

## EDITORIAL

*Editorial opinions expressed are those of the writers.*

## Comments on WHO/AFRO's "Post-Elimination" Strategy Paper: A New Bottle with Old Wine of the "Final Push"

We are told that after 2005 we will enter a new, "post-elimination" era, during which leprosy cases will be *rare*. It is understandable that a new era requires a new strategy, which is why WHO/AFRO is circulating a strategy paper, which will be discussed at the AFRO annual meeting on leprosy, to be held from 27th to 29th June 2005 in Brazzaville, by the leprosy program managers of the WHO African region, and by the representatives of international non-governmental organizations. Nevertheless, the strategy is not really new; in fact, it does not differ substantially from the "Final Push" strategy. It remains "elimination"-oriented, and the quality of leprosy services continues to be ignored.

### MY COMMENTS

**1. *The WHO/AFRO strategy misses a golden opportunity to re-define the priorities of leprosy control programs.***

During the "elimination" era, the only priority was achieving the elimination target by bringing down the prevalence rate at any price. Hence, a number of simplified techniques for diagnosis and treatment of leprosy were implemented intensively, without paying adequate attention to quality control. At the same time, many essential activities — *e.g.*, prevention of disability — were completely neglected in the field, primarily because these activities were unrelated to the prevalence. As a consequence, the quality of leprosy services was poor and achievement of the final goal of leprosy control was jeopardized. Now, in the "post-elimination" era, because political pressure to achieve the elimination target is diminished, the leprosy programs could, and

should re-define the priorities of the activities, by focusing on quality of diagnosis and treatment and prevention of disability. Although the title of the strategy paper includes the phrase "*to maintain the quality of leprosy services,*" the relevant paragraphs in the text are extremely sloppy and vague, and fail to suggest concrete actions (see **5.2.2** and **5.2.3**). "Prevention of disabilities" is mentioned only once (p. 3), but without details; one might therefore wonder how seriously the strategy deals with the issue of quality.

**2. *The strategy paper stubbornly upholds the poorly-justified technical policies that have already damaged the quality of leprosy services during the "elimination" era.***

- The strategy paper *over*-estimates the sensitivity with which leprosy can be diagnosed using only clinical criteria, and *under*-estimates the important role of the skin-smear (see **5.2.1**) in the diagnosis of smear-positive MB leprosy patients and relapsed MB patients, who represent the major sources of leprosy infection in the community. Apparently, the authors of the strategy paper do not understand that a significant proportion of smear-positive MB patients (especially those close to the lepromatous end of the spectrum), and the great majority of relapsed MB patients cannot be diagnosed without skin-smears; the strategy paper therefore fails to recommend re-introduction of skin-smear service in the field.
- Supervised administration (or directly observed treatment) of the monthly

component of MDT regimens is an important element of the multi-drug therapy for leprosy, which ensures that the patients take the right drugs, in the right doses, at the right intervals. However, the strategy paper continues to ignore the supervised administration of the monthly component of MDT regimens by promoting "flexible MDT," especially so-called "accompanied MDT" or "self-supervision" (which is, in fact, no supervision) (see 5.2.8). The recommendation that the patient who has received the total amount of MDT drugs at the beginning of treatment and "*who is not seen in a health facility at the end of his treatment should be considered as having no concern on his condition and being cured*" (original phrase in 5.2.8) is ridiculous; it is virtually the same as declaring that the patient is cured *at* the time he receives the total amount of MDT drugs.

- Relapse and emergence of drug resistance are the most serious outcomes of poor treatment in any large-scale treatment campaign including MDT for leprosy, and all efforts should therefore be made to prevent or reduce their occurrence. Surprisingly, the strategy paper omits any mention of detection and prevention of relapse after MDT and emergence of rifampicin-resistant leprosy, as if these phenomena have not been encountered and will not occur; such a blindly optimistic attitude is an invitation to disaster.
- As already mentioned, "prevention of disability" is grossly neglected.

### MY RECOMMENDATIONS

1. The strategy paper should be thoroughly revised. Involvement in the revision of the program managers and representatives of NGOs and scientific community is highly desirable.

2. The priority of leprosy control activity should focus on quality and sustainability of leprosy services, especially in the areas of diagnosis, treatment and prevention of disability.

3. The efficiency of integration and decentralisation should be reviewed.

4. The potential role of general health workers in case-finding and case-

management should be reviewed and, possibly, revised. When leprosy cases become rare, it would be more logical that general health workers at the most peripheral level be responsible only to detect suspected cases; the diagnosis of leprosy will be validated or confirmed by more experienced workers from either the district or the referral center.

5. Serious efforts should be made to increase the number and improve the quality of the referral centers; ideally, each endemic district will have one. The role of these centers should be defined in detail.

6. Training of health workers should be an important component of the strategy. With support from NGOs and other partners, AFRO should provide assistance to train the trainers for each of the national leprosy programs. At the country level, basic training must be provided to those workers responsible for the leprosy program at the national, intermediate and district levels, to make certain that they are able to manage the program and deal with patients independently; for those workers at the most peripheral level, training is still necessary but needs only to be task-oriented.

7. The recommendation that leprosy might be diagnosed by the presence of anaesthetic skin lesions alone is problematic, because about 30 per cent of leprosy lesions are non-anaesthetic, and most of these are observed in smear-positive MB cases. To improve the quality of diagnosis, instead of relying upon a single criterion, leprosy should be diagnosed by presence of one or more of the three cardinal signs (anaesthetic skin lesions, thickened peripheral nerves, and acid-fast bacilli in the skin-smear or biopsy specimen). Diagnosis of leprosy will mainly be the responsibility of health workers who have received better training and have access to skin-smears, presumably at the district level or at the referral centers.

8. The skin-smear service must be reintroduced in the field, beginning in leprosy endemic areas; the skin-smear service may be associated or combined with the laboratory facilities of the tuberculosis program.

9. To improve the quality of MDT treatment, adherence of patients to treatment should *never* be compromised; therefore, supervised administration of the monthly component of MDT must be ensured. The

supervisor could be one of the staff in the health facility; for those patients who may have difficulty to visit the health facility once monthly, the supervisor could be a community health worker or a trained local community member. In general, members of the patient's family should not serve as treatment supervisor.

10. To detect relapse after MDT and the emergence of rifampicin-resistance, post-MDT surveillance should be reintroduced, and skin-smear positive MB patients should be examined both clinically and microscopically (skin-smears) once yearly for as long as 7 years after completion of MDT. AFRO should identify the facilities that are capable of testing the rifampicin-susceptibility of the relapsed strains detected by the programs.

11. Because the prevention of disability

has been neglected for too long, the national leprosy program should make special efforts to initiate this activity, including training of health workers, health education of the patients and the community, identification and upgrading of the referral centers, supplying medications, and providing social and financial support to the patients when necessary.

12. Community participation in leprosy control activities should be encouraged, especially in the areas of case-finding, case-holding, prevention of disability and social rehabilitation.

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