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Leprosy Control and Field Work

Leprosy control in Burma; Annual Report, 1985

The Health Unit of OXFAM in Oxford has kindly sent a copy of the latest annual report from Burma. The introductory paragraph describes how, since the implementation of the Peoples Health Programme, all routine leprosy control activities have been integrated into the Basic Health Services in all 314 townships of the country. The 'special rifampicin treatment programme', conducted in all highly endemic areas since 1983, is carried out by Leprosy Control Teams. All registered leprosy patients throughout Burma receive domiciliary treatment with dapsone monotherapy, but in the highly endemic areas (Magwe, Mandalay, Sagaing, Pegu, Rangoon, Irrawady Divisions and Shan State), multibacillary cases are given rifampicin 1200 mg once a month for 6 consecutive months, followed by 1500 mg annually. Numerous tables give detailed information about prevalence, incidence, deformity rates, and numbers of cases on dapsone monotherapy, and on rifampicin. During 1985 6600 new cases were detected and the impression gained from this excellent report is that there is still a formidable pool of cases, many of them multibacillary, awaiting diagnosis and treatment. A contact for further information is: Dr Tin Myint, Department of Leprosy Control, Department of Health, Theibyn Road, Rangoon, Burma.

A microscope in every village; the portable, plastic McArthur model

A user's handbook available from Eritrean Relief Association Public Health Programme, BCM Box 865, London WC1V 6XX, describes the development and intended use of this plastic version of the well-known McArthur portable microscope. The following is extracted from the preface:

The Eritrean Relief Association, a British Registered Charity, inaugurated an extensive public health programme in 1981 as part of its attempt to provide a framework for longer term development in its programme area, where the population have been afflicted by war for over 20 years and, for the last five years, by a severe drought. In May 1982 a decision was taken in the Eritrean Public Health Programme (EPHP) that a considerable input of microscopes and microscopy skills would be required in order to change disease patterns in the areas of Eritrea where the programme was operative. Since this involved approximately 200 villages at the time, a project for purchase of this number of microscopes was drawn up. A large number of instruments were reviewed, and the design made initially by Dr John McArthur in 1982 was chosen as the most suitable. The first commercially available instrument appeared in 1933, since which time it has been refined and added to. EPHP took responsibility for redesigning it in plastic.

The purchase price of 200 of these instruments covers the entire cost of establishing a production line, making a settlement with the designer and hiring a draftsman to redesign the instrument for mass production. Funding for this scheme was obtained by EPHP from ICCO, the Dutch Protestant inter-church development agency, co-financed by the Dutch government. By the end of 1983, the first 1000 sets of components had been produced. One year later, components for a further 10,000 sets were made.

This small handbook is intended for use in conjunction with a manual of techniques for specimen collection and preparation. Used in this context, it should go some way towards explaining the particular microscope design adopted for the 'Microscope in Every Village' project.

(We would welcome information from any area where this low-price, highly portable instrument has been tried out. Further enquiries to: Dr Neil Andersson at the above address.)

Essential Drugs Monitor, WHO

The Essential Drugs Monitor is a newsletter produced and distributed by the WHO Action Programme on Essential Drugs and Vaccines. Since the Action Programme was launched in 1981, more than 80 countries have either drawn up essential drugs lists or started projects in support of primary health care, providing reliable essential drugs and vaccines which:

Meet people's common health needs; have significant therapeutic value; are acceptably safe; and offer satisfactory value for money. All correspondence should be addressed to the Editor, Essential Drugs Monitor, World Health Organization, CH-1211 Geneva 27, Switzerland.

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In Number 3, 1986, a particularly interesting item concerns the choice of injection equipment for the Expanded Programme of Immunisation; joint guidelines issued by WHO and UNICEF. Their opening paragraphs read: 'Since the possibility exists that unsterile needles and unsterile syringes can transmit not only LAV/HTLV-III (AIDS-related virus) but other infectious agents including hepatitis viruses, immunization programmes have the obligation to ensure that a sterile needle and a sterile syringe are used with each injection', (EPI Global Advisory Group, November 1985).

Countries which for many years have tolerated unsterile immunization and injection techniques are becoming increasingly aware of the risks they run.

