WORKSHOP 4: LEPROSY CONTROL, EVALUATION AND INTEGRATION

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The strategy for leprosy control continues to be based on secondary prevention, that is, early detection and chemotherapy for all cases of leprosy. Today, the most effective chemotherapy is multidrug therapy (MDT). Already 40% of the world's 5 million registered leprosy cases have benefited from its introduction. There is urgent need to speed up MDT implementation to make it accessible to at least 80% of the estimated cases. This should be done in a phased, time-bound, target-oriented program as part of national health plans. To achieve this target of MDT implementation, in many circumstances, the advantages of integration within a well-functioning health service should be recognized. Primary Health Care can provide a comprehensive, continuous and adequate leprosy service, with specialized training, technical support, referral services, treatment delivery, supervision and evaluation. Many issues pertinent to leprosy control have been discussed in other workshops, and hence are not included in this report (epidemiology, health education, etc.). The recommendations of the Sixth WHO Expert Committee on Leprosy were generally endorsed, taking special note of the definitions of "case of leprosy" and "prevalence rate" in operational terms.

There was full discussion of a number of important operational points, and the recommendations accepted by the group were:

1. MDT be implemented as a country-wide, community-based service. Reports received suggest that with proper implementation MDT can not only reduce the case load, but can also constitute an important factor in the decline of leprosy.

2. The effectiveness of MDT suggests that no deviation from the present recommended paucibacillary (PB) and multibacillary (MB) regimens (adapted as necessary for operational reasons) is needed. Reports indicate that acceptance and compliance are good; therapeutic problems during and after therapy, including reactive episodes, relapses and persistence of active lesions, do not hamper program implementation. On the other hand, injudicious use of MDT without proper supervision or correct combinations must be avoided because of the risk of drug resistance. The use of thioamides is not recommended under field conditions.

3. The suggestion by the Sixth WHO Expert Committee that all smear-positive patients be treated as MB was endorsed. The

* Dr. M. Christian, originally designated as Chairman of this Workshop, carried out its organization and preparation until his untimely death in June 1988.

need for improving the quality of skin smears was recognized. It was recommended that in MB cases smears should be taken at least once at the start of MDT and again upon completion of treatment. Although in some circumstances it may be necessary to start MDT based on clinical judgment alone, efforts must be made to carry out a bacteriological examination as soon as possible.

4. The operational problems of continuing surveillance after stopping chemotherapy and continuing treatment in MB cases after 2 years if they are still positive were recognized. At the moment, however, there is insufficient evidence to deviate from the original WHO guidelines.

5. Skills in the prevention and management of disability should be strengthened. The training of appropriate staff in the recognition and treatment of reactive episodes, involving nerves and eyes, with steroids in the field is essential. Adequate referral facilities for all cases, as well as the correction and care of established deformity, needs the urgent attention it deserves.

6. The cost effectiveness of different types of surveys for case detection needs further evaluation. It is suggested that contact examinations be done systematically, at least once at the registration of a new case. The importance of health education in case detection was emphasized.

7. Greater attention has to be paid to monitoring and evaluation. There is an urgent need to apply the established indicators and to develop new ones to help program managers in decision making. Such monitoring and evaluation are not only needed at every level of program implementation but should include all the components of a leprosy control program. Management information systems should be designed with this in mind in order to improve the effectiveness of the program implementation.

8. The rapidly increasing urban population, slums, shanty towns and the related leprosy problems threaten all the achievements of leprosy control to date. Although in both urban and rural areas the methodology is similar, urban leprosy control has to be recognized as a specialized area, varied and complex, calling for an imaginative and an unconventional approach within the framework of urban health care systems. Program managers should recognize that involvement of all medical personnel, the community, the use of health education, selective surveys and emphasis on rehabilitation are needed.

9. Multidisciplinary, action-oriented, health-systems research will go a long way in clarifying operational problems. Research at selected regional centers is needed to evaluate the impact of MDT. Operational research in key result areas needs to be carried out to improve efficiency of the program.

10. Tests for the detection of subclinical infection, when applicable in the field, will greatly assist in the control of leprosy. The results of vaccine trials in progress are not yet available. Until the availability of a field-tested vaccine, the strategy for leprosy control will have to rely on secondary prevention.

11. The rapidly increasing prevalence of the human immunodeficiency virus (HIV) infection and the increasing concern of governments should not result in lowering the priority given to leprosy control. The relationship between HIV infection and leprosy needs investigation. Suitable precautions should be taken by leprosy control staff dealing with patients possibly infected with HIV, hepatitis B, and other such infections.

12. The assistance already given by non-governmental organizations (NGOs) and contributing agencies was fully recognized. In view of the need for the governments of endemic countries to increase MDT coverage, even greater efforts are called for to mobilize resources. Governments should strengthen their cooperation with the NGOs and coordinate their activities, within the national health plans, so that no leprosy patient is denied MDT for want of resources.

In conclusion, there is renewed optimism that with increased MDT coverage, integration, mobilization of resources, human resources development, training, increased participation by the NGOs, enhanced monitoring, evaluation and health systems research, leprosy control will become a reality.