Lepr Rev (2010) **81,** 336–339

Prospects for sustaining leprosy control in Uganda

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Accepted for publication 11 October 2010

Introduction

The Uganda Ministry of Health launched a National Tuberculosis and Leprosy Programme (NTLP) in 1990. The programme functions at three levels: Central, Zonal (intermediate) and District. The first 4 years of NTLP saw the change from Dapsone monotherapy and several Rifampicin and Clofazimine containing treatment regimens to World Health Organization (WHO) recommended Multidrug Therapy (MDT). National coverage with MDT was achieved in 1994.

At the time of starting NTLP there were over 2000 leprosy patients on treatment and following introduction of MDT the numbers of registered cases declined dramatically while the number and rate of new cases notified especially the Multibacillary (MB) type showed a more gradual decline (see Figure 1).

The country achieved the target of elimination of leprosy in 2004. In 2006 Uganda adopted the WHO Strategy for further reducing the burden of leprosy and sustaining leprosy control services.[1] According to the strategy, quality is one of the essential components of an effective programme. The quality and coverage of a programme are key determinants of its sustainability.

This paper presents a review of the performance of the Uganda National Leprosy Control Programme in terms of quality services as defined in the Operational Guidelines of the Enhanced Strategy[2] and suggests steps to take in order to ensure sustainability of quality leprosy control services in the country.

QUALITY LEPROSY SERVICE IN UGANDA

Quality leprosy services in Uganda, as in other settings, should be accessible to all who need them, patient centred and addressing each aspect of case management, based on solid scientific evidence.[2] In effect this means that the country should continue acknowledging that leprosy patients have the right to have timely and appropriate treatment, privacy and confidentiality like other nationals; the people affected should be involved at appropriate levels in decisions regarding the services provided for them. The country should have in

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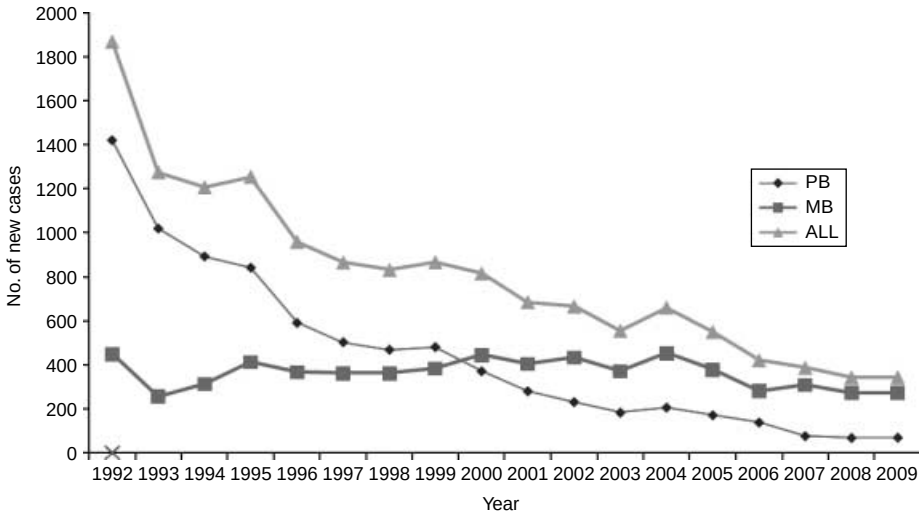

Figure 1. Trend of new leprosy case detection (1992–2009) in NTLP, Uganda.

place: a) strategies to ensure timely diagnosis of leprosy and provision of appropriate counselling of the cases found; b) a system for recording of essential individual information about cases detected that feeds into a national monitoring system; c) mechanisms for procuring and providing free MDT within easy access to the patients; and d) a referral system for management of complications, organising interventions for prevention of disabilities (POD) and rehabilitation.