Guidelines on Treatment; National Leprosy Eradication Programme, India, 1985

We have received this excellent booklet from the Leprosy Division, Directorate General of Health Services, Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi 110011, India. It comprises operational guidelines on case detection, treatment, follow-up and reporting forms. Compared with the WHO recommendations ('*Chemotherapy of leprosy for control programmes*'; Report of a WHO Study Group; *Technical Report Series 675*, WHO, Geneva, 1982), the important differences in the Indian recommendations for MDT are as follows:

1 Multibacillary patients. There is an initial, supervised, 'intensive phase' of 14 days, during which drugs are given as follows (adult doses)—rifampicin 600 mg daily; clofazimine 100 mg daily; dapsone 100 mg daily. This is followed by a 'continuation phase', given for a period of at least 2 years, consisting of rifampicin 600 mg monthly, supervised; dapsone 100 mg daily, unsupervised; clofazimine 300 mg once monthly supervised and 50 mg daily unsupervised. (This phase is thus identical with the basic WHO regimen for multibacillary patients).
2 Paucibacillary patients. Under the heading of treatment for this group of patients (page 12), two choices are given: (a), dapsone monotherapy with 100 mg daily, self-administered (adult dose), to be continued until the patient is declared 'inactive'; and (b), multidrug treatment, using rifampicin 600 mg once monthly, supervised (adult dose) with dapsone 100 mg daily, self-administered; to be continued until 6 monthly doses have been administered. The concluding paragraphs in this section are as follows: 'Clinical inactivity cannot be achieved with chemotherapy for 6 months. The objective of short course chemotherapy is to render the patient free from viable bacilli and to initiate regression of lesions. Resolution of skin and nerve lesions will occur gradually, promoted by the high cell mediated immunity in this type of patient. It must also be appreciated that some lesions are partially or totally irreversible and may persist. Rarely, lesions of a trophic or degenerative nature may occur much later and should not be considered as evidence of activity.

Occasionally on completion of adequate treatment (6 supervised doses of rifampicin), the lesions may show no evidence of regression and, on the contrary, new lesions may appear. This is liable to occur especially in patients who are smear negative and have multiple lesions widely disseminated symmetrically or bilaterally. The diagnosis must then be carefully reviewed by a medical officer after detailed clinical and bacteriological examination for errors in classification. If the classification is correct, the treatment should be continued with rifampicin and dapsone in the same dosage for a further period of 6 months. If the patient was classified wrongly, the treatment should be changed to that recommended for multibacillary leprosy.'

Although perhaps not fundamental, there are nevertheless some important points of difference in the Indian recommendations for MDT, compared with those of WHO. These guidelines from Delhi should be studied in the original, particularly by those who believe that meaningful 'comparisons' between MDT programmes can be made by computer, or other means.

AHRTAG: Low cost packaging of drugs for developing countries

Late in January 1987, a meeting was held in the offices of AHRTAG (Appropriate Health Resources and Technologies Action Group Ltd), 85 Marylebone High Street, London WIM 3DE, to discuss the production of various forms of container (packaging) for the issue of drugs to patients in developing countries.

Based on a pilot field test in Bangladesh, Mr Jon Vogler described the production and possible use of: 1, paper envelopes; 2, simple boxes made out of card; 3, small plastic pots, made from scrap plastic; 4, bottles or jars made locally from clay (i.e. pottery); and 5, paper tubes. Simple machinery has already been developed for pressing out the plastic and for cutting card into appropriate shapes for small boxes. He has contacted the WHO Essential Drugs Programme in Geneva, who have encouraged further efforts for the better presentation of drugs in developing country situations. Discussion included the need to train and re-train pharmacists, so that any containers developed are used to best advantage. It is now planned to extend these pilot studies to several other countries, and also to consider the production of simple stamping machines in the UK, and their export through ECHO and similar agencies. This initiative has direct relevance to the use of dapsone, clofazimine and rifampicin for leprosy, especially where these drugs are issued 'loose', i.e. not as a fixed combination or in a blister (calendar) pack. Further enquiries to Mr Ken Ritchie, Director, AHRTAG, at the address above.