Customers become more selective in where they purchase the service, an oversupply of providers exists, and a shake-out of the weakest of these suppliers takes place.

- **Maturity phase**

The users of the service have reached saturation. Providers focus on refining their share of the market and find it difficult to grow market share. Emphasis is placed on service efficiency and keeping costs low.

- **Decline phase**

Number of uses of the service declines and some of the providers leave the market. Selective redistribution of market share takes place between remaining providers.