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Address for correspondence

The Editor
Sri Lanka Journal Dermatology
Wijerama House
6, Wijerama Mawatha
Colombo 7
Sri Lanka

Editorial

Leprosy in Sri Lanka

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Leprosy has been a disease prevalent in this part of the world for thousands of years. Leprosy control in Sri Lanka has had a colourful history in the past[1-4]. It has been a journey from 'segregation' to 'integration'[5].

Dermatologists have worked closely with the medical and paramedical personnel of the Anti Leprosy Campaign in Sri Lanka to achieve the 'Elimination Target' of 1 case per 10,000 population, set by the WHO, in 1995; much before the anticipated date. The director, medical and paramedical personnel of the Anti Leprosy Campaign, both past and present, have to be congratulated for their efficient, dedicated work in achieving this feat. The trained public health inspectors of the Anti Leprosy Campaign need a special mention here as they too played a major role in detection and treatment of leprosy cases in remote areas.

On recommendations by the WHO and by the Anti Leprosy Campaign in Sri Lanka, after much deliberations, leprosy care in Sri Lanka has been integrated into the general healthcare system with effect from this year. The reasons behind this are many; firstly, it was felt that, although the total case load was relatively low, the rate of deformities was rather high due to late presentation. Secondly, as the new cases have reduced over the years, it was felt that a vertical leprosy control programme would not be cost effective in the long run.

With the 'integration', now it is possible for any medical officer or a registered medical practitioner in the state sector to diagnose and treat leprosy. Even the doctors in the private sector can now obtain the drugs from the Anti Leprosy Campaign for their patients if they agree to fill the relevant forms and return to the regional epidemiologist. Thus a new chapter of leprosy care began in 2001 in the final push for eradication of leprosy in Sri Lanka.

Though the idea of integration is very logical, there are several important aspects that should not be forgotten. Firstly, the diagnosis should be accurate, as some of the drugs used such as dapsone can cause serious side effects. Secondly record keeping and sending completed forms ('returns') to the regional epidemiologist/Anti Leprosy Campaign should be meticulous and prompt. Maintaining adequate drug stocks for children and adults at all times is of paramount importance. If proper care is not exercised, leprosy can raise its ugly head once again, like in the case of malaria control in Sri Lanka in the sixties. There is no room for any complacency. Leprosy is a disease which manifests many years after exposure, therefore, when the effect of a breakdown of leprosy care services is felt it will be too late to rectify.

It is encouraging to note that all dermatologists have extended their fullest cooperation to the Anti Leprosy Campaign to make the integration process a success. All complicated cases of leprosy, reactions and any doubtful cases are referred to dermatology clinics or dermatology wards all over the country. Educational programmes were held in the provinces by dermatologists and medical personnel of the Anti Leprosy Campaign to upgrade the knowledge of doctors, nurses and pharmacists before the 'integrated care' became effective. Dermatologists should continue to play a pivotal role in continuing medical education programmes on leprosy to medical personnel in all areas of the country. The provincial health administrators should work closely with dermatologists in the respective areas in these educational programmes. Diagnosis and treatment of leprosy should be given more emphasis in undergraduate teaching, more than in the past, as the newly graduating doctors will be expected to diagnose and treat leprosy rather then referring to specialist clinics.

Whilst early case detection and multi drug treatment are cornerstones of the current leprosy care strategy, it should be emphasised that avoiding overcrowding in homes, adequate ventilation and good nutrition too are very important to achieve a sustainable reduction of leprosy. Clearly, the incidence of leprosy went down in the western world much before the advent of multi drug therapy due to improved housing and living standards. Thus, for a long lasting reduction in the disease leading to eradication, the government should plan community based development projects to improve the living conditions of the poor. Otherwise the overcrowded urban slums will continue to provide a source for propagating leprosy and other infectious diseases. This aspect is also highlighted by the fact that the Western Province has the highest incidence of leprosy and the prevalence of leprosy in this province has not still reached the 'WHO Elimination Target although the country as a whole has achieved it.

Now it is the time for a very concerted and sustained effort by the Anti Leprosy Campaign, dermatologists and all other medical personnel to work together with renewed vigor, to work towards the goal of achieving complete eradication of leprosy from Sri Lanka or at least come near this goal within a reasonable time frame.

S P W Kumarasinghe

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