Keynote address

Not as a scientific leprologist but as a medical practitioner concerned with the health of people in countries where leprosy is but one health problem among

many, I want to make a few comments on multidrug therapy in leprosy as compared with the hitherto commonly practised monotherapy. I then reflect on the relationship between research fellows and all those in the field who have to apply the research findings. Finally, I should like to remark briefly on the integration of MDT into the general health services.

We all are eagerly looking forward to the reports of this symposium which will present the advantages of MDT compared to monotherapy. These advantages are so evident and probably so convincing for all of us that there will in principle be little doubt on the superiority of MDT and its success.

We shall, however, notice in the forthcoming discussions that MDT is not just a matter of combinations and doses, but that MDT alters the relationship between the healer and the sick substantially. MDT in its relative complexity considerably raises the level of preconditions required to implement it. To apply MDT successfully an advanced standard of training is wanted to keep pace with the new developments, e.g. those reported here, a standard of organization which only a percentage of centres have presently at their disposal, and certainly much more money would be needed—but we don't want to talk about money as guests of GLRA.

Leprosy therapy by MDT happens at present mostly on the level of the individual doctor/patient relationship—a level which is well above the paramedical worker-level which has been established so successfully with monotherapy. When we exclude for the moment a series of excellent pilot projects in Africa, Asia, and the Americas—many of whose masters are among us and to whom I pay respectful tribute—MDT is still reserved for the wise doctor who knows what is good for his patient, who has learned for many years to study, to compare and to question. The tricky problem when to end MDT is still left entirely to the doctor, as he alone can bear the responsibility on the basis of his experience and laboratory criteria, not definitely defined so far.

Due to the very special and detailed knowledge which is needed to apply MDT, there is the real danger that the gap may widen between the fully trained doctor and the paramedical staff—a gap that was reasonably bridged at the time of monotherapy. If the distance becomes too great this may result in a reduced service rendered to the patients, the majority of whom are, and will be, served by field staff.

The relationship between the theorist and the practitioner, as well as the relationship between those who favour monotherapy and those using MDT already deserves—I believe—our particular attention. We have got to give the same intensive priority and passion to the training of all who apply MDT as we give to its research.

We don't want to wait for a new generation of fieldstaff, do we? We need to rely on the old and experienced staff, who will, however, require further extensive training.

Training again which ought to bridge the gap between the doctor and the

auxilliary staff, training which can really be put into practice by the trainees, such a training requires appropriate language. We academics have to make efforts to translate the aim and methods of MDT into a language which makes these clear and at the same time stimulates enthusiasm and co-operation among leprosy workers. The technique of translation of scientific results into practical instructions needs to spread from training centres like ALERT to the peripheral centres and it needs to be adapted to local contexts. Paramedical workers know how their patients react to monotherapy and by experience they are suited best to overcome weariness and defaulting. Qualities which are also needed badly for the implementation of MDT.

The field staff doctors and paramedics alike depend on an MDT which is: relatively simple to apply; somehow standardized; as safe and reliable in the hands of leprosy workers as possible; convincing in its effects both for the workers and patients; and suitable for supervision and evaluation.

The claim for simplicity is paramount—we cannot do without it under the difficult conditions of urban as well as rural leprosy work. Not only the MDT-regime, but the entire operational set-up has got to be so simple that it will work under adverse conditions in the hands of paramedical workers. I just want to mention some of the possible stumbling blocks for them:

Are they certain about the criteria to define whether the disease is active or inactive?
Do they recognize reactions and drug induced side-effects?
Is it necessary to stick rigidly to fixed dates of tablet administration without allowing for circumstantial variations?
How many control smears are adequate in a certain regime?
Does the feedback in the so called 'smear chain' from the laboratory back to the fieldworker happen in a reasonable time?
What about the higher demands made on the recording system?
And last but not least, are doctors able to provide the intensified medical supervision that is needed?

In the laboratories and units where you study the effects and interactions of old and new compounds and the clinical aspects of MDT with refined techniques and statistical methods, you use 'high tech'. That means much more than photometers, HPLC and data-processing; it comprises the entire highly specialized ways and aims of leprosy research without the findings of which MDT would just not be. Out there in the field not only electrical power, gear (equipment) and know how are missing, the entire setting asks for an approach which I want to call with respect 'low tech'. Now 'low tech' is not a 'by chance' second-class method', primitive but cheap—it is rather an intelligent development of existing technically simple methods. Such a solution of problems adapted to the situation, needs an input of purposeful health education—and an analysis of the economic proportions (terms of references), e.g. a detailed knowledge of

how workers and populations accept the new therapy offered. Adapted appliances like solar or battery operated microscopes and standardized smear-reading fall in with it. Thus the success of MDT cannot be reduced to the simple question 'What does a drug-regime effect?' It is dependent on the answers to questions like:

'Does it work under given circumstances?'
'How good is the in-service training?'
'How good are the controlling eyes?'
'How can results be evaluated?'

The considerations of the user of 'low tech' are just as important as the aims of the researcher for 'high tech'. The cause of the fieldworker asks not only for our tolerance but our full intellectual and emotional support as their lobby is weak compared to the one of the researchers. All of us here, biologists and doctors, are the servants of the practitioners who have got to do the job on the spot.

The fieldworkers are faced with a situation which makes it more and more difficult to keep up a vertical leprosy service. It meets not only the philosophy of primary health care but our own conviction of a modern leprosy service too, that it should become integrated into the general health services. MDT demands, on the other hand, detailed medical knowledge more than ever before from all workers so that the leprosy units might be reluctant to integrate MDT in order not to water down their special services. Leprosy patients, however, are part of their urban and rural communities and rightly claim their integration into the health and educational opportunities of their region.

We bio-medical researchers would, I think, be well advised to discuss and investigate the possibilities of applying our research results with epidemiologists and educationalists. This would probably lead us to extend our research interests to problems of basis health care, the application of leprosy treatment within these services and the organization of programmes and training of suitable personnel.

The aim is, colleagues—or is it not—to let the people suffering from leprosy all over the globe participate fully in the excellent progress that you have made in leprosy therapy.

Thank you for your patient attention.

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