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Editorial

DERMATOLOGY—GLOBAL PLANNING IN RELATION TO LEPROSY MANAGEMENT

It was in the eighteenth century that a new emphasis on the classification of biological systems, based on their appearance, stimulated in Europe the recognition, naming and classification of physical signs in the skin. The word 'lepra' was applied to a number of diseases; later it was thought better to name these in other ways to avoid confusion with leprosy. Dermatologists who further developed such classifications in the ninteenth century continued to include leprosy in their textbooks and to take an interest in its diagnosis and management.

Leprosy has many components besides its early recognition and classification. Not least of these are stigma and disability. It is these components that attracted the attention of the Church. The later discovery of bacteria as its underlying cause led to the link of leprosy with tuberculosis, with which, in many countries, it is paired for administrative purposes.

Today, the management of leprosy requires a profession interested and expert not only in early recognition but also in contact tracing, disability, as well as bacteria. Dermatology is a profession offering to play a bigger role in the management of leprosy because it can now demonstrate an interest in all of these aspects; and in some parts of the world, such as China, major eradication programmes and the management of disability, have been organized through dermatology institutes. In recent years, budding dermatologists have been expected to explore the basic mechanisms underlying disease processes, and most training programmes have a big component of basic science and especially immunology. More recently, the consequences of disease have received more attention and disability is attracting more interest on conference programmes. Dermatologists are now encouraged to measure aspects of disability that have economic value, such as the distance people with sore feet can walk, manual dexterity, and above all, what it means to be unwelcome because of disfigurement. The literature on stigma now is as likely to refer to psoriasis or vitiligo as it is to leprosy.

Skin diseases have long been paired with sexually transmitted diseases because so many early manifestations of syphilis could be seen in the skin, and in most countries this link has been retained. Consequently, dermatologists are familiar with the language of infectious disease control, social hygiene, contact tracing and the appropriate use of drugs, or terms such as 'prevalence', 'incidence' and 'distribution'. What has been lacking until recently, has been any programme formulated by dermatologists showing that they are interested in the global control of disease. An important contribution has been made

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by the International Society of Dermatology; Tropical, Geographic and Ecologic,[1] which has a journal and a regional teaching programme much concerned with this topic.

Dermatology on an international scale is organized on the basis of International Congresses, held every 5 years. The Committee which organizes these is elected by delegates from national societies. It has existed for 100 years and has always included within its remit the need for encouraging better practice worldwide. An English dermatologist, Dr Darrell Wilkinson of High Wycombe, encouraged the International Committee of Dermatology to take more seriously the problems of skin disease in the developing world. In 1987, at the International Congress of Dermatology in Berlin, the Assembly of Delegates unanimously approved the formation of the International Foundation for Dermatology, and this Foundation has a number of missions listed as follows:

THE PRIMARY AIM:

The International Foundation for Dermatology, which serves under the aegis of the International Committee of Dermatology of the International League of Dermatological Societies, has as its primary aim to: 'Aid patients afflicted with diseases of the skin, through the promotion of dermatologic service, training and science, in the developing countries.' These aims are to be carried out under the guiding principles of resource allocation to manage those preventable, curable, and common diseases of the skin which affect so many in developing countries.

The following are the principal missions of the International Foundation for Dermatology:

Mission 1 Promote dermatologic education and training in developing countries at all health-care levels.

Mission 2 Establish regional dermatological training centres in developing countries.

Mission 3 Improve delivery of dermatologic care in developing countries.

Mission 4 Promulgate collaborative programmes between institutions from developed and developing countries of the world.

Mission 5 Document the current status of dermatologic manpower, technical resources, and the burden of dermatologic disease worldwide.

Mission 6 Develop a cadre of experienced dermato-venerologists willing to serve on short- or long-term basis as visiting teachers, lecturers, advisers, or practitioners of dermatology.

Mission 7 Support the establishment of fully-fledged departments of dermatology in at least one medical school in each country.

Mission 8 Promote dermatologic education and communication in developing countries at national and international meetings.

Mission 9 Develop a model list of essential dermatological therapeutic agents for all health care levels.

Mission 10 Promote research oriented to the dermatologic priority needs in developing countries.

The Board of Directors of the Foundation include: Dr Alfred W Kopf, New York, USA (Chairman); Dr Henning Grossman, West Germany; Dr Stuart Maddin, Vancouver, BC Canada; Dr Hans R Rorsman, Sweden; Dr Stephen I Katz, Bethesda MD, USA; Dr Francisco Kerdel-Vegas, Venezuela; Dr Atsushi Kukita, Japan; Dr Ramon Ruiz-Maldonado, Mexico; Dr Terence J Ryan, Oxford, UK; Dr Jean Thivolet, France; and Dr Klaus Wolff, Vienna Austria.

