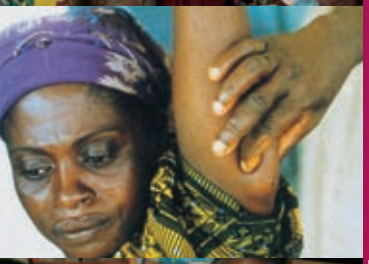

Linda Lehman
Valérie Simonet
Paul Saunderson
Pius Agbenorku

Buruli ulcer

Prevention of disability (POD)

World Health Organization

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Buruli ulcer

Prevention of disability (POD)

Linda Lehman
Occupational Therapist and POD/Rehabilitation Consultant to American Leprosy Missions for the Americas and Africa, USA/Brazil

Valérie Simonet
Occupational Therapy Consultant to Aide Aux Lépreux Emmaüs Suisse, Bern, Switzerland

Paul Saunderson
Medical Consultant, American Leprosy Missions, Greenville, South Carolina, USA

Pius Agbenorku
Consultant Plastic Surgeon/Senior Lecturer, Komfo Anokye Teaching Hospital, School of Medical Sciences, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana

World Health Organization

Objectives of this manual

Health workers should be able to use this manual to:

- understand the importance of an early **prevention of disability (POD)**
- identify and document the person's problems
- determine interventions based on identified problems
- provide the needed interventions in order to prevent or minimize disability
- teach the person affected by Buruli ulcer and the family how to do self-care
- monitor the response to the intervention and modify as needed
- refer to other specialized services

Target groups for this manual

GROUP I – Health workers starting to practice some POD activities who need a theoretical basis for POD, plus practical guidelines that will help them do a better job and avoid common mistakes.

GROUP 2 – People who provide supervision and training of others in POD.

GROUP 3 – Programme managers at various levels who need to understand that POD services are an essential component in the correct management of Buruli ulcer, even if they are not themselves practitioners.

Implementing POD

The manual will be most helpful if it is used in conjunction with a participatory method of training to develop knowledge and skills.

Periodic supervision will be the key to assuring that POD activities are developed and appropriately implemented.

POD should be integrated within the relevant training and supervision programmes. Specialized POD training can be introduced when health workers have participated in general Buruli ulcer control workshops and have worked with persons affected by Buruli ulcer.

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- Mr Sampson Adjei, Agogo Presbyterian Hospital, Asante-Akim North, Ghana
- Dr Julien Aké Aké, MAP International, Côte d'Ivoire
- Mr Kingsley Adumata, Juaso District Hospital, Asante-Akim North, Ghana
- Mrs Margaret Agbenorku, Global Evangelical Mission Hospital, Apromase, Ghana
- Dr Edwin Ampadu, National Buruli Ulcer Control Programme, Accra, Ghana
- Mr Isaac Ansong, Bekwai Government Hospital, Ashanti, Ghana
- Dr Maria Aparecida de Faria Grossi, UFMG, Brazil
- Ms Agnes Appiah, Nyinahin Government Hospital, Ashanti, Ghana
- Dr Kingsley Asiedu, Global Buruli Ulcer Initiative, World Health Organization, Geneva, Switzerland
- Mr Edward Kwabena Brobbey, Ashanti Regional Health Administration, Kumasi, Ghana
- Mr Emmanuel Debrah, Agogo Presbyterian Hospital, Asante-Akim North, Ghana
- Ms Vivian Gozah, Global Evangelical Mission Hospital, Apromase, Ghana
- Mr Samuel Gyamfi, Korle-Bu Teaching Hospital, Accra, Ghana
- Mrs Margaret A. Karikari, Komfo Anokye Teaching Hospital (KATH), Kumasi, Ghana
- Ms Vida MacCarthy, Nkawie-Toase Government Hospital, Ashanti, Ghana
- Mr Charles Mensah, St. John of God Hospital, Duayaw-Nkwanta, Brong-Ahafo, Ghana
- Dr Federico Montero, Disability and Rehabilitation Team, World Health Organization, Geneva, Switzerland
- Mr Simon K. Tieku, Komfo Anokye Teaching Hospital, Kumasi, Ghana
- Mr Lawrence G. Tuuli, Agogo Presbyterian Mission Hospital, Agogo, Ghana
- Ms Corrianne van Velze, OTASA, Pretoria, South Africa

PHOTOS AND ILLUSTRATIONS

by: Linda Lehman

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Additional contributions

- Photo in Figure 2.1 of oedematous plaque with beginning ulceration by Paul Saunderson.
- Photo in Figure 3.1 on participation in sports by Brenda Davidson.
- Photo in Figure 5.1.6 of person affected by Buruli ulcer with a leg amputation by Charles Mensah.
- Photo in Figure 5.1.7 of man with Buruli ulcer lesion by Eric Bafende.
- Wound-healing illustrations in Table 5.2.2 by Hugh Cross.

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Contents

Preface

Buruli ulcer was described decades ago in both Australia and Uganda. Buruli County in Uganda – the site of an outbreak of the disease in the 1960s – gave its name to the condition, which is an infection caused by *Mycobacterium ulcerans*. Since 1980, the disease has emerged rapidly in several parts of the world – particularly West Africa – prompting action by the World Health Organization (WHO) in 1998.

In view of the increasing geographical spread, the severe consequences, and the limited knowledge of the disease, the World Health Assembly in 2004 adopted a resolution to improve the surveillance and control of Buruli ulcer and to accelerate research to develop better tools for its control. WHO and its partners have produced a number of publications to facilitate the mobilization and training of health staff in the affected areas.

In developing countries, the persons who are most affected live in remote rural areas with little contact with the health system, and often seek treatment late. In most affected areas, health and rehabilitation services are poorly developed or non-existent. Although mortality from Buruli ulcer is low, the main problem is long-term disability in an estimated 25% of those affected. The scarring process is similar to that in severe burns and often leads to contractures, sometimes resulting in marked disability and deformity. In some severe cases of Buruli ulcer, amputation may be necessary. Stigma may add to the burden of those affected, leading to loss of participation in normal community affairs.

Current strategies for treating Buruli ulcer are antibiotics (a combination of rifampicin and streptomycin/amikacin) to limit the infection; surgery to remove necrotic tissue and restore skin coverage; and interventions to prevent or minimize disabilities. So far, however, not enough attention has been devoted to preventing disability. It is now clear that “prevention of disability” activities must be started in every case of Buruli ulcer – right at the beginning of treatment – if the contractures, stiffness, and weakness so typical of late cases are to be avoided or reversed.

This manual has been developed – after extensive training sessions for health workers in Cameroon and Ghana – to assist Buruli ulcer programme managers, policy-makers, health workers, social workers, and other actors in the field of prevention of disabilities and rehabilitation to implement activities that can reduce suffering and disability. It is also the hope of the authors, WHO, and partners that the implementation of the manual will contribute to strengthening general rehabilitation services in affected areas.

Dr Kingsley Asiedu
Global Buruli Ulcer Initiative
World Health Organization
Geneva, Switzerland

Dr Paul Saunderson
American Leprosy Missions
Greenville, South Carolina
United States of America

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Editors:
Linda Lehman
Valérie Simonet
Paul Saunderson
Pius Agbenorku

Buruli ulcer disability is preventable: go to hospital without delay!

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