COMMENT: LEPROSY CONTROL AND THE IMPLEMENTATION OF MULTIPLE DRUG THERAPY AND THE PREVENTION OF DISABILITIES

Sir,

The suggestion under 'Further simplification' in the above Editorial, published in *Lepr Rev*, 1992; **63:** 193–8[1], to separate case detection and chemotherapy from disability prevention and management calls for comments. Do the authors[1,2] really mean that the prevention of disabilities (POD) should be achieved by a different person (agency) than the people administering MDT?

POD is an essential component of any leprosy control programme, as is, for example, chemotherapy. Disappointing experiences when combining the above-mentioned components into an integrated leprosy control service should not lead to the decision to abandon (separation, simplification) POD at PHC/DHP level altogether. The overall objective should be that no disabilities should occur apart from those that are irreversible at diagnosis.[3]

Renewed efforts could be directed, for example, at the introduction of only the most essential POD components at PHC/DHP level and at strengthening the supervisory structure.

In my opinion POD at peripheral health service level should at least consist of:

Health education of new patients (and patients released from treatment) concerning the risk of reactions and about prevention of disabilities.

2 Recognition of early nerve damage.

3 Prompt treatment of severe reactions with prednisolone.[4]

4 Teaching of simple self-care: for example care for insensitive hands and feet, simple exercises, advice on suitable commercially available footwear, etc.

I can easily agree with separating physical and social rehabilitation activities (e.g. footwear for patients with deformed feet, orthopaedic appliances, physiotherapy, reconstructive surgery, vocational training, etc.) from case detection and chemotherapy.

In order to combine case detection and chemotherapy with POD, the supervisory and supporting structure (including a referral system) has to be strengthened. The leprosy control supervisor should visit each clinic at least once every 3 months. An important task for the supervisor will be to give on-the-job training regarding, for example, diagnosis and classification, chemotherapy, POD, etc.

MDT implementation with early case detection considerably improves disability prevention. It is, however, inconceivable that when giving health education to new patients no attention is paid to the risk of reactions and the prevention of disabilities. Instead of separating POD (and especially referring to the above-mentioned essential POD components at peripheral health service level) from case detection and chemotherapy, more attention should be paid to strengthening the supervisory structure of an integrated leprosy control programme.

Medical Advisor, Leprosy Control Centre, Zone 6 P. A. M. SCHREUDER
P.O. Box 58
Khon Kaen 40000
Thailand

References

[1] McDougall A. Leprosy control and the implementation of multiple drug therapy: to what extent can the operational strategy be simplified for primary health care? *Lepr Rev*, 1992; **63:** 193–8.
Yuasa Y. MDT for all; target oriented leprosy control program in the 1990s. *Int J Lepr*, 1991; **59:** 624–38.
[3] Watson J. Preventing disability in leprosy patients. London: The Leprosy Mission International, 1986.
[4] Becx-Bleumink M, Berhe D, 't Mannetje W. The management of nerve damage in the leprosy control services. *Lepr Rev*, 1990; **61:** 1–11.