NEW DEVELOPMENTS IN ALERT LEPROSY CONTROL PROGRAMME AND THE ISSUES OF INTEGRATION

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ABSTRACT

Introduction of Multidrug Therapy (MDT), as recommended by the WHO in 1982, started in Shoa Administrative Region in the beginning of 1983. From the results of introduction of the new regimens in two districts in the north-eastern part of the region, it can be concluded that implementation of MDT for paucibacillary patients has proven to be successful and feasible. Implementation of MDT in Addis Ababa and two surrounding districts, which started in March 1984, gives so far very promising results. Essential requirements for successful implementation of MDT are discussed. Reasons are given for a continuously high workload, at least during the .first years after the majority of the patients have been released from chemotherapy. Integration of leprosy control with the general medical services should definitely be aimed at; however, integration should be carefully planned and timed. Implementation of MDT requires reorganization and upgrading of virtually all aspects of leprosy control. This asks for specialization as regard planning, organization and evaluation. Another aspect of integration is the combination of tuberculosis and leprosy. The leprosy control services could strengthen the tuberculosis services at the time laboratory services have been established and the initial phase of intensive treatment has been secured.

NEW DEVELOPMENTS

Introduction

The ALERT Leprosy Control Department is responsible for the leprosy control activities in Shoa administrative region. The region has an estimated population of seven million. In July 1983 about 20,000 leprosy patients were on treatment in the region in 294 centres. About 60% of these centres are attached to the general medical services and 40% are leprosy clinics. Almost all clinics are conducted by special leprosy staff.

New developments in the ALER T Leprosy Control Programme

A recent development in the ALERT Leprosy Control Programme has been the introduction of Muitidrug Therapy (MDT) as recommended by a Study Group of the World Health Organization (1).

MDT was first introduced in the north eastern part of the region: in Tegulet & Bulga and Yifat & Timuga districts, also known as the Debre Berhan area (Fig. I). All 65 clinics which exist in the area were included in the programme.

First- results of implementation of MDT: During the first six months of implementation of MDT 1,684 paucibacillary patients were put on MDT. A cohort analysis on the completion of the treatment shows that out of these 1,684 patients 1,501 (89.1%) completed their, course of MDT{Table 1). An analysis of the proportion of the paucibacillary patients in the 65 clinics who completed their course of