THE LEPROSY CONTROL STATUS IN UGANDA (2006 – 2010) PLANNING PERIOD

Policy

Leprosy was included in the Health Sector Strategic Plans (HSSP) of the Ministry of Health for 2006–2010.[3] In the plan leprosy control is part of a combined Tuberculosis (TB)/Leprosy Programme. The combined programme is threatened by heavy dependence on donor funding, and the leprosy component having to compete for resources with a bigger burden partner. Leprosy control services are integrated into the general health services but implementation is still dependent on expertise acquired within the more vertical approach in the past. National operational guidelines have been revised and streamlined to the Global Enhanced Strategy.[2] Leprosy is included in a desk-aide provided by the Ministry of Health to assist Health Centre service providers in identifying common conditions. According to the revised national guidelines, district and zonal level supervisors are expected to validate the diagnosis and disability status of new leprosy cases in their areas.

Involvement of people affected by leprosy

The involvement of affected people and their communities is thus far restricted to aspects of Community Based Rehabilitation. People affected by leprosy are not involved in any other decisions regarding their management.

Programme performance indicators[4]

A total of 1500 new leprosy cases were notified in the period 2006 to 2009 (annual detection ranges from 423 in 2006 to 346 in 2009). About 8% of these new cases were children. The proportion of new cases with visible (Grade 2) disabilities shows an increasing trend from 10% to 19% in 2005 and 2009 respectively. The proportion of Multibacillary (MB) patients, who are at greater risk of developing disabilities, is on the increase.

Management of MDT supplies

Ensuring availability of MDT within easy access of patients is a challenge mainly because of the uneven distribution of the patients. In recent years, rates of MDT completion are showing a declining trend particularly among MB cases.

Recording and reporting

An individual patient's leprosy record card and Unit Leprosy Registers are in use, but lower level health workers regard them as too complicated and only useable after detailed skills training. There is no clear system for reporting complications and prompting referral to the next level.

The referral system

The general health referral system based on health centres, district and regional hospitals does not cover leprosy referral services. There are a number of dermatology officers whose training has a significant leprosy component but they are deployed in less than half of the regional referral hospitals. There is a parallel referral system for leprosy that is still largely dependent on non-government (NGO) health facilities. There is no system for quality assurance of those referral facilities.

Training

Training in leprosy is included in the curricula of medical schools and other pre-service health training institutions but the mode of implementation is entirely dependent on the managers of the various institutions. In service training is mostly organised by a designated National TB/Leprosy Training Centre (also located in an NGO facility). It comprises: a) basic management training in tuberculosis/leprosy for district managers; b) orientation training for health centre staff (the annual intake covers about 100 out of thousands of health centre staff); c) refresher training for district level leprosy control managers; d) information updates provided to groups of district supervisors during quarterly zonal level meetings (all district level supervisors attend). Zonal level managers undergo training at ALERT in Ethiopia in the Course 'Clinical Leprosy and Tropical Dermatology for Physicians.'

WHAT NEEDS TO BE DONE TO ENSURE SUSTAINABILITY

The government, through the national programme has to:

- Remain committed to sustain leprosy control activities as an integral part of general health services, including referral services; that would imply commitment of financial and other resources as well as finding local and international partners.

- Establish a national level focal point in the department of communicable disease control to oversee the mechanisms for monitoring leprosy trends.
- Promote the establishment of national associations or interest groups including people affected by leprosy and other stake holders.
- Engage the services of dermatologists.[5]
- Ensure equitable coverage by national health services including special population groups (nomadic, those recovering from prolonged civil war, island populations and those affected by cross-border migration); this makes integration meaningful.
- Invest in aspects of human resource development that are key to sustaining elements of quality leprosy services; this would include maintaining at referral levels competences to respond effectively to referrals from lower levels.
- Develop and disseminate appropriate information and communication materials for people affected by leprosy and their communities.
- Ensure that leprosy is covered by the mainstream Health Management Information System with a minimum of indicators of the leprosy disease burden.
- Promote the dissemination and use of the revised national operational guidelines.
- Revise the leprosy training programme to ensure appropriate pre-service training and task oriented in service training.
- Define a cost effective method for MDT distribution taking advantage of newer communication technologies to ensure access to the patients.

Conclusion

Since leprosy can not yet be considered an eradicable disease,[6] Uganda is facing the challenge of ensuring the sustainability of leprosy control services in order to avoid a reversal of the present trend. The essential actions highlighted in this review are required at a time when resources are scarce. Their implementation will require, in the first place, that the central and local governments and partners remain aware of the responsibility to afford the present and future people affected by leprosy their basic rights to quality care.

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