reported in 26 states. Of thi*s,* 132 cases were confirmed in 17 states (Rivers, Bayelsa, Cross River, Imo, Akwa Ibom, Lagos Delta,Edo, Abuja, Abia, Oyo, Enugu, Ekiti, Nasarawa, Benue, Plateau, Anambra). All reported cases (suspected and confirmed were males and are all of the age between 32–39 years. In the reporting month, fifteen (15) new suspected monkey pox cases were reported out of which six confirmed cases were recorded in five states (Rivers-1, Bayelsa-2, Delta-1, Cross Rivers-1, Edo-1) stated by [1]. Usually, the incubation period of monkeypox ranges from 6 to 16 days. The onset of this disease when symptomatic usually starts gradually with fever, intense headaches, myalgia, general weakness, back pain. After some days (within 1–3 days) it progresses to swelling of the lymph node, appearance of rash on the face which spreads to the palms of the hand and soles of the feet after which crust develops say the spot. Monkeypox is usually a self-limited disease with the symptoms lasting from 14 to 21 days [1]. Diagnosis. Optimal diagnostic specimens are from vesicular swabs of lesion exudate or crusts stored in a dry, sterile tube and kept cold. Blood and serum can be used can be used as well but it's inconclusive [1]. Prevention and control. In the absence of specific treatment or vaccine, the only way to reduce infection in people is by raising awareness of the risk factors and educating people about the measures they can take to reduce exposure to the virus. WHO supports surveillance measures and identification of new cases of outbreak, supports member States with preparedness and outbreak response activities for monkeypox in affected countries. And the government in Nigeria has organised a Nigeria Centre for disease control (NCDC) responsible for keeping Nigerians updated on its efforts control the monkeypox outbreak through regular situations reports available on its website as well as regular press interview including Nigerian guardian newspaper. Health-care workers caring for patients with suspected or confirmed monkeypox virus infection, or handling specimens from them, should implement standard infection control precautions by the use of gloves and use of personal protective equipment when caring for the patients. Practice good hygiene after contact with infected animals or humans. For example, washing your hands with soap and water or using an alcohol based hand sanitizer. Consider being immunized against smallpox through their national health authorities because globally small pox vaccines which have proven effective (85 %).

Conclusion

Monkey pox is endemic in Nigeria, especially in central and western part of the country. The weekly incidence of this disease in 2019 has no record of death. In endemic states the National RRT team (NCDC staff and NFELTP residents) are deployed to support response, environmental hygiene and eradication of rodents are implemented to control the spread of illness. Diagnosis is based on storage of vesicular swab of exudate lesion or crust in a dry sterile tube and kept cold.

REFERENCES

1. World health organisation Monkeypox. Fact sheet. — November, 2016 (cited 2017 Nov 22) https://www.who.int/news-room/fact-sheets/detail/monkeypox.

УДК 616-002.73-036.2 (540)

EPIDEMIC SITUATION OF LEPROSY IN INDIA

Khan Juhi Urf Nilofar

Scientific advisor: Ph.D., Prof. *L. P. Mamchits*

Establishment of education
«Gomel State Medical University»
Gomel, Republic of Belarus

Introduction

Leprosy currently affects approximately a quarter of a million people through out the world, with majority of these cases being reported from India [1].

India is a signatory of United Nations Convention on the Rights of Persons with Disabilities (UN — CRPD). India is currently running one of the largest leprosy eradication program in the world, the National Leprosy Eradiation Program (NLEP). Still, 1.2 to 1.3 hundred thousand new cases of leprosy reported every year, 58.8 % of the total number of new cases reported every year [2].

Aim

To give a territorial temporal characterization of the incidence of leprosy in India and evaluate the affectiveness of the organization of preventive measures.

Material and Methods

We analyzed literature and statistical data on leprosy cases in India.

