the first is presumably a consequence of migration patterns, but is the second correct? Among Bangladeshis there are apparently three times as many men as women in the older age groups both in Greater London and in the rest of England while there are fewer men than women aged 35-54. One could speculate as to how this might have arisen, but underreporting must be a possible explanation. Among Pakistanis there are more men than women aged 55-79. Again, this might be correct or a consequence of underreporting.

The point is simple: while there are good grounds for supposing underreporting by ethnic minority groups, it is not clear that this is confined solely to Afro-Caribbeans or to Londoners. Given that deprivation scores are currently used to calculate each of the component scores relative to a national average, the case for a specific adjustment in London is doubtful.

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- 1 Glover GR. Sex ratio errors in census data. *BMJ* 1993;307:506. (21 August.)
- 2 Thompson EJ. Underenumeration in 1991 census. *BMJ* 1993;307:803. (25 September.)

Forms not retrieved

EDITOR,—Two letters have drawn attention to underenumeration in the 1991 census.^{1,2} The importance of establishing the degree of underenumeration of the resident population in health districts in inner London prompted my department to include in a local health survey a question about respondents' completion of a census form. Given that non-completion of a census form is illegal, ascertaining the extent of possible census underenumeration in the census posed a methodological challenge for the survey's designers. In the study respondents were asked if their census form had been collected. This would identify two potential sources of underenumeration: the failure of respondents to complete a census form and the failure of census enumerators to collect completed forms.

The survey was undertaken in the eight wards of the former Parkside District Health Authority with a standardised mortality ratio ≥ 110 ; a total of 821 interviews were carried out, giving a response rate of 77% (821/1059). Overall 64 (8%) respondents reported that their census form had not been collected. The table shows that non-collection of a census form was most likely to be reported by respondents aged 16-34 and by respondents from ethnic minorities.

These data suggest that the 1991 census may have greatly underenumerated the population that

Details of respondents to survey and of those reporting non-collection of census form

	No of respondents	No (%) reporting non-collection of census form
Age (years)*:		
16-24	85	10 (12)
25-34	219	28 (13)
35-44	149	13 (9)
45-54	91	8 (9)
55-64	113	2 (2)
≥ 65	154	3 (2)
Sex†:		
Male	282	22 (8)
Female	530	42 (8)
Ethnic group:		
White	497	30 (6)
Black	191	13 (7)
Asian	33	4 (12)
Other	71	10 (14)
Not stated	29	7 (24)

*Data on age were missing for 10 respondents.

†Data on sex were missing for nine respondents.

is resident in inner cities and in particular may have failed to enumerate many people from all those ethnic minorities. This underenumeration may result in underfunding of district health authorities in inner cities, and use of inaccurate population denominators may artificially inflate the prevalence of disease and rates of use of services.

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Malaria prophylaxis

Mefloquine should be first choice

EDITOR,—We are surprised that J C F M Wetsteyn and A de Geus felt able to reach any conclusion on the basis of their study four to six years ago of various chemoprophylactic regimens against malaria, all of which included proguanil.¹ They seem to acknowledge that their study lacked adequate power, with only 12 confirmed cases of falciparum malaria distributed among the three arms of the trial and correspondingly wide confidence intervals. Similarly, the number of adequate specimens was too small to provide useful data on compliance. The authors' confident assertion of the low overall risk of failure of prophylaxis is based on the examination of single thick blood films prepared by the subjects—a method of unknown sensitivity. Some subjects who developed fever might have been disinclined to comply with this procedure and consequently become non-respondents.

The authors' recommendation for the continued use of chloroquine-proguanil combinations for travellers to Africa flies in the face of results of recent comparative studies, which have shown mefloquine to be superior. For some time we have expressed the view that it is unsatisfactory to recommend chloroquine-proguanil when mefloquine is not contraindicated, particularly for visitors to areas of multiple drug resistance such as east Africa.² This view is now reflected in the most recent guidelines of a committee of British experts on malaria,³ who had previously been the main champions of chloroquine-proguanil. Wetsteyn and de Geus provide no evidence to contradict our view.

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- 1 Wetsteyn JCFM, de Geus A. Comparison of three regimens for malaria prophylaxis in travellers to east, central, and southern Africa. *BMJ* 1993;307:1041-3. (23 October.)
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Authors' reply

EDITOR,—Our study was designed to compare the efficacy of three regimens for malaria chemoprophylaxis, particularly two chloroquine-proguanil combinations. We did not compare chloroquine-proguanil with mefloquine.

G Baily and colleagues question our methods.

Malaria infection during travel is not usually confirmed parasitologically.^{1,2} The participants in our study were carefully instructed what to do if they developed fever; this included making two thick blood films and filter paper bloodspots themselves. As 54 of the 58 blood films were examined in our laboratory in Amsterdam we know that the sensitivity of this method is high. The response rate among the subjects who developed fever was over 90%.

Fifty eight (5%) of the 1421 travellers with a fever sent a blood film. This proportion is higher than the 2% (15/767) of travellers to east Africa reported by Fogh *et al*, who used the same method.³ Fogh *et al* found the rate of failure of prophylaxis to be 0.9%, which corresponds with our rate of 0.8%. Our figures on the risk of prophylaxis with chloroquine-proguanil failure were similar to those found for various prophylactic drugs by means of self administered questionnaires.^{1,2}

The failures of prophylaxis in our study overestimate the resistance of *Plasmodium falciparum* to the drugs used as we estimated that about half of the participants in our study were compliant. This percentage accords with other studies.^{1,2}

Our study was indeed performed four to six years ago. There is no indication, however, that resistance has become more severe in east Africa recently.⁴ In our hospital in Amsterdam the number of patients with malaria resistant to chloroquine using the chloroquine-proguanil combination has been stable since 1984. The data on the protection given by the chloroquine-proguanil combination in our study is supported by published reports.^{1,3} We have found that patients suffering from falciparum malaria despite compliance with chloroquine prophylaxis are usually protected from severe complications. Death is almost always due to delay by the doctor or patient.

We agree with Baily and colleagues that mefloquine is superior to chloroquine-proguanil in areas with high transmission of multidrug resistant *P falciparum*, such as west Africa. For this reason the National Health Authority in the Netherlands recommends prophylaxis with mefloquine for people visiting west Africa for a short time. The incidence of malaria in travellers not taking prophylaxis is 1.5 times higher in west Africa than east Africa.²

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- 1 Lobel HO, Philips-Howard PA, Brandling-Bennett AD, Steffen R, Campbell CC, Huang AY, *et al*. Malaria incidence and prevention among European and North American travellers to Kenya. *Bull WHO* 1990;68:209-15.
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Total quality management

EDITOR,—In modern revolutions which building do the rebels seize first? The royal palace? The houses of parliament? No. It is the television centre that holds the keys to the city: language is power. If you can control the dissemination of language you will win (as in the general election of 1992).

The organisation of medical care in Britain is