ILAE, DEVELOPING COUNTRIES AND THE TREATMENT GAP

The ILAE leadership has had a long interest in trying to improve services in developing countries. It was this issue which aroused passions amongst the ILAE executive since at least 1965. In June 1970, an International Meeting was held in São Paolo in conjunction with the Pan American Congress of Neurology in October 1971 in association with the IBE, and the League also set up a Committee for Latin America (which seems not to have lasted) to foster activities in that part of the world. Its first activity in Africa was a planned workshop for June 1971 in Kampala, Uganda, on managing the epilepsies, which unfortunately never happened because of the coup in that country. Instead, the League and the IBE planned a travelling seminar on epilepsy in seven African countries for the spring of 1972. A major step forward was the establishment, by Harry Meinardi, of a Commission for Developing Countries in 1985. Meinardi who had had always a strong commitment to the developing world, was the first chair of the commission and the topic rose up the agenda of the League. In 1988, the term 'epilepsy treatment gap' was coined. The 'gap' was calculated using estimates of the prevalence of epilepsy, the amount of drug supplied to a country (using national drug supply data) and making assumptions about the drug dosage. Simple calculations were made showing what proportion of patients with epilepsy could have been supplied with the drug. The results indicated that, in four of the developing countries studied, only 6–20% of the patients with active epilepsy could have been taking antiepilepsy medication (even at low doses) at any one time. These figures were a great surprise but were confirmed in subsequent prospective surveys in Kenya, Ecuador and Pakistan.

It was partly in response to this measure that the ILAE/IBE/WHO Global Campaign Against Epilepsy was launched. The concept proved to be a powerful lever in the global campaign and could also be used as a long–term measure of the success of any epilepsy intervention. There are of course many reasons why a treatment gap might exist, but the quantification of the problem provides a measurable target for improvement, and there are indeed signs now that the gap is diminishing.

The first reported treatment gap figures (1988)

Country	Estimated no. of people with active epilepsy	Estimate no. of people receiving treatment	Treatment gap
Pakistan	450,000	22,000	94%
Philippines	270,000	14,000	94%
Ecuador	55,000	11,000	80%