Results and Discussion

Leprosy is one of the least infectious diseases as nearly everyone has some measure of natural resistance against it [3]. Nevertheless, it continues to spread, partially due to its extremely long incubation period, which may last as long as 30 years, as well as widespread ignorance and mis information about the symptoms and effects of the disease [2]. Stigma against the disease due to its disfigurement causes its victims to be isolated and shunned. They may also isolate themselves out of fear of discrimination. Patients may be impacted in every area of their life, including interpersonal relationships, economic security, and mental health and wellbeing [4]. Leprosy is also the leading cause of permanent disability in the world and is primarily a disease of the poor. The disease is now readily treatable with multidrug therapy, which combines three drugs to kill the pathogen and cure the victim [3]. Disability and disfigurement can be avoided if the disease is treated early, while conversely delay in treatment is linked to greater disability [5]. Unfortunately, individuals with leprosy are still shunned, isolated, and stigmatised, leading to the fear of leprosy being worse than the disease itself [6]. Additionally, the initial symptoms are not obvious and may easily be mistaken for other conditions, such as insect bites or allergic reactions. Patients may consider the disease too minor to warrant a visit to a doctor and fear losing their wages [5]. People suffering from severe leprosy-related disabiliies face extensive discrimination. Often, the only way they can make money is by begging. Under these conditions, they may mutilate themselves to garner more sympathy and therefore more money [7]. Sufferers may also hide their symptoms or diagnosis from their family or colleagues, have difficulty maintaining a job, or avoid physical contact with their family [4]. Leprosy colonies exist throughout India. These are typically made up of patients that have moved to the colony from a significant distance away, and their children and grandchildren. These colonies have a very strong community bond, formed in reaction to outside discrimination. India is considered the point of origin of leprosy with skeletal evidence of the disease dating to 2000 B. C. The disease is thought to have spread through trade and war to other parts of Asia, the Middle East, North Africa, and later Europe and the Americas. In ancient Indian society, individuals suffering from leprosy were alienated because the disease was chronic, contagious, resulted in disfigurement, had no cure at the time, and was associated with sin. In colonial India, the government enacted the Leprosy Act of 1898, which institutionalised leprosy victims and separated them based on gender to prevent reproduction. These laws mainly affected the poor because those who were self-sufficient were not obligated to be isolated or seek medical treatment. In 1991, India contained 75 % of the world's leprosy cases. Leprosy treatment was handled by the National Leprosy Elimination Programme, which was completely separated from other healthcare services. In 2005, this was incorporated into the broader healthcare system, and shortly afterwards, India announced that it had eliminated leprosy as a public health problem. However, this only means that there is less than 1 person in 10,000 infected with the disease. There is a lower

percentage of affected individuals, but this number is still enormous in absolute terms, and India still makes up 58.8 % of the world's leprosy cases [2]. Since this announcement, funding for leprosy prevention and education programs has been drastically reduced [5]. The prevalence and rate of infection have remained steady from 2005 to 2015, and there are still significant delays in treatment, both from the patients and the healthcare system itself, due to a lack of knowledge about the disease [5]. Current programs include house-to-house examinations designed to identify hidden cases of leprosy. Early detection of the disease is important, since physical and neurological damage may be irreversible even if cured. Medications can decrease the risk of those living with people with leprosy from acquiring the disease and likely those with whom people with leprosy come into contact outside the home. The WHO recommends that preventative medicine is given to people who are in close contact with someone who has leprosy. The suggested preventative treatment is a single dose of rifampicin (SDR) in adults and children over 2 years old who do not already have leprosy or tuberculosis. Preventative treatment is associated with a 57 % reduction in infections within 2 years and a 30 % reduction in infections within 6 years. The Bacillus Calmette-Guérin (BCG) vaccine offers a variable amount of protection against leprosy in addition to its target of tuberculosis. It appears to be 26 to 41 % effective (based on controlled trials) and about 60 % effective based on observational studies with two doses possibly working better than one. WHO concluded in 2018 that the BCG vaccine at birth reduces leprosy risk and is recommended in countries with high incidence of TB and leprosy. Development of a more effective vaccine is ongoing.

Conclusion

Despite having had a positive effect on leprosy, mass BCG vaccination for the prevention of TB at national levels is often overlooked as an important factor in current leprosy control programs. BCG does not provide complete protection but, by revealing the potential for vaccination, provides a foundation for the development of newer, hopefully more effective vaccines. It is believed that effective immunization will provide a much broader protective window than the estimated two-year protective window provided by chemoprophylaxis alone. Adapting control strategies to provide both chemoprophylaxis for immediate and short-term protection with immunization for longer-term protection has a distinct appeal and could have an immediate impact. Such trials could also provide a gateway for the assessment and, ultimately, the implementation of defined vaccines that are emerging.

REFERENCES

1. WHO (September 2011). «Leprosy update, 2011» // Weekly Epidemiological Record. — 2011. — Vol. 36. — P. 389–400.

2. *Sengupta, Utpal.* Elimination of Leprosy in India: An Analysis / Utpal Sengupta // Indian Journal of Dermatology, Venereology and Leprology. — 2009. — Vol. 84. — P. 131–136. — doi:10.4103/ijdvl.IJDVL_1070_16. — via EBSCOhost.

3. World Health Organization (2009): Leprosy. http://www.who.int/mediacentre/factsheets/fs101/en/index.html.

4. Dehabilitation in the Era of Elimination and Rehabilitation: A Study of 100 Leprosy Patients from a Tertiary Care Hospital in India / Divya Sheshadri [et al.] // Leprosy Review. — 2015. — Vol. 86. — P. 62–74. — via EBSCOhost.

5. I Wasted 3 Years, Thinking It's Not a Problem: Patient and Health System Delays in Diagnosis of Leprosy in India: A Mixed-Methods Study / Muthuvel Thirumugam [et al.] //PLOS Neglected Tropical Diseases. — 2011. — Vol. 11. — doi:10.1371/journal.pntd.0005192. — via EBSCOhost.

6. Bhattacharya, S. Leprosy in India / S. Bhattacharya, Virendra N. Sehgal // Clinics in Dermatology. — 1999. — Vol. 17. — P. 159–170.

7. *Barrett, Ron.* Medical Anthropology: Leprosy on the Ganges. Conformity and Conflict: Readings in Cultural Anthropology, edited by James Spradley and David W. McCurdy, 14th ed. / Ron Barrett // Pearson. — 2012. — P. 351–358.