

WORKSHOP 11: GUIDELINES FOR LEPROSY CONTROL MANAGERS

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The current multidrug therapy (MDT) regimens for multibacillary (MB) and paucibacillary (PB) leprosy are appropriate for routine field conditions. Experience has shown that they are effective, safe and operationally feasible. They are acceptable to patients and field staff.

Regular and complete treatment with MDT of all known leprosy cases and early diagnosed new cases is the most cost-effective element of the strategy to achieve leprosy control objectives. Therefore the establishment of early case finding and treatment with MDT remains the top priority for leprosy control programs. The diagnosis can be made with simple techniques in the vast majority of cases and there are only two groups within the classification, each with its own standardized treatment which can be safely applied under field conditions.

In April 1993 the total number of leprosy cases was estimated at 3.1 million in 90 endemic countries of whom 2.3 million were registered for chemotherapy. The MDT coverage varies widely between the leprosy endemic countries and within individual countries. The fall in MDT coverage from 55% in 1990 to 48% in 1993 indicates that it has become more difficult to reach the remaining patients. The reasons for this failure to consolidate MDT implementation are multiple and vary from country to country and also within individual countries. The major explanations are: lack of political

commitment, competition with other health problems in the countries, weak management capacities and organizational problems of the health services, inadequate training in leprosy of general health staff, lack of resources, lack of an appropriate plan of action and/or an operational manual, poor referral facilities and the rigid and demanding requirements for the introduction of MDT which were identified in the early 1980s.

Far too many leprosy patients do not yet have access to the benefits of MDT. Successful introduction of MDT so far has been achieved mainly in those countries or areas where conditions are relatively "easy" for the implementation of MDT: countries or regions with a good infrastructure or with sufficient numbers of well-trained health workers, a good coverage with health services, or with a pre-existing, well-managed leprosy control program based on dapsone monotherapy, adequate financial resources, etc.

A lot has to be done in order to achieve and to sustain full MDT coverage. Unless the obstacles are really unsurmountable, such as war situations, all known cases must be submitted to MDT within the next 3 to 5 years. We have to rationalize the leprosy control strategy in order to achieve this goal and to maintain adequate and appropriate services. The MDT coverage of registered cases is often taken as the only measure for progress in MDT implementation. This is

wrong. We must also look at the coverage of the real case load and the cure rate (MDT completion).

WHO and ILEP publications have called for increasing attention to the basic rather than the optimal requirements to enable program managers to achieve full MDT coverage. Further progress has been made with the acceptance of the essential indicators which should reduce the data requirements, the recent publication and the distribution of the ILEP document on guidelines for program managers for the prevention of disability and the introduction of the WHO modules on training of program managers in leprosy control.

Even more simplification and flexibility will be required for universal MDT implementation and to sustain it under low endemic conditions. Creative local approaches, sometimes specific for individual patients, will have to be developed by local health staff.

Recommendations for further simplification of guidelines for program managers

Health education, awareness and stigma. Managers should encourage the widespread use of the mass media for promoting early case presentation. Groups in the community, particularly patients and ex-patients, can be utilized to support leprosy control services, promote case-finding, case-holding and the prevention of disability. Despite this and the widespread use of MDT, stigma is still a major problem in many areas and is even a problem within the health and medical professions. Integration of the leprosy services, more effective health education to the population and improvement of the socioeconomic status of patients, particularly those with disability, will assist in diminishing stigma.

Case-finding, diagnosis and classification. Passive case-finding is the mainstay of new patient detection. This voluntary reporting requires the support of health education and awareness programs, especially using mass media. Good quality services, presented in a user-friendly manner, should promote early case detection. Furthermore, contact examination should be prompt and should be stimulated by the newly diag-

nosed leprosy patient. It does not have to be done repeatedly.

Diagnosis should be made at the peripheral health unit and must result in the immediate start of MDT. Only the PB/MB classification should be used in the field. The hoped-for adoption of a single agreed drug regimen will enable classification in the field to finally be abandoned. The presence of slit-skin smear services are not a prerequisite for the implementation of MDT and these services do not need to be developed at the peripheral level. While there is still a role for skin-smear microscopy at the referral center level, histopathology services and the lepromin test have no relevance in routine leprosy control.

Case-holding. Services to patients must be flexible and should encourage regularity of attendance. The fixed drug treatment regimens of 6 and 24 months should be adopted forthwith. Supervised intake of the once monthly pulse is still advocated, but this does not necessarily require fixed monthly clinic days. When necessary, patients or their relatives can be provided several months of MDT. The use of blister packs is indicated in these circumstances.

In view of the low relapse rates, no active post-cure surveillance is indicated. Following adequate health education, it is the responsibility of the patient to report promptly any adverse developments including nerve function loss.

Referral services, prevention of disabilities (POD) and rehabilitation. Effective POD is not only for the benefit of the patients, but also for the credibility of the program. Increased credibility results in earlier self reporting of new cases and in better treatment compliance. As such, POD will contribute to the elimination of the disease. Secondary referral services must be available. POD activities should be an integral part of the job description of the primary worker at the peripheral health unit. The simplest possible, reliable method to identify new nerve function loss should be used, including asking the patient; and a quick VMT/ST should be able to be performed by all health workers dealing with patients. The earliest interventions for POD (reactions and neuritis) are the priority but, where circumstances permit, rehabilitation ser-

vices should be made available, preferably as a part of the national rehabilitation services for the disabled, from whatever cause.

Integration and combination. Vertical programs conduct their clinics only periodically (monthly) and are often associated with the stigma of leprosy. As such they hinder an optimal relationship between the leprosy services and the community. Poor accessibility and acceptability result in delayed case detection and reduced compliance with chemotherapy. It is obvious that the general health services, which usually are closer to the community, permanently accessible and more acceptable, must be involved in the treatment and retrieval of patients. The peripheral general health services staff should be aware of, should feel responsible for and should be involved in the management of leprosy. Integration does not mean that specialized services disappear, but rather that they should be available at a higher level, possibly in conjunction with other referral services.

While supporting technical expertise at national, regional and district level is needed, a large work force of peripherally based technical staff is not likely to be cost-effective, especially in low prevalence areas. Combination with other vertical programs may, in these circumstances, be more cost-effective and the chosen combination (TB, TB and chest diseases, tropical dermatoses, prevention of blindness, etc.) will depend on the local situation.

Training. Multipurpose health workers should receive training in leprosy in their

basic training curriculum. In addition, those posted in the field should have adequate, appropriate training followed by post-training supervision suitable for their job description. All of this training should conform to nationally agreed curricula. Training, including training in management, implies that the trainees are appropriately posted and can carry out the duties expected of them. Training of district level managers also should include the provision of more patient-oriented services and in dealing effectively with the media.

Motivation of staff. Maintenance of high quality work performance is often difficult in the field. Job satisfaction is provided by enabling staff to do the work they are trained for, by providing the necessary facilities and drugs, and by having supportive, regular supervision. Feedback to peripheral staff on their performance and the progress of the program will promote the feeling of direct involvement. Financial security does not necessarily require special incentives but a realistic salary and allowances should be paid promptly. A career structure is a necessity.

Monitoring and evaluation. Despite the general adoption of the six essential indicators of leprosy control, there should be no prerequisite that all or any of these indicators are in place prior to the implementation of MDT. The most essential indicators which should be available are the number of patients newly diagnosed and the proportion of these patients who are cured.