CHAPTER IX

CONCLUSIONS: AN ALTERNATIVE PERSPECTIVE

A perusal of the main findings of the present study provides some very important guidelines for developing an alternative perspective for dealing with leprosy as a community health problem in India. The very fact that it is an alternative perspective rules out the "more of the same" approach adopted in the Sixth Plan. The findings of this study also go strongly against some of the major recommendations made by the working group. The alternative proposed on the basis of the present study does not share the optimism of the working group about the critical role of immunological research in the fight against leprosy and also the absolute necessity of launching of a multi-drug therapy. The findings of the present study also go against the recommendation of the working group that only a vertical approach to the programme will have an epidemiological impact on the leprosy problem in India.

The perspective proposed on the basis of this study gets considerable encouragement from the very firm and categorical political commitment to leprosy control work in the form of repeated assertions by the Prime Minister of the country. The alternative proposed also will be considerably strengthened by the recommendations of the working group concerning establishment of National
Leprosy Eradication Commission and a National Leprosy Eradication Board and corresponding institutions at the state level.

The following findings from the present study have formed the basis of the proposed alternative:

1. To the community leprosy is perceived overwhelmingly in terms of deformities which result from the disease and these form barely 15 to 20 per cent of leprosy cases within a community.

2. There is big gulf between leprosy workers and leprosy patients. The gulf is even wider between leprosy workers and the community at large.

3. There are major shortcomings in:
   a. the work of the leprosy inspector,
   b. work of the non-medical supervisor,
   c. working of the health educator,
   d. working of the way side clinics,
   e. working of M&T centres and leprosy control units including work of the pharmacist, the laboratory technician and physiotherapy technician.

4. Because of inadequacies in health education and mass communication, inadequacies in the service
organisation and because of limitations in the motivation for treatment acceptance among patients, there is a very high proportion of treatment defaulters; there is also a significant group who failed to register themselves for treatment.

5. There is deep dissatisfaction among patients about the services made available to them for dealing with intercurrent ailments.

6. Patients have to suffer loss of wages and often they have to spend considerable amount of money for travel for drug collection.

7. The cost to the patient is much higher when he receives services through a voluntary agency. In addition, even comparatively the efficiency of leprosy work of this voluntary agency is much lower; corruption is much more extensive.

8. Linking of district leprosy control with the district medical officer is a very weak link in the chain of command. Lack of integration of medical care with activities of primary health centres and other public services also adversely affects leprosy work.
9. Creation of as many as six directorates dealing with different aspects of health services poses additional problems of integration.

10. There are major gaps in the data concerning epidemiology of the disease.

Integration of leprosy work with general health services forms the corner stone of the suggested alternative. The observations of the Assistant Director General of Health Services (Leprosy) and of the state leprosy officer, Tamil Nadu that leprosy work has suffered when it was integrated with the general health services in the multipurpose workers' scheme may be very valid. However as is evident from the findings of this study the solution does not lie in making leprosy a vertical programme: emphasising the "essentially of verticality". The solution lies in removing what Banerji has described as stigma from leprosy workers and leprosy work within health services. Because of these, compared to other health problems, leprosy has not received attention and care proportionate to the suffering it causes to a community. The categorical political commitment and increasing realisation among health administrators for more intensive work in the field of leprosy is expected to provide a major thrust in removing these stigma. The implementation of the
recommendations of the working group to upgrade the
posts in the Leprosy Control Programme will be a positive
step in this direction.

If the basic postulate of dealing with leprosy as
an integrated component of general health services is
accepted the leprosy programme is expected to receive a
powerful boost from the accepted strategy of providing
health for all by the end of the century. Leprosy work
then becomes an integral part of functioning of the
community health worker (guide), male and female
multipurpose workers and the entire supervisory echelon.
In the context of the findings of the present study, the
role of the community health worker (guide) becomes very
crucial. As one belonging to the community itself, she/
he becomes an important medium for providing correct
perspective to the community concerning the nature of the
disease, its curability and impressing on the patients
the utmost necessity of undertaking the prescribed treatment.
The community health worker also becomes valuable in
acting as a drug distribution agent. She/he can also be
helpful in ensuring that leprosy patients receive the
proper services for inter-current ailments.
Another feature of the alternative strategy is that the two multi-purpose workers and their immediate supervisors can provide second or third lines of support to patients in case of failure of the community health worker.

By providing "staff" support for leprosy control to the general health services, upgraded and strengthened leprosy cells at district, state and national levels will provide additional strength to leprosy control work.

Leprosy work as an integral part of general health services certainly cannot be considered as a hindrance to launching a concerted attack on the disease as a community health problem. The principle of integration is not inconsistent with emphasis on a specific health problem which might be singled out as a cause of extensive suffering and devastation within a community. This emphasis could also involve a very elaborate mass communication and education drive in areas where leprosy is highly endemic.

Such an integrated approach also puts the research priorities in their correct perspective. Research on the various aspects of epidemiology of the disease,
clinical field trials of chemo-therapy drugs in their various permutations and combinations and for varying durations, social science studies on what Banerji has described as health culture\textsuperscript{101} which includes cultural perception and meaning of leprosy, patient behaviour in relation to existing services and development of an inter-disciplinary approach to formulate a nationally applicable, socially acceptable and epidemiologically effective leprosy programme for India within the constraints of the resources that are made available for the programme. Laboratory research to develop vaccines or immunomodulators and to promote in-vitro culture gets subordinated to the requirements of the programme as determined from an analysis of its functioning under field conditions; instead of the laboratory deciding what should be handed down to leprosy patients, it should be the requirements of leprosy patients and the community at large which should determine the priority and the pattern of leprosy research that should be carried out.