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Editorial

AFTER MULTIDRUG THERAPY (MDT): WHO IS RESPONSIBLE FOR CONTINUING CARE?

Before considering who is responsible for providing continuing care, it is necessary to look at the present situation regarding multidrug therapy (MDT).

Most leprosy endemic countries in the world have introduced, or are in the process of introducing the WHO recommended MDT regimens for leprosy control.[1] However, data available in 1986[2] showed that only 8·8% of the total number of registered cases in the world were receiving MDT. This was four years after the WHO Study Group recommended that, as a matter of urgency, combined chemotherapy regimens should be introduced in all leprosy control programmes.

This slow progress in the introduction of MDT is understandable to planners and field staff alike, and is a cause for concern. It is partly due to inadequate financial and personnel resources, and very often due to transport problems. It could well be argued that with limited resources, those that are available must first be used for implementing MDT, and that it is unrealistic to consider continuing care until all leprosy patients have been treated with MDT. However, the importance of patient care was underlined at a recent meeting of WHO and nongovernmental organizations.[3] Some programme planners are already aware of this, and recognize that continuing patient care not only helps the individual but also reinforces the credibility of the MDT programme.

Surveillance and continuing care

Many leprosy control programmes plan for the surveillance of both paucibacillary (PB) and multibacillary (MB) patients after the completion of chemotherapy in order to monitor and treat relapse or reaction. The mechanism for doing this varies from country to country. For instance, PB patients are checked annually for 4 years in western Nepal; at 3, 6 and 8 months after release from treatment in Ethiopia, and annually for 2 years in India. Multibacillary (MB) patients in India and Ethiopia are asked to report annually for 5 years for clinical and bacteriological examinations; in Nepal, the annual surveillance period is 8 years, and in Bhutan 10 years. In these countries patients are not followed up if they do not report voluntarily for examination. Indeed, some patients in Nepal requested not to be followed up either by a home visit or by letter.

But continuing care is more than surveillance, and is usually designed to meet the felt needs of patients who have been discharged from chemotherapy, but who are still faced with a variety of problems. Some will need help with readjustment problems or job training: the elderly and disabled may need residential care; those with insensitive feet will need protective footwear. Others may develop deformity after the completion of chemotherapy, and require teaching and care. There will need to be a flexibility of approach to continuing care, just as there is in the surveillance of patients after release from treatment.

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Already some leprosy control programmes have made provision for continuing care, and this varies from country to country, according to the number of leprosy patients and the resources available. In Lesotho, some disabled patients are provided with a pension, and are able to purchase subsidized protective footwear. The National Leprosy/Tuberculosis programme in Kenya[4] is proposing to have a care register to list those patients who will require long-term care for insensitive hands, feet or eyes, the provision of footwear or reconstructive surgery. In India,[5] an ambitious 3-year scheme 'Care after Cure' is in operation, and is designed to follow up all patients who have been released from control since the early 1970s. They number about 9700, of which 30% or 3000 had visible deformity on discharge. Perhaps 2000 still need care; the project aims to contact them and review them medically and offer help in the form of social service or employment opportunity.

Timing

During the preparation phase for the introduction of MDT, and during the first year of implementation, there is an increased workload for the staff.[6] Obviously if continuing care is proposed, it is not feasible to attempt it early on in the programme. However, after the discharge of many PB patients from treatment, the caseload will be reduced and staff will, in theory, have more time for patient care—both for those still receiving treatment, and for others needing continuing care.[7]

But in some projects, it may already be too late to reassign staff time to continuing care, as staff in the leprosy control programme have been given new tasks, or have been diverted to other work. All patients on treatment are usually screened before the introduction of MDT, and many inactive PB cases released from treatment. If a disability register is kept at this point for those who need continuing care and protective footwear, then this will assist in later planning and budgeting.

Resources

Having identified those patients who need continuing care, the next question will be 'who will provide it?' In some projects it will be appropriate to select leprosy control or health centre staff who have shown an aptitude for communicating with patients and the community in which they live. It may also be useful to look wider and enlist the help of others outside the health centre team. Perhaps a physiotherapist at the district hospital will be able to supervise the production of footwear,[8] or the local village carpenter help with the production and repair of simple artificial limbs.

Another possibility in the future will be to cooperate with the Community Based Rehabilitation Worker (CBRW)[9] in continuing care for leprosy patients. This is a new approach to the care of the disabled in the community and is closely related to primary health care. Until now rehabilitation services have been town based, but CBRWs will make these services available to people with physical, mental and sensory disabilities within their own community. To make this concept a reality, a one-year course is now available to train the teachers and supervisors of CBRWs.[10] It is encouraging to see that sessions on the prevention of disability in leprosy are included in the course.

Many governments find it difficult to finance the implementation of MDT and look to nongovernmental organizations (NGOs) for assistance. Would it not be appropriate that these agencies, because of the flexibility of their approach take some of the responsibility for continuing care by providing funds or experienced staff?

One purpose of this article has been to stimulate thought and discussion about the need for continuing care for selected leprosy patients after the completion of chemotherapy, and to suggest possible approaches. Perhaps the key activity will be the selection of a suitable person to plan and

co-ordinate continuing care, with the ability to enlist the help of a wide variety of people in order to provide this care.

Finally, continuing care needs to be planned in consultation with the patients themselves. The main responsibility for continuing care will rest with the patients and their families and it is therefore logical to invite them to contribute their ideas to the ongoing discussion.

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Note. As this issue goes to press our attention has been drawn to more recent data on MDT coverage published in the *WHO Statistics Annual*, December 1987, pp 23–4.

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