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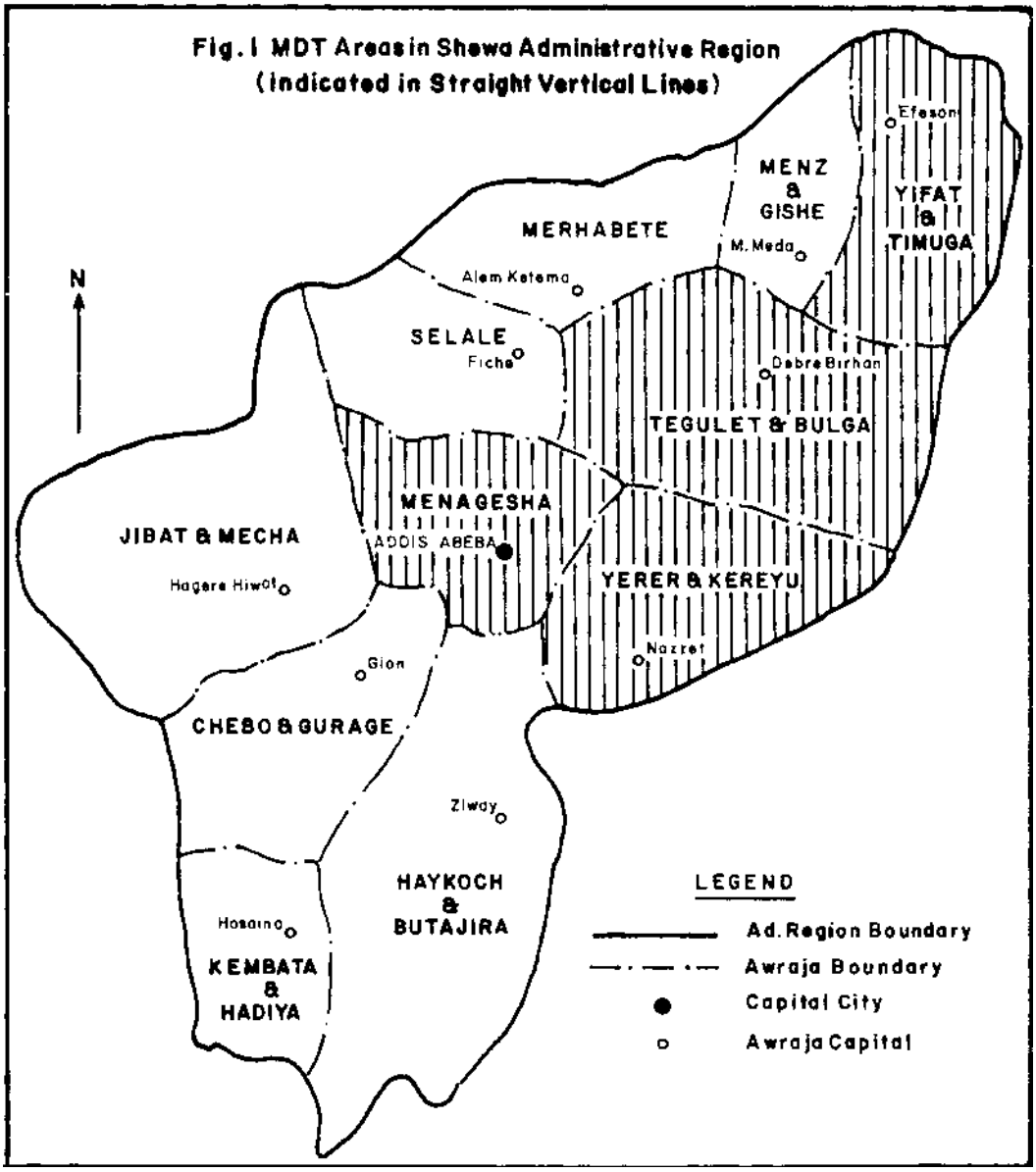
Fig. I MDT Areas in Shewa Administrative Region
(Indicated in Straight Vertical Lines)
N
MERHABETE
MENZ & GISHE
YIFAT & TIMUGA
Efeson
M. Meda
Alem Ketema
SELALE
Fiche
Debre Birhan
TEGULET & BULGA
MENAGESHA
ADDIS ABEBA
JIBAT & MECHA
Hagere Hiwot
YERER & KEREYU
Nazret
Gion
CHESO & GURAGE
Ziway
HAYKOCH & BUTAJIRA
Hosaino
KEMBATA & HADIYA
LEGEND
Ad. Region Boundary
Awraja Boundary
Capital City
Awraja Capital

Table 1. Cohort analysis on completion of treatment of paucibacillary patients

	Tegulet & Bulga		Yifat & Timuga		Tota1	
	Nr. of Pat's	%	Nr. of Pat's	%	Nr. of Pat's	%
Pat's who started MDT	814	100	870	100	1684	100
Pat's who completed MDT	733	90.0	768	88.3	1501	89.1
Pat's whose MDT was discontinued (irregularity of attendance)	64	7.9	93	10.7	157	9.3
Pat's who died	7	0.9	5	0.6	12	0.7
Pat.' s transferred out	10	1.2	4	0.4	14	0.8

(Under first results of implementation of MDT)

Table 2. Percentage of patients who completed treatment in 65 clinics

No. of Clinics	% of Patients
13 clinics	100
20 clinics	91- 99
21 clinics	81- 90
10 clinics	71- 80
1 clinic	61- 70

(Under first results of implementation of MDT)

MDT shows that in 33 clinics between 91 and 100% of the patients completed their course of treatment. In only one clinic, less than 70% of the patients completed their MDT (fable 2). It can therefore be concluded that implementation of MDT for paucibacillary patients has proven to be successful and feasible in the area. As the treatment of the multibacillary patients has to c9ntinue for a period of at least two years, no multibacillary patients so far completed their course of MDT. These patients are clinically and bacteriologically examined every year. The majority of these patients will be released during the fIrst six months of 1985.

