Letter to the Editor

A-MDT, A SLOWLY TICKING TIME BOMB?

Accompanied MDT (A-MDT) is a treatment strategy in which a patient receives the complete course of treatment on the first visit after diagnosis. Informing and counselling about the disease and treatment are essential prerequisites for its success. The purpose is to make the treatment more accessible to patients from difficult and remote areas.\textsuperscript{1–4}

WHO supports the use of A-MDT to ensure the regularity of treatment and patient compliance on account of its effectiveness and user friendliness.\textsuperscript{4} Field trials in Madagascar, Mozambique, Angola, Tanzania and a recently conducted operational study by the Damien Foundation in the Madhupura district of Bihar state of India have shown encouraging results.\textsuperscript{4–6}

The Regional Leprosy Training and Research Institute (RLTRI) besides other activities, carries out technical monitoring and evaluation of leprosy in one of the high endemic states for leprosy in India namely, Chhattisgarh. It was noted that in two community Development Blocks (namely Darsiwa and Abhanpur) covering a population of 562,606 the prevalence of leprosy has fallen from 305 to 159 between April 2005 and March 2006. Case validation, scrutiny of records and MDT stock checking were also carried out. It was noticed that between September 2005 and March 2006 103 patients in two blocks (60 MB and 43 PB) received more than one pulse of MDT during their last visit. Of these 103 patients 98 (95.1\%) received between 2–5 MDT blister packs whereas the remaining 5 (4.9\%) patients were given 5 MDT blister packs or more. All the cases were shown as RFT (released from treatment) in the records. This led to an artificial decline in the prevalence of leprosy. Eighty of these 103 cases were then visited at their homes. It was found that for 30 cases health workers kept MDT blister packs with them and distributed to patients every month; entries for this were maintained in separate diaries. To another 17 cases no MDT was given. The patients also did not know which health facility to contact for drugs. To the remaining 33 patients, the drugs were given as shown in PHC records. These patients were aware of the drug regimen, but none of them were asked to report back to PHC after treatment completion. Patients were also ignorant about the side-effects of drugs and possible reactions. It was obvious that none of these patients were counselled, as recommended. The matter was brought to the notice of the health authorities concerned for corrective measures.

In such a scenario, indiscriminate use of A-MDT is fraught with danger. It should be used sparingly in exceptional circumstances. In A-MDT there are no clear guidelines about the people responsible for supervising treatment compliance.\textsuperscript{7} Accountability of adherence to treatment lies primarily with the patients themselves.\textsuperscript{8} The issue of A-MDT has been controversial as it deviates from the principle of supervised drug administration of monthly MDT regimen.\textsuperscript{9,10} However, the treatment behaviour of most patients is very unpredictable.\textsuperscript{11} Poor adherence to treatment has been identified as a common problem in chronic diseases like tuberculosis\textsuperscript{12} and leprosy.\textsuperscript{13–15} It may be difficult to justify change in the strategy from supervised to self-administration without giving due weight to operational problems prevailing in field conditions. Experiences with diseases like malaria have taught us that over-enthusiasm to achieve targets at any cost may prove to be too costly in the long run. Setbacks in leprosy may take a long time to be overtly evident, by then it may be too late. The efforts of dedicated health workers achieved through years of hard work should not be wasted. Most of the studies on which the recommendations of A-MDT are based were undertaken in controlled field conditions following extensive IEC activities. But in remote areas the situation is quite different. Moreover, assessing patient compliance just by attendance does not appear to be justified. This has been shown earlier with dapsone
monotherapy, when for monitoring the dapsone ingestion urinary dapsone / creatinine ratio methods were used.16,17 Do we have such bio-markers for A-MDT? For tuberculosis we rely on DOTS (Directly Observed Treatment Short Course) for success, how then can we assume large-scale use of A-MDT will succeed in the same socio-cultural set up? How do we explain this paradox? Hard-pressed health workers may find A-MDT a convenient route to achieve targets. In our haste to achieve the targets, are we going off course?

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