

Полученные результаты говорят об определенной значимости волос в социальной жизни людей.

Среди лиц мужского пола 7 вопросов из 10 имели преобладающее количество утвердительных ответов. Кроме вышеперечисленных вопросов, лица мужского пола чаще отвечали «Да» на следующие вопросы:

«Станете ли Вы относиться предвзято к мужчине, с покрашенными волосами?» – На данный вопрос ответили «Да» 57,7 % респондентов мужского пола.

«Имеете ли вы какие-либо предрассудки насчет лысых женщин/мужчин с длинными волосами?» – На данный вопрос ответили «Да» 53,9 % респондентов мужского пола.

В ходе анализа результатов анкетирования было замечено, что на некоторые вопросы мужчины отвечают утвердительно чаще, чем женщины.

На вопрос «Вызывает ли у Вас недоверие специалист в области здравоохранения с окрашенными в яркие цвета волосами (зеленый, синий)?» утвердительно ответили 19,1 % лиц мужского пола и 10,5 % лиц женского пола.

На вопрос «Вызывает ли у Вас дискомфорт вид обильного оволосенения подмышечных впадин?» утвердительно ответили 42,6 % лиц мужского пола и 28,2 % лиц женского пола.

На вопрос «Считаете ли Вы, что неухоженные волосы – показатель, характерный для низших слоев населения?» утвердительно ответили 30,1 % лиц мужского пола и 15,3 % лиц женского пола.

На вопрос «Может ли у Вас вызвать отвращение вид девушки с оволосенением по мужскому типу (усы, бакенбарды, оволосенение груди)?» утвердительно ответили 44,0 % лиц мужского пола и 22,5 % лиц женского пола.

Из вышеизложенного следует: для лиц мужского пола в большей степени, чем для лиц женского, волосы играют роль предмета притяжения, отвращения, дискомфорта или недоверия. Это подтверждается так же и тем, что в настоящее время активно развивается трихология, косметология, лазерные технологии удаления нежелательных волос, в которых, в основном, заинтересованы женщины.

Выводы

Волосы играют важную социальную роль в жизни общества. Их потеря или избыток оказывают негативное влияние на социальную жизнь человека. Особенно требовательны к внешнему виду волос оказались мужчины.

СПИСОК ИСПОЛЬЗОВАННОЙ ЛИТЕРАТУРЫ

1. Hudson, Monica & Hunter. Hair and outrospection in the nonprofit and public sectors / Hudson, Monica & Hunter, Keith & Rogers, Pier // Qualitative Research Journal. – 2017. – Vol. 17, № 2. – P. 124–139.
2. Sociological study examines the importance of hair. [Электронный ресурс] // EurekAlert. – Режим доступа: <https://www.eurekalert.org/news-releases/570450>. – Дата доступа: 20.02.2023.

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PROGRESSION OF VARIOUS TREATMENT METHODS OF LEPROSY IN INDIA

Introduction

Leprosy is a chronic granulomatous disease caused by Mycobacterium leprae, primarily affecting the peripheral nerves and skin [1]. Worldwide, about 720 000 new cases of leprosy are reported each year, and about 2 million people have leprosy related disabilities. Six major

endemic countries (India, Brazil, Myanmar, Madagascar, Nepal, and Mozambique) account for 88% of all new cases [1,2]. *M. leprae* is discharged from the nasal mucosa of people with untreated lepromatous leprosy, and spreads, via the recipient's nasal mucosa, to infect their skin and nerves. It is a hardy organism and has been shown to survive outside human hosts in India for many months [2,3]. Risk factors for infection, include household contact with a person with leprosy [3]. The clinical picture depends on the individual's immune response to *M. leprae*. Nerve damage may occur before, during, or after treatment. Some people have no nerve damage, while others develop anesthesia of the hands and feet, which puts them at risk of developing neuropathic injury. Weakness and paralysis of the small muscles of the hands, feet, and eyes puts people at risk of developing deformity and contractures. Loss of the fingers and toes is caused by to repeated injury in a weak, anesthetic limb. These visible deformities cause stigmatisation [3, 4].

Goal

To study progression of various treatment methods of leprosy in India.

Research material and methods

The analysis and generalization of scientific literature on this topic from PubMed, National library of medicine and other scientific articles were done. The search terms were 'leprosy, *Mycobacterium leprae*, India, treatment of leprosy, multi-drug therapy, review, treatment'.

The results of the research and their discussion

When considered about the global epidemiology multi drug therapy has been the most cost effective and efficient weapon in the leprosy control programs [1]. Starting from 1985, the number of leprosy cases globally has decreased from more than 10 million to less than 0.2 million and more than 14.5 million patients have been cured of leprosy with the use of MDT [2]. By the end of year 2000 MDT became the winner in the battle against the leprosy, with the elimination of leprosy at the global level. By 2008, out of 122 countries 119 endemic countries reached the goal of elimination of leprosy with less than one case per 10,000 population [3].