In July 1984 1,350 multibacillary patients were on MDT in the area. Also in July 1984, a small group of patients still received dapsone monotherapy. The main reason why they were not put on MDT is that they were not able to attend the clinics every month for the supervised treatment.

In the next few years, about 300-350 new patients would be expected in the area. of these about 500/0 would be paucibacillary and 50% multibacillary patients: This would mean a workload, on the average, about 10 patients on MDT in each clinic.

Expansion of the MDT programme during 1984: In March 1984 implementation of the MDT programme started in Addis Ababa, Menagesha rural and Yerer & Kereyu districts (Fig. 1). In those districts, implementation of the procedures described in the 'Manual for implementation of multidrug therapy in Ethiopia (2) got started including the testing of their operational feasibility.

The manual was prepared in September 1983 by the senior staff of the National Leprosy Control Project in cooperation with a short-term WHO consultant and senior staff of the ALERT Leprosy Control Department. The programme in that Addis Ababa area includes 47 centres. In this area a release from treatment programme of patients who were considered as having received sufficient chemotherapy and need not be given MOT was are carried out prior to the introduction of MDT .

About 2,000 patients who represent 40% of the patients who were on treatment in the area were released from monotherapy.

Since March 1984, about 1,500 patients of which 75% are multibacillary and 25% paucibacillary have started MDT, The first 100 PB patients have already been released from MDT. The attendance of the patients in all clinics has 80 far been above 90%. Compliance studies by way of urine testing on the presence of dapsone give between 83 and 92.5% positivity during the different rounds of supervised treatment.

This is a remarkable increase as compared with previous compliance studies which were carried out at ALERT and which gave positive urine results in only about 60% of the patients who attended the clinics for their treatment.

Future expansion of the multidrug therapy programme: In the districts where the patients still receive dapsone monotherapy, a programme of reorganization of the leprosy control activities started in November 1983.

This programme includes:
- systematic examination of all the patients, including skin smear examinations,
- (re)classification of the patients,
- recording of findings,
- release from treatment of patients who are considered having received sufficient chemotherapy, and
- the introduction of a recording and reporting system which allows for operational and epidemiological evaluation of the leprosy control activities.

At the end of 1985, the MDT programme will be expanded to the two southern districtsof Shoo region, Kembata & Hadiya and Haykoch & Butajira districts.

CONCLUSIONS AND DISCUSSION

In conclusion it can be said that the introduction of the MDT programme in the two areas has 80 far been successful. During the first months of implementation of the programme, we experienced some problems in the Debre Berhan area which were mainly due to the fact that at that time, clear guidelines for the implementation of the programme had not yet been formulated. We have realised that reorganisation and upgrading of virtually all aspects of a leprosy control programme are essential in order to guarantee a proper implementation of the programme. We also learned that the preparation of detailed guidelines as regards the many aspects of the programme are vital in order to guarantee the smooth running of the programme.We are of the opinion that conducting regular workshops with the staff involved in the programme should be part and parcel of the programme. Workshops with our staff are conducted at intervals of about six months. During each workshop, the following programme implementation phase is discussed in detail:

Although the number of leprosy patients who will be on anti leprosy treatment will have been reduced drastically within a few years time, the total workload will continue to be high for quite some years, for the following reasons:

1. A systematic and regular follow-up of the patients after their release from treatment should be carried out. This is necessary in order to determine the relapse rate after MDT. This is of extreme importance, in as far as little is known about the efficacy of the regimens so far.

2. Care for patients with disabilities due to the disease should continue to be given. About one-third of our patients are, to a lesser or a greater extent disabled. These patients will continue to need care.