At its first meeting, the Board decided that some of the most urgent problems were to be found in Africa and that its first major plan should be to set up a Regional Training Centre for Africa. A number of governments were contacted and Tanzania provided a firm indication of support in the form of promises of land and administration; so a site visit was made in May 1989. During this visit, the curriculum was discussed and leprosy was placed firmly on the list of topics to be taught. An important concept, somewhat new to dermatologists, was that the profession should concentrate on primary health care and that therefore the Training Centre should be aimed at the future organizers and teachers of programmes in rural areas. This was one reason why a rurally-based site, Kilimanjaro in Moshi, was chosen for the development of the Teaching Centre. It was made plain from the outset that the Training Centre would be run by Africans, assisted by ex-patriots, and that the curriculum should be approved by the governments and dermatologists of all 12 African members of the East African Community. Initial discussions were held with the Vice-Chancellor of Dar-es-Salam University, who emphasized that only the highest academic standards were acceptable. To ascertain what Africans require for such a curriculum, Professor A M Nhonoli, Regional Secretary of the Commonwealth Regional Health Secretariat, is arranging a workshop on Training in Dermatology at all levels, to be held in Nairobi, 27–31 August 1990. Provisionally, it is expected to include dermatology, sexually-transmitted diseases, leprosy and AIDS, a grouping that would not be unfamiliar to a number of countries with a social hygiene programme. In addition, it will include instructions on the collection and retrieval of data and will provide a component on teacher training. The Course will be aimed at medical assistants, clinical officers or leprosy officers, to whom much of the work of dermatologists will be delegated. The initial course should be thought of as a pilot scheme, taking up to 30 trainees, and it will be reduplicated elsewhere only if it is proved to be a success. For this reason the Foundation is seeking funds for an evaluation programme aimed at surveying some 20 communities before and after placing within their midst, persons who have been trained at the Centre. It is hoped that the communities will consequently have less scabies, pyoderma and fungi, and a much greater understanding of how sexually-transmitted diseases, such as AIDS, are transmitted. Great emphasis will be placed on the early detection of leprosy, its appropriate treatment and the managment of disability. It is important that early recognition should include a willingness and capability to treat nonleprosy patients. Pityriasis alba, pityriasis versicolor, vitiligo, sarcoid or localized scleroderma, for example, are not adequately managed by dismissing them as nonleprosy. Early cases of leprosy are more likely to be detected if all persons with skin lesions are encouraged to attend skin clinics, and such early recognition is easier in skin free of common infections.

The changing perception of dermatology as a discipline needed by populations with

skin disease so that they may achieve their full potential at work and play, has not yet resulted in resources being made available. Perhaps we should return to the eighteenth century and embrace more skin diseases by the term 'lepra' because they might receive more charitable funding and incite greater missionary zeal for their elimination.

The training provided by current leprosy control programmes includes the use of a disability index.[2] This is essential for assessing the economic consequences of disease and it is needed by dermatologists who, up to now, have not estimated how much disability is caused by skin disease in countries such as rural Africa.

It may be relevant that the esteem with which dermatologists are held is thought to be low because high scoring phenomena, such as mortality or high technology management, are not characteristic of skin disease. However, governments are mostly willing to support low technology and professions active in the management of chronic disabling disease, provided appropriate and cost-effective solutions are well presented to them.

In the first three years of its existence, the International Foundation for Dermatology has sought funds chiefly from within the profession, and the response of individuals and of societies has been encouraging. It has also appealed to charities concerned with leprosy, because there are many costs incurred even in the early stages of seeking to include leprosy in its curriculum. The help of many experts who have spent their lives in programmes for the eradication of leprosy or in the management of disability is needed, and indeed it is sought, in order to facilitate teaching programmes. Conversely, where leprosy is well managed and has adequate staffing, it is hoped that dermatologists will be invited to expand the programme so that other diseases affecting the skin are equally well controlled.

In the first year of its existence, the International Foundation for Dermatology took note of the work in China of an ex-patriot, Ma Haide,[3] who epitomizes what a dermatologist can achieve in the control of sexually-transmitted diseases, fungus infection and leprosy. The three eradication programmes aimed at these diseases, succeeded in his lifetime as a consequence of his policy of advising governments, setting up regional training centres, and creating armies of primary health care workers. They are examples of what can be achieved for huge populations by one man interested in creating a programme that combines dermatology, sexually-transmitted diseases and leprosy.

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