Letter to the Editor

INTEGRATION OF LEPROSY SERVICES

Editor

Your special issue on integration does not address how general health services are to be strengthened so that early recognition of a disease in the skin and management of disability is ensured.

The dermatological approach represented by the International Foundation for Dermatology, about which I first wrote in Leprosy Review in 1990, was also identified in the ILEP Workshop (1997): ‘Sustaining Leprosy Related Activities: Guidelines for Responding to Change’. It does exactly focus on answering this question:

1. Dermatologists with a public health orientation are identified to act as programme co-ordinators for countries or regions. There are many of these worldwide.
2. Where no such dermatologists exist as in Africa, a Regional Dermatology Training School selects Allied Health Professionals for a 2-year training in public health dermatology integrated with sexually transmitted infections and leprosy.1-3 So far, 100 individuals have been so trained and are active in 12 countries.
3. The focus for strengthening the General Health Services must be the Primary Health Centre. Knowledge there of common diseases will ensure that patients visit the centre.
   Mostly, the knowledge must address scabies, pyoderma, eczema and fungal infections. Currently, these fall within the third to fifth commonest reason why a patient requires help from health centres. If the dermatological approach is not activated in such centres there is approximately 40% mismanagement and such mismanagement is costly to the patient.4,5 Ineffective remedies are an economic burden on every community.
   The solution requires a 1-day training programme and the issuing of supporting booklets as well as easy access to expertise. A picture on the wall or in the handbook and a package of referral letters on the desk that mention leprosy will ensure that this disease is not forgotten.
4. Building up an exchange of knowledge with traditional systems of health also strengthens utilisation of general health services. Patients can also be cross referred. It need not be a one-way process. The Traditional healer is held with great respect in many communities and certain systems such as Ayurveda in India or Chinese traditional medicine in China deserve respect.
5. Self help is the basis of the management of disability. Currently, dermatology advocates it very much along the lines of Benbow and Tamiru.6 None of the papers in your special issue refer to this report, which is all about promoting self help and the management of leprosy in the context of the environment of the patient within the general health services. It identifies skin care as desirable in general rather than specifically for leprosy. While dermatologists will not focus on a single disease such as leprosy, Benbow and Tamiru’s guidelines will be followed, and I find it strange that they are not referenced by any of the authors of your special issue. The other Elimination Alliance concerned with lymphatic filariasis (GAELF) has as its partners the International Foundation for Dermatology and the International Skin Care Nursing Group. The programme of skin care suggested for this alliance has universal value appropriate for lymphoedema due to lymphatic filariasis but equally
appropriate for leprosy, the skin complications of AIDS and for tropical ulcer. It focuses on washing, emollients, which may be traditional if appropriate, and on posture and a full range of movement.

I cannot understand why dermatology has such a low rating by so many of those concerned with leprosy. Why, when Paul Saunderson asked the members of his organization, ALM, to list objectives, did only two express the wish to see a link with dermatology? Why cannot they read Xiang-Sheng et al.,7 or Chen Shumin et al.8 and see how a country with the largest population has managed and is still managing leprosy through a programme that is essentially dermatological. It is not irrelevant that in that country Western practice and Chinese traditional medicine are more nearly integrated than in any other.

Ideally, each region or country will concentrate on building gold standards and evidence based practice in expert centres (tertiary care). Here it works best if there is a full time leprosy expert working as part of a team able to call on colleagues with other specialist interests. Ideally, every region will also have a Department of Rehabilitative Medicine, which will identify someone to take a special interest in leprosy and work with a dermatology team as well as with others experts in other problems requiring physiotherapy, occupational therapy and community medicine. Thus the horizontal approach is activated in the general health services and it remains vertical in the tertiary centre. By working with a multidisciplinary team, someone specializing in leprosy oscillates between the vertical and the horizontal. Leprosy gains by having a focussed carer acting as a magnet for all appropriate expertise in the wider team.

Emeritus Professor of Dermatology
Oxford Brookes University

TERENCE J. RYAN

References