EDITORIAL

Reflections on Global Forum on Leprosy Control

H. JOSEPH KAWUMA
Medical Adviser, German Leprosy &TB Relief Association, PO Box 3017 Kampala, Uganda

At the time of publishing the Global Strategy to Further Reduce the Leprosy Burden, it was envisaged that more detailed operational guidelines would be published to ‘enable countries to develop their own country-specific strategies and plans of action’. The plan was turned into reality (albeit later than anticipated) through a Global Forum on Leprosy Control that met in the University of Aberdeen, Scotland (UK) between 18th and 20th April 2006. The over 500 years old university (one of the oldest ones in the UK), through its Institute of Medical Sciences, has earned a reputation as a pioneer of leprosy research.

The meeting brought together the National Leprosy Control Programme Managers of the top leprosy endemic countries of the world (including India, Brazil, Myanmar, Indonesia, Madagascar, Democratic Republic of Congo, United Republic of Tanzania among others), members of WHO’s Technical Advisory Group on Leprosy Control, representatives of the Technical Committee of the International Federation of Leprosy Organizations (ILEP), Staff of the WHO Global Leprosy Programme, and several other leprosy experts.

The objective of the Forum was to discuss and agree on the technical contents of a proposed set of Operational Guidelines for implementation of the Global strategy for Leprosy Control 2006–2010. The various national leprosy control programmes would use the guidelines as a basis for developing country specific strategies and guidelines.

In line with the goal of the Global Strategy, the discussions and resulting guidelines emphasized measures to further reduce the burden of leprosy as well as providing access to quality leprosy control services within integrated health services.

While it is expected that the complete document will be finalized and published later in the year, it is important to put on record some of the important issues debated by the Forum before arriving at consensus on the technical content of the Guidelines. This list (not at all exhaustive), which should serve as an illustration of the background against which various decisions were made, includes:

- The lack, at the moment, of a comprehensive way to define the leprosy burden without deviating from generally accepted criteria for defining disease burden.
- Having to agree on interventions and monitoring tools for a setting beyond the Elimination Strategy while there are indeed countries that had not yet achieved the elimination target by the time of the meeting, and others that considered extending the target to sub-national levels.
- While the intended provision of quality services for diagnosis and treatment through an integrated system assumes that the most peripheral services would be provided by staff of
the general health services, the discussions brought to light the wide disparity in the health services designs and coverage in the different countries; there was no universally accepted definition of a peripheral health worker.

- A lot of barriers to early case detection surround patients and communities but apparently many Health Service Providers (including would be providers of referral services), are ‘scared’ of contracting leprosy and may not be relied upon for fighting fear and prejudice among the general public.

- Whereas skin smears of reasonable quality cannot be ensured in many programmes, their potential value in the diagnosis of early MB cases and in the investigation of relapses was appreciated; it was deemed unrealistic to think that all staff and health units performing sputum smear microscopy for TB would be able to participate in leprosy skin smear services.

- Leprosy patients should be the most important stakeholders in the Health Service relating to them (at least they should be regarded as equal partners), but the discussions illustrated a lack of trust in the ability of patients to reliably handle affairs that are intimate to them, e.g. their own treatment. Not enough attention seems to be paid to the failure of health service providers to equip the patients with sufficient knowledge and skills to address their own health care needs.

- Concerns over guidelines for the management of multibacillary (MB) patients found with a BI of 4 or more dominated discussions on the importance of adhering to fixed-duration treatment under programme conditions, given the scarcity of quality skin smear services and the implications of sending out non-specific instructions to the most peripheral health service providers.

- The proportion of patients who successfully complete their treatment is included as one of two ‘mandatory’ indicators. Quite some time was spent on sorting out the definition for a related and relevant treatment outcome: ‘defaulting’. Consensus was reached on basing the definition on a total interruption of treatment of more than 3 and 6 months in the case of PB and MB patients, respectively.

- A renewed emphasis on prevention and management of impairments and disabilities while the capacity by peripheral health workers to perform, basic nerve function assessments could not be ensured by some national programme managers.

- One of the most challenging aspects to handle in the integrated setting seems to be of the management of leprosy reactions and acute neuritis; it is hard to determine at which level the differentiation between reversal reaction and ENL as well as their severity would be determined in order to ensure that befitting attention would be paid to the management of this ‘leprosy emergency’.

- This time, the subjects of Prevention of Disability, Rehabilitation, Programme Management and Evaluation, were accorded ‘stand-alone’ status.

- Quality of care has a strong bearing on quality of technical supervision and the effectiveness of the referral system. These needs can only be addressed effectively against a background of adequate training of the general health staff and their technical supervisors. A disproportionately small amount of time was spent on discussing this aspect hoping that the various countries have already well formulated strategies to address their training needs.

It was repeatedly stressed during the 3-day meeting that it is not possible to design a single approach that will apply to the health systems and levels of endemicity of every country (or
even of every region in the country). Once the final version of the Operational Guidelines has been published, the various National Programme Managers and their partners will have to rise to the challenge to produce, widely disseminate and promote the use of local versions. The final benefit of the Aberdeen Forum will only be felt when, as a result of this intervention, people affected by leprosy regardless of where they are or the level of leprosy endemicity in their country will be assured of quality services.

References