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Leprosy Control and Field Work

Disabled Village Children. David Werner. Hesperian Foundation

'*Disabled Village Children* is a book of information and ideas for all who are concerned about the well-being of disabled children. It is especially for those who live in rural areas where resources are limited. But it is also for therapists and professionals who assist community-based programmes or who want to share knowledge and skills with families and concerned members of the community.

Written by David Werner with the help of disabled persons and pioneers in rehabilitation in many countries, this book has been prepared in a style and spirit similar to the author's earlier works, *Where There is No Doctor* and *Helping Health Workers Learn*. It gives a wealth of clear, simple, but detailed information concerning the most common disabilities of children: many different physical disabilities, blindness, deafness, fits, behaviour problems, and developmental delay. It gives suggestions for simplified rehabilitation, low-cost aids, and ways to help disabled children find a role and be accepted in the community.

Above all, the book helps us to realize that most of the answers for meeting these children's needs can be found within the community, the family, and in the children themselves. It discusses ways of starting small community rehabilitation centres and workshops run by disabled persons or the families of disabled children.

Over 4000 line drawings and 200 photos help to make the information clear even to those with little formal education.' (There is a full section on leprosy. This astonishingly comprehensive book of 654 pages is modestly sub-titled *A guide for community health workers, and families.* The illustrations and diagrams are superb. Every page of the book underlines the importance of what can be attempted and achieved in the community. Published by The Hesperian Foundation, P.O. Box 1693, Palo Alto, CA 94302, USA.)

Tropical Health Technology, Cambridgeshire, UK

Tropical Health Technology is a non-profit making organization, formed '. . . to assist developing countries by a sharing of resources.' The Directors are Monica and G E Cheesbrough, 14 Bevills Close, Doddington, March, Cambridgeshire, PE15 0TT (Telephone 0354-740825). The main objectives are the provision of low-priced training manuals, learning aids and appropriate equipment for use in district laboratories. Brochures available from the above address deal with: 1, Publications in tropical medicine, medical laboratory sciences, nursing and midwifery; and 2, laboratory equipment service to developing countries.

Of particular interest to those working in leprosy (and perhaps even more in tuberculosis), is the *Tropical Health Technology Microscope* of which the details are as follows:

A mains and battery operated high quality microscope, with special applications for tropical medicine work in developing countries is available from Tropical Health Technology and at a special low price to developing countries.

Specifications

Quadruple nosepiece with high quality 10 ×, 40 ×, 100 × objectives. High powers are spring-loaded. Tubelength 160 mm. Abbe condenser with iris and holder for dark-field stop and filters. Smooth-running mechanical stage fitted with coaxial controls and scales. Single easy to use focusing knob, incorporating coarse and fine movements. Trouble-free non-lubricating mechanism. In-built illumination with 6V 10 Watt quartz halogen lamp operating from mains electricity or from 12V battery (battery leads provided). Fitted with brilliance control knob and power indicator. Spare lamp is supplied. Rotatable mirror for use with daylight when mains or battery power is not available. Fully adjustable and rotatable binocular head with two wide-field 10 × eyepieces or monocular head with wide-field 10 × eyepiece. Dust cover and instruction booklet.

Model MIC.010 Monocular microscope with above specifications. A monocular viewing aid is available as an accessory.

Model MIC.020 Binocular microscope with above specifications.

A range of accessories is also available including dark-field stop, calibrated measuring graticule in 10 × eyepiece, 20 × objective, self-indicating silica gel. Wooden carrying case with lock, 12V sealed battery, solar panel.

For prices and further details, contact Tropical Health Technology at the above address.

Leprosy Hospital, Moniaya-Ogoja, Cross River State, Nigeria

The Medical Missionaries of Mary, a Congregation of sisters dedicated to medical work, was founded by Mother Mary Martin, in 1937—1987 was the Golden Jubilee year. The Medical Missionaries of Mary came to Ogoja at the invitation of Bishop McGettrick in 1946, to care for the leprosy patients in the area. Whilst other medical works have since been taken on by the sisters, the leprosy work continues to hold a place of great importance.

