Lepr Rev (1993) **64,** 362–364

Teaching Materials and Services; News and Notes

CBM/LEPRA Ophthalmic Course, Karigiri, India 1993

The Eighth Annual Five-day Ophthalmic Teaching Module was held at the Schieffelin Leprosy Research and Training Centre, Karigiri from 1 to 6 March 1993. This course, which was again sponsored jointly by the Christoffel Blindenmission and LEPRA, was designed to give instruction to leprologists on the detection, prevention and management of the ocular complications of leprosy by means of a series of lectures, clinical and surgical demonstrations, videos and slide-tapes.

Teaching included presentations on basic anatomy, physiology and pathology of the eye with special emphasis on leprosy: in addition there were lectures on the clinical signs and management of lagophthalmos, corneal ulcers, intra-ocular inflammation and infiltrative lesions, together with discussions on 'high risk eyes', ocular manifestations of relapsed disease, rehabilitation and the global aspects of blindness in leprosy.

The course, which was attended by 15 participants from India, Bangladesh, Nepal and the U.K., was run by Dr Margaret Brand of The Leprosy Mission and Mr Timothy ffytche from St Thomas's Hospital, London, together with Dr Ebenezer Daniel and Dr Mary Jacob of Karigiri.

The Director and staff of Karigiri and The Leprosy Mission are to be congratulated on their continued support for this important and popular contribution to teaching.

Report on the visit of Mr T. J. ffytche FRCS to the SLRTC Karigiri, 1–6 March 1993

I have just returned from the Schieffelin Leprosy Research and Training Centre, Karigiri, having assisted in the running of the annual ophthalmic course, and I would again like to express my sincerest thanks to LEPRA for their financial support.

This was the 8th annual CBM/LEPRA ophthalmic course held at Karigiri and it continues to be an established part of the training programme in the Centre, taking place at the end of the 6-week general course. This year there were 15 participants of whom 13 were leprologists working in India, Bangladesh and Nepal and 2 were ophthalmologists, one from TLM in Delhi and 1 from England about to take up an appointment working in ocular leprosy for TLM in West Bengal. In all 1 participant was sponsored by LEPRA and 11 by TLM, 2 doctors from Bangladesh were supported by the Damien Foundation and the Dansi Leprosy Mission respectively; 6 leprologists who were due to attend the course failed to turn up, and of these 5 were sponsored by LEPRA.

The length of the course was again $5\frac{1}{2}$ days and the structure was similar to that of previous years with a total of 13 lectures of 1 hour each covering the following topics:

Basic anatomy and physiology;
Ocular pathology in leprosy;
Clinical signs, management and surgery of lagophthalmos;
Infiltrative ocular lesions in leprosy;
Diagnosis and management of the red eye;
Ocular manifestations of relapsed disease;
The 'high risk' eye;
Ocular manifestations of relapsed disease;
Blindness in leprosy and its global considerations.

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In addition there were daily clinical demonstrations where participants were instructed in methods of examination and shown simple surgical and therapeutic procedures, together with teaching videos and slide-tape presentations. Participants were given a multiple choice exaination paper at the beginning and at the end of the week to assess their progress, and they were asked to evaluate the completed course by filling in a short proforma.

The teaching faculty consisted of Dr Margaret Brand, Mr Timothy ffytche, Dr Ebenezer Daniel, Dr Mary Jacob and Mr Prem Kumar, and the course was organized by the staff of Karigiri under the directorship of Dr J. A. Ponniah.

The group, which consisted of doctors from India, Bangladesh, Nepal and the U.K., proved to be an excellent mixture. This was the most extensive of the 8 courses that have been held, and this meant that participants were less able to have 'hands on' experience in surgery, and individual tuition in clinical examination was less easy to organize; however, the presence of 2 ophthalmologists, Dr Thompson and Dr Silas, was most helpful as they were able to assist in the clinical teaching.

It was very gratifying to see that several members of the staff were able to attend the morning lectures in addition to the course participants, as this had been recommended in previous reports.

The week ended with a formal ceremony in which certificates were presented to participants on the ophthalmic, physiotherapy and workshop courses, with a valedictory address given by Dr Ernest Fritschi, a previous Director. This event was highly successful and it is hoped that it will be repeated in future years.

We would again like to pay a special tribute to Dr Ebenezer Daniel, the resident ophthalmologist to Karigiri, whose enthusiasm and teaching skills greatly contributed to the success of the course.

