They identify the aggressive promotion of infant formula, the distribution of useless and dangerous drugs, and the manufacture of arms as the 'killer industries'. Examples from Africa and Latin America are used to illustrate how empowerment, democratisation and equity, and the education of women are the keys to true development and health for all. Werner and Saunders, in their courageous crusade, urge us not to despair but to help communities to develop their own solutions. All who are truly concerned about the welfare of children in our country should read this deeply disturbing account of the failure to confront the real causes of poverty and disease.

Dave Woods

Drug Alert

Recommendations pertaining to the use of viral vaccines: influenza

Review of influenza activity — 1997

Gauteng area (National Institute for Virology)
The 1997 influenza season in Gauteng was relatively quiet with comparatively low absenteeism recorded in school and industry. Some 160 isolations of influenza were made from specimens sent to the National Institute for Virology during the course of the year. The majority of isolates and the predominant cause of morbidity was influenza A (H_3N_2) – 80 isolates, followed by 56 influenza B isolates and only 3 influenza A (H_1N_1) isolates were obtained (the latter was a relatively minor contributor to the 1997 influenza season). Influenza isolates commenced in mid-May and continued until 3 September.

Cape Town area (Department of Medical Microbiology, University of Cape Town)
Noticeable influenza activity started in Cape Town towards the end of July 1997. There were sporadic cases of influenza in the community including staff and family of laboratory staff. A total of 6 isolations have been made from staff, community patients of general practitioners and routine viral culture on children in hospital for respiratory infections. Two were Type A and four were Type B. Influenza activity continued through August and September but diminished in October.

Durban area (Department of Virology, University of Natal)
The winter influenza season in Natal commenced in mid-May with influenza B (Beijing-like) isolates. Some 20 of these isolates were made in May and June. Influenza A (H_1N_1) isolations were made in June and continued until September.

Recommended vaccine formulation

The following strains have been recommended for the 1998 influenza season by the World Health Organisation Collaborating Centre for Influenza Reference and Research, Melbourne, and the Southern Hemisphere Network for Influenza Vaccine:

- A/Bayern/7/95 (H_1N_1)-like strain
- B/Harbin/7/94/-like strain or B/Beijing/184/93-like strain
- A/Sydney/5/97 (H_3N_2)-like strain

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;
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; and
7. 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 I.M.
Children:	(< 12 years) Split-product or subunit vaccine	1 dose I.M.
	< 9 years who have never been vaccinated should receive 2 doses 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; and
3. The vaccine, although considered safe during pregnancy should, nevertheless, be delayed until the 2nd or possibly 3rd trimester to minimise the theoretical risk of teratogenicity. However, if high-risk indications exist, delaying immunisation should be avoided.

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.

Department of Health