The Leprosy Hospital at Moniaya-Ogoja was, and still is, the Leprosy Referral Centre for the three Local Government Areas of Ogoja, Obudu and Ikom. In the 50-bedded hospital many patients are admitted for the treatment of ulcers and for skin grafting. Because of the good results nonleprosy patients also present themselves. Buruli ulcer appears to be endemic in this area. As the treatment is protracted, using antileprosy and antituberculosis drugs in combination, we have committed ourselves to the care of those patients, who, prior to coming to us will have made little progress after spending many months in various hospitals and clinics. In keeping with the World Health Organization's policy of integration of Leprosy and TB Control Services, we reopened the TB Service (closed for about 15 years). Some beds are given over to those who need hospitalization, whilst those admitted for supervised treatment are housed in the 'village' with the disabled and homeless leprosy patients.

The TB and Leprosy Unit in Obudu continues to give a good service to the patients in that area. In Ikom, the TB Unit is still separate from the Leprosy Unit but we are planning the integration of the two services.

The Multiple Drug Therapy Programme for the leprosy patients was pursued and by the end of 1987 almost all patients receiving chemotherapy in the Ogoja, Obudu and Ikom Local Government Areas, were receiving MDT.

Short course therapy for TB patients has been introduced in Obudu and Ogoja.

Signs of progress in the leprosy eradication campaign are:

1 A continuing fall in the numbers of patients needing chemotherapy.
2 Increasing numbers of patients released from treatment as cured.
3 Very few new cases found in school surveys, which is in contrast to the numbers admitted from school surveys in the past.

The monthly or bi-monthly staff meetings held in Obudu, Ogoja and Ikom continue to be the forum for the discussion of difficulties and problems related to the work, and for up-dating. Visual aids such as slides and flow charts, have been useful.

We welcome the opening of the Armauer Hansen Institute in Würzburg that will assist us through skin biopsies, with the quality control of the smears and in diagnosis, classification and response to treatment.

That we have been able to initiate and continue the MDT programme, is due largely to the long tradition of leprosy control (41 years) in this area. Dr Margaret Chambers was not only a great organizer, with vision, but a Trojan worker. Treatment centres were opened in all clan areas and staff were posted to these areas. Field work was well backed up by a laboratory service (smear examination) run by specially trained staff. School surveys were an important aspect of the work. Much of the treatment was actually taken to the patients in their homes so that contacts were seen and examined and so that the home situation was known to the staff.

In the late 1970s the new antileprosy drugs, first clofazamine and then rifampicin were appearing on the scene. These were utilized in the Moniaya Leprosy Control Services in various combinations. MDT was introduced on a regular basis in the referral hospital and therefore given only to those patients who had advanced disease or were suffering from reactions. This initiative introduced the staff to the concept of MDT. They had seen the obvious good effects and so welcomed the programme that embraced all their patients.

Even though the Moniaya Leprosy Control Services were without continuous medical supervision the staff were faithful to their duty of administering dapsone. The treatment centres were visited monthly, the work supervised, the staff encouraged and the needs of the disabled and abandoned patients were cared for. So it was that when it came to reviewing all patients prior to introducing MDT, many patients were considered ready to be released from treatment. During these 'reviews' it was also discovered that large numbers of patients were not attending even though their names were still on the register. Their records were scanned and it was obvious that many had received sufficient treatment, that their disease was inactive and that to attend clinics was an unnecessary burden. They were released from treatment 'in absentia'. The true defaulters were taken off the registers.

There was no elaborate retraining of staff or recruiting of staff for the MDT programme. The staff we worked with were those who had borne the heat of the day—the hours of trekking looking for patients, the large numbers presenting for surveys, the misunderstandings of a society that treated leprosy, its victims and those working against it, with fear and prejudice. Updating sessions in the form of seminars were held and all were trained to do the simple monthly review on every patient.