LEPRA had sponsored 6 participants this year, although 5 were unable to attend. The reasons for this have yet to be ascertained, although from a practical point of view the increased numbers would have made the group too large and therefore less effective for clinical teaching. The length of the course is now established at $5\frac{1}{2}$ days, and this has the advantage of allowing the participants to spend extra time in the out-patient department, so that by the end of the week most felt confident that they would deal with the sort of ocular problems that leprosy produces, and had had sufficient experience in eye examinations to be able to train their paramedical workers. This represents one of the fundamental aims of the course.

Recommendations for 1994:

On the basis of the experience with the 1993 course, I would like to repeat some of the recommendations that have been made previously:

1. That the CBM/LEPRA ophthalmic course should continue to be held annually at the end of the 6-week January general course, and that the length of the course should be $5\frac{1}{2}$ days (Monday–Saturday am).
2. That the 2 main invited speakers should continue to be supported by CBM and LEPRA (Dr Brand or her successor by CBM; Mr ffytche or his successor by LEPRA), and that these 2 charities should make an appropriate contribution towards the administrative costs incurred by the Centre in the running of the course.
3. That the participants should be mainly leprologists *not* ophthalmologists and that the numbers accepted for the course should be not less than 12 and not more than 16.
4. That LEPRA should be allowed the option of sponsoring at least 3 leprologists to attend the course, and that these individuals should be selected before September 1993 by LEPRA (India) if possible, and the information about them relayed to the Director at Karigiri with copies sent to LEPRA in London.
5. That the course be advertised at an early stage through leprosy journals and health authorities as well as through charities such as CBM, TLM and LEPRA.
6. That the structure of the course remains basically the same as before, and that the morning lectures should be open to anyone working in Karigiri or attached to the Centre. The afternoon sessions of clinical and surgical teaching should be restricted to course members only.

I would like to conclude by thanking LEPRA again for their continued support, and by expressing my sincerest gratitude to Dr Ponniah and all the staff at the Schieffelin Leprosy Research and Training Centre for their kindness and hospitality during my short stay in Karigiri.

T. J. ffytche FRCS, FCOphth
21 March 1993

The Panafrican Institute of Community Health (IPASC)

IPASC aims to provide the quality of care in NGO and church-related health programmes in Africa. It is situated in the Rural Health Zone of Nyankunde Hospital, Zaire, and has academic support and collaboration of the Liverpool School of Tropical Medicine.

The activities of IPASC include:

a The **training** of health programme leaders, supporting them on their return to their work through follow-up visits, and working in collaboration with the communities and NGO/church-related programme leaders. IPASC courses are at various levels, using a participatory learning approach and including considerable field experience.

b **Research** into the causes of the poor quality of care, and the lack of sustainability, particularly at the peripheral level, so that guidelines may be established for the formulation of health policies and for the organization and management of health programmes.

c Developing a **consultancy service** in community health, including making available IPASC's training resources for use in other countries.

For further details: Institut Panafricain de Santé Communautaire, PO Box 21285, Nairobi, Kenya, Fax number: AIMSERVE (2542) 501651.

PAHO: Eradication plan for the elimination of leprosy from the Americas

The following is extracted from the *Proceedings of the XLIV Meeting* of the Pan-American Health Organisation, September 1992, held in Washington, DC, USA:

'In the consideration of this item at the 109th Meeting of the Executive Committee, the point was made that, because of the stigma associated with leprosy and its potential to produce serious disability, the Region's experts consider that the disease is a much greater public health problem than the prevalence figures alone would indicate. There are approximately 300,000 cases of leprosy in the Region, the case rate being 4·2 per 10,000 population. In 1991, 30,000 new cases were detected. The disease is not uniformly distributed in the Region or in the countries; 80% of all cases are found in Brazil, where the majority of new cases are also detected. Colombia, Mexico, and Venezuela also have more than 10,000 cases each. Leprosy can be considered a public health problem in 21 of the countries.

At present—through multidrug therapy (MDT) with dapsone and rifampicin for paucibacillary cases and with dapsone, clofazimine, and rifampicin for multibacillary cases—it is considered possible to attain the goal of elimination, i.e., less than one case of leprosy per 10,000 population. Unfortunately, MDT has not been as widely used in the Americas as elsewhere in the world. The plan for the elimination of leprosy in the Region emphasizes the need for early detection of cases and increased MDT coverage, and proposes that the required actions be carried out through the local health systems.

In the Committee's discussion of this item, it was mentioned that technical assistance and advisory services should be concentrated in the countries where incidence and prevalence of the disease are high. It was pointed out that there are several potential obstacles to the goal of elimination—for example, the difficulty of determining incidence and detecting cases early, and the possibility that, in countries where leprosy is not very prevalent, the integration of leprosy prevention and control activities into other programs might interfere with accomplishment of the program's goal of reducing prevalence rates. Concern was also expressed about the cost of multidrug therapy.'