When considered about the scenario in India MDT was added to the National Leprosy Eradication Program of India in 1982 [1]. By 1989, out of 201 highly endemic districts 45 districts with prevalence rate > 50/10,000 were covered by MDT. In 1992 all districts of India were covered [2]. MDT importance can be measured from the fact that before the introduction of MDT, the number of registered leprosy cases in India was 3.9 million and by 1986 this number has fell to 3.4 million [3]. By 2008 it has reduced to 87,228. So the prevalence rate has decreased from 5.7 cases per 10,000 populations in 1983 to 0.74 per 10,000 in 2008. Since the considering of elimination of leprosy as a public health problem, the Annual New Case Detection Rate has reduced by 50 %. By 2009, 32 States have gain the level of elimination and Bihar has a rate between 1 and 2 per 10,000 population. Two States Chhattisgarh and Dadra and Nagar Haveli have a rate more than 2.30 and 2.21 per 10,000 population, respectively [1]. current MDT of 12 months for multibacillary leprosy and six months for paucibacillary leprosy has shown good response but still problems like poor compliance due to long duration of the current MDT and threat of development of rifampicin-resistant *leprae* bacilli exists [4].

The starting of treatments for leprosy in India is dated back to 600 BC. According to 'Sushruta Samhita', "Chaulmoogra oil" also called *Hydnocarpus* oil has been used to treat leprosy in India. It is extracted from the nut of a tree native to India and is administered as an ointment, by injection or by mouth [1]. In 1870, another remedy called "gurjon oil" was used by Surgeon Dougall of the Madras Medical Service for treatment of leprosy. Gurjon oil was extracted from the wood of a tree native to Andaman and Nicobar Islands and was rubbed on the skin. Although there is little evidence to support the effectiveness of chaulmoogra oil, it was continued to use as a treatment of choice for leprosy in India until 1946 [2].

Then came the introduction of dapsone as a treatment and changed the face of leprosy drastically. But dapsone resistance started to emerge in the 1960. As increase in dapsone resistance world widely occurred in *M. leprae* in 1970, dapsone monotherapy could not no longer used as a treatment for leprosy [3].

The 1970 discovery of various drugs including clofazimine and rifampicin for treatment of leprosy occurred. By late 1970, many countries including India realized the importance of combined therapy for leprosy. They included it in the national leprosy program in 1982 [4].

The use of vaccine in primary prevention of leprosy is very limited because various trials have shown variable protective efficacy. Trials of other vaccines based on cultivable mycobacteria for example Indian Cancer Research Centre mycobacterium 'W' and *M. habana* as immunoprophylactic agents have not able to show favorable results. So with these results, MDT remains the only effective therapy available for leprosy. But vaccine therapy in combination with MDT can be used for the treatment of highly bacilliferous cases with Erythema Nodosum Leprosum lesions to clear the dead bacilli from the tissues, to help in preventing any relapses of leprosy [4].

Under the Disability Prevention and Medical Rehabilitation plan, a number of hospitals have been identified in India to provide reconstructive surgeries to the disabled patients. The cases will be first screened by the medical officer in a Primary Health Centre and also by a Dermatologist or a Medical Specialist at a district hospital and assess the suitability of any surgeries. In the Reconstructive surgery unit of a tertiary level hospital, the surgeon and physiotherapy technician would examine the case and decide who would benefit from the surgeries and who would not [1].

Also there is a provision of cash encouragement of Rs. 5000/- paid to patients below the poverty line for major Reconstructive surgeries. But lack of a team of specialists from orthopedics, plastic surgery, physical medical rehabilitation and ophthalmology specialties at each of these hospitals was seen in the Disability Prevention and Medical Rehabilitation plan. This issue is need to be addressed to ensure effective delivery of a quality service [3].

Conclusions

Earliest description of leprosy in the world comes from India around 600BC and since then various treatment methods were used to reduce morbidity, prevent complications and eradicate the disease. Although many treatment methods have not shown encouraging results, since the introduction of MDT, there is a fall in new case detection in India. But poor compliance, due to the low socioeconomic status, gender differences, residence and long duration of treatment, the minor and serious known side-effects of MDT drugs has caused major drawbacks in reducing the morbidity in India. Continuous monitoring of drug intake by the patients, and advice on self-care to the patients, the counseling of the patients by the healthcare staff in relation to the disease and its management such as course of the disease, transmissibility of infection, side-effects of the drugs and self-care advice at the time of registration, during treatment and discharge from the treatment was deemed necessary to achieve better results.

LITERATURE

1. WHO (September 2011). «Leprosy update, 2011» // Weekly Epidemiological Record. – 2011. – Vol. 36. – P. 389–400.
2. Sengupta, U. Elimination of Leprosy in India: An Analysis / Utpal Sengupta // Indian Journal of Dermatology, Venereology and Leprology. – 2009. – Vol. 84. – P. 131–136.
3. Barrett, R. Medical Anthropology: Leprosy on the Ganges. Conformity and Conflict: Readings in Cultural Anthropology, edited by James S. and David W. McCurdy, 14th ed. / Ron Barrett // Pearson. – 2012. – P. 351–358.
- 4 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 T. [et al.] // PLOS Neglected Tropical Diseases. – 2011. – Vol. 11. – doi:10.1371/journal.pntd.0005192. – Via EBSCOhost.