The main reason for the successful launching of the programme was the fact that we had at hand *a certain and adequate supply of drugs*, thanks to the generosity of our benefactors. Each supervisor collects a monthly supply for his patients from Moniaya. He must present a list of his patients and indicate the number of tablets and capsules needed for the month. Much is left to the supervisor. He keeps problems and discharges for the medical officer who might visit every 3–6 months. Any patient with a serious problem is referred to Moniaya.

Patients are taught to care for themselves. Much emphasis has been put on the prevention of ulcers and deformities, and the care of hands and feet. Foot wear for insensitive feet is provided by the Rehabitation Unit. At first patients received the 'release from treatment' pronouncement with mistrust and reluctance. All staff were taught to give a simple 'discharge talk' covering 5 points, to dispel anxiety:

1 It is explained to the patient that leprosy is a disease caused by a germ. It can be cured by regular attendance. He/she is told that the full examination has proved that the disease has been cured.
2 New hands and feet are not available. The patient is given full instruction on hand and foot care.
3 The patient is advised to report any problems or suspected recurrence of the disease.
4 The patient is asked to attend for review after 3 months, 6 months and then annually.
5 The patient is invited to share in the work by passing on his or her knowledge of the disease (the true facts) and encouraging those needing treatment to attend a clinic.

In the Annual Report for 1986, we outlined plans for the future. In administering MDT to all patients needing treatment, in giving time to teach patients to care for themselves, in being diligent about contact tracing and school surveys to find untreated patients, in availing of opportunities to enlighten the public about leprosy, in integrating tuberculosis control into the Leprosy Control Services, in improving mobility of staff, we have come a long way in fulfilling these plans.

Staff salaries are paid by Cross River State Government but without the continuous and generous support of our benefactors overseas and the support in goods and kind from our local friends and charitable organizations, we could have achieved very little. We are deeply grateful.

Cecily Bourdillon

Action Health 2000

The following is extracted from the latest *Bulletin*, March 1989:

'In 1988 Action Health successfully continued to run its elective programme, sending medical students to a variety of placements in developing countries. The value of spending an elective overseas is increasingly recognised by students, tutors and future employers. The experience exposes students to a wide range of health care systems, providing a valuable contrast to Western medicine. The elective scheme is instrumental in fostering a long term interest in health and development.

Action Health is able to offer a 'package' to medical students contemplating an elective abroad. This includes a placement which has been personally vetted, an orientation course to prepare them for their time abroad, and support overseas through project correspondents. Follow up on return is provided, to ensure that the experience is put to good use in this country.

We offer electives in a variety of health care settings from hospitals to rural primary health care projects. The focus of all of our placements however, is community orientated. Action Health has been organizing electives in China, India and Bangladesh for some time and has recently expanded into Africa. We now send students to Tanzania, Rwanda, Zaire, Zimbabwe and Uganda.

Action Health is hoping to expand this educational aspect of its work, and would like to encourage more students to apply for the scheme. We would be pleased to give an address about our programme to any interested medical schools, and to send details of placements and application procedure to individual students considering an elective abroad.'

Address: AH 2000, The Bath House, Gwydir Street, Cambridge, UK.

Mission Project Service

Sister Catherine Howard Executive Director of MPS, One Haven Plaza 25A, New York, NY 10009, USA has kindly sent the following information:

'The MPS offers a wide scope of services which include: consultative services for project organization, proposal review, planning for future support, and selecting suitable agencies for assistance. The staff will assist the project organizer in determining a project's suitability for international support, preparing a written proposal, and designing a plan for application to appropriate agencies. These services are provided free of charge by phone, mail, and office visit. In response to the needs of those seeking assistance from international agencies, the MPS has designed project education workshops and seminars. These programmes enable those seeking support to understand the world of international grant-seeking, to learn how to write proposals, to train others in proposal writing, and to select suitable agencies for support.'

A book entitled *Agencies for Project Assistance*, 3rd edition, 1988, profiles over 280 agencies that provide assistance in the developing world. Price US$50.00, handling and postage included, from the above address.