potential role of dermatologists and dermatological services in developing and sustaining the leprosy control referral system in resource constrained settings
HERMAN JOSEPH S. KAWUMA
German Leprosy and TB Relief Association, PO Box 3017 Kampala, Uganda

Summary General Health Services that pay due attention to the management of skin conditions are opportune for suspecting and diagnosing early leprosy. In many developing countries, patients with dermatological conditions can only access specialist services in the larger cities and university hospitals; unaffordable costs make the services even less accessible if they can only be provided in the private sector. The high profile of dermatologists in the health services, gives them the opportunity to facilitate the development and implementation of a referral system that includes leprosy. This potential benefit for leprosy control must be initiated by current National Leprosy Programme Managers through establishing formal relationships with the dermatologists and involving them and other partners in the re-designing of leprosy control strategies to keep them in tandem with changing epidemiological patterns, national policies and on-going health sector reforms. The same health service managers should avail of the opportunities from the dermatologists (both in public and private sectors) about the current knowledge on the management and control of leprosy.

Introduction

Many countries are now faced with the challenges of sustaining leprosy control services under the circumstances of diminished disease burden and in the face of ongoing health sector reforms.1,2 The World Health Organization (WHO) and members of the International Federation of Anti-Leprosy Associations (ILEP) have responded by developing a global strategy for further reducing the burden of leprosy and sustaining the activities.2 More recently, a set of operational guidelines has been produced, which should be used as a template for developing national guidelines.3

Country programmes remain challenged with decisions of who should implement the proposed strategies. Hitherto, many countries had specialized leprosy programmes right from the lowest implementation levels, through supervision at district and regional levels to national levels. It was also commonplace to have medical doctors specialized as leprologists.
These and other aspects of leprosy control programmes will no longer be cost effective in the future. New strategies have to be developed for ensuring quality care for the leprosy cases that will continue to be detected. The backbone of the strategies is thought to be integration of leprosy control activities into the general health services.3–6

Dermatological services, although considered as one option for managing integrated leprosy services, have been deemed inappropriate for taking over the responsibility for the control of leprosy because they concentrate mainly on curative treatment.5 That notwithstanding, dermatologists will continue to play a pivotal role in sustaining leprosy control services.

Relative distribution of dermatologists and the leprosy burden

The relatively few dermatologists in developing countries are mainly concentrated in cities and universities.5 Dermatologists in the public sector are usually so occupied with administrative issues that they are left with lesser time to practice their profession. The services of the ones in the private sector are usually not affordable. In the particular case of Africa, there are not even enough dermatology books to consult.8

Like dermatologists, leprosy cases are unevenly distributed, although the concentration of the latter follows a different pattern.

Early leprosy would most appropriately be diagnosed in a general health care setting that pays due attention to skin conditions. In Uganda (where practically all dermatologists are located in large towns), about 3% only of new leprosy cases are detected in urban settings; an even lower proportion are actually residents of urban or peri-urban areas.9 Extremely few of them are either diagnosed by a dermatologist or ever get to see one throughout the course of their treatment.

Leprosy control services

Leprosy control services usually refer to those dedicated to suspicion, diagnosis, medical management and rehabilitation of people affected by leprosy. They may take the form of fully or partially integrated services at different levels of the health system: national, regional, district or in implementing health units.

Front line implementation of multidrug therapy (MDT) services is often the responsibility of general health workers supported by a supervisory system made up of general purpose or specialized supervisors.

Basic dermatological services at primary health care (PHC) level

These could be defined as the services comprising the diagnosis and management of common skin problems and channeling the more complicated ones into an appropriate referral system. Leprosy can be accommodated into the system either as one of the common skin conditions (if it is present in the area) or one covered by the referral service (if it is rare). It is usually not doctors and definitely not specialists who implement these and other PHC functions. They are commonly provided by multipurpose health workers with appropriate skills. The efficiency of such health workers is dependent on a number of factors like the level of training and the availability of effective support supervision.
Dermatology may not be reflected as an entity in national health plans because of its crosscutting nature but can be implied as part of practically all aspects of any basic health care package. In contrast, leprosy is a stand-alone item in national health plans but at the same time remains listed among the ‘neglected tropical diseases’. One of the essential criteria for inclusion in the latter group is having low profile and status in public health priorities.

Since health policies of many resource constrained countries require that strategies for control of communicable diseases be integrated into PHC services, it is quite logical to make leprosy control part and parcel of dermatological services which (however scanty they may be), are already integrated into the PHC services.

**Role of dermatologists**

In the above context, the few dermatologists, given their relatively high profile in the health service hierarchy, would have the following opportunities to promote sustainable leprosy control services:

- Having access to decision making processes regarding the content of curricula of Medical Schools and other pre-service training institutions.
- Being involved in the implementation of various training programmes.
- Having easy access to the normal cross-referral (horizontal) system involving other specialties like General and Orthopedic Surgery and Ophthalmology.
- Making better use of the vertical referral system already under development in the country; this could involve, for example, the engagement of Dermatology Clinical Officers (paramedical specialists) to support the basic services at Regional level. The training of Dermatology Clinical Officers offers significant amounts of time to leprosy. 11

Through taking advantage of those and other opportunities, the dermatologists would carry the responsibility to ensure that leprosy cases identified along the way receive good quality care. In addition they would be made more alert to their duty to continue the search for solutions to the many unanswered problems posed by dermatology in general and leprosy in particular. 12

**Role of National Leprosy Programme managers**

Even in countries where dermatologists are not yet in any formal relationship with the National Leprosy Control Programme, they have the potential to form an essential component of the referral system for leprosy.

In addition to formalizing that relationship, the National Managers have the responsibility to get their other already existing partners to support the development of dermatological services especially by training some more dermatologists and Dermatology Clinical Officers or their equivalent. In this way, both the national managers and their partners would be responding appropriately to the main objectives of the Global Leprosy Control Strategy. It may be quite reasonable to take the approach of encouraging present day specialists in Medicine and even leprosy alone to study dermatology. 11
National Programmes should ensure that the few dermatologists (whether in the public or private sector) remain well versed with trends in the leprosy control field not only for purposes of perfecting their own practices but also for developing and leading the dermatological services’ referral system with leprosy as an integral part.

References

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