3. Another aspect which should not be for gotten is that our method of case detection has almost exclusively been passive. About 15% of the patients who have been diagnosed during the last year had already rather severe disabilities at the time of diagnosis. This indicates a delay in detection of patients. The case detection rate among children is high in some parts of Shoa region, which indicates continuous transmission of the disease. An active case detection approach may reveal quite a number of new patients. If they are diagnosed early during the course of the disease the occurrence of severe disabilities can he prevented in many of them.

Furthermore, a more active case detection approach will ultimately have its effects on reducing the transmission of the disease. In some parts 0£ Shoa where the patients are not able to attend the clinic every month due to accessibility problems, the MDT regimens as recommended by WHO cannot be implemented. Supervised treatment at less frequent intervals may be the only practical solution for such patients.

THE ISSUES OF INTEGRATION

The need for integration and its practical constraints

At present general medical staff carry out leprosy control activities in only a few clinicsin Shoa region while leprosy is diagnosed and treated in the general medical centres, ingeneral it is also done by special leprosy staff. In addition there are 126 leprosy clinics inremote areas where a general medical service has not begun yet.

Leprosy control activities need to he carried out for a long period, at least for some decades. In the long run, this epidemiological requirement cannot be achieved with a specialized service only.

Integration of the leprosy control services with the general medical services, with the objective of making the general medical staff responsible for diagnosis and treatment of the patients should definitely be aimed at. However integration of the leprosy services with the general medical services should be to the advantage of the patients. Integration should not have the intention to stop providing services to those patients who live in remote area where, as yet, a general medical service does not exist. If the leprosy clinics in the areas should be closed and patients have to cover longer distances to reach a clinic, this will certainly not be to their advantage.

Multidrug Therapy: A Specialized Field
The World Health Organisation (3) and other international organisations stress that specialized services should be restricted to areas where specialization is essential on technical grounds.

From our experience we have learnt that introduction of MDT, particularly during itsinitial phase, is in fact a specialized field. Specialization in implementation of MDTrefers to planning, organisation and evaluation of the different aspects of the programmewhich require managerial skills. Badly-applied MDT programmes in which the regularity of the drug-intake cannot be guaranteed may result in an unmanageable situation in the future.

Aspects of leprosy control programmes which often need considerable improvementbefore an MDT programme can be introduced are (4):

1. the standard of diagnosis and classification of patients,
2. the laboratory services,
3. the system of drug distribution and the delivery of the drugs to the patients,
4. the compliance of the patients,
5. health education to the patients,
6. the monitoring of clinical and bacteriological improvement of the patients,
7. the supervision of clinics in frequency and quality,
8. the accuracy and reliability of recording and reporting, and .
9. the evualuation of the programme. Reorganisation and upgrading of the leprosy

services are big undertakings, especially in areas where there are many patients. To allocate these responsibilities to the general medical staff, for whom leprosy control work is only one of the many tasks, will not be very realistic if one aims at implementation of the MDT programme on a large scale, as soon as possible and at a satisfactory level.

But at the time the programme has been established and the backlog of old patientshas been properly treated and are not in need of chemotherapy any more, integration of the leprosy services with the general medical services should be given a high priority .However, as long as leprosy appears to be a public health problem, managerial and supervisory staff at national, regional and district level will continue to be needed in an integrated programme.

COMBINATION OF LEPROSY AND TUBERCULOSIS CONTROL

Another aspect of integration is the combination of leprosy and tuberculosis control activities. At present two aspects in the control of tuberculosis in Ethiopia need serious consideration. These are: 1) the laboratory services -both in quality and quantity as regards the examination of sputum by direct microscopy, and 2) the first two months of treatment, during which the patients should receive daily streptomycin injections beside thiacetazone and isoniazide.

With the present structure of the leprosy control services in Shoa region, the responsibility for the treatment of tuberculosis patients after the initial period of intensive treatment could certainly be secured.

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