CHAPTER V
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INTEGRATION OF LEPROSY CONTROL WORK WITH PRIMARY HEALTH CARE (PHC)

5.1 INTRODUCTION

We need short-run and long-run perspectives in planning for leprosy control. In the long-run PHC approach is ideal but the complexities of leprosy control are so enormous that it would be unwise to integrate the existing vertical program in PHC without proper preparation.

Integration of leprosy control and care of leprosy patients into the primary health care (PHC) system is making difficult and slow progress in most endemic countries or throughout the world.

In order to identify the optimal methods for integrating vertical leprosy control programmes into the PHC system in different situations, it is necessary to have a full understanding of the constraints involved, and to identify the most important problems and their solutions. The PHC approach is considered as an overall approach of the entire health system directing itself to the following main principles:

- equitable use of health resources;
- community participation;
- intersectoral co-operation.

In most countries the district level is considered the most appropriate level for the organization of an effective PHC infrastructure but it has been reported that the administration of the districts is generally very weak.
5.2 PRESENT NEED FOR VERTICAL PROGRAMME

- There is an estimated 4 million leprosy patients in India.
- Change of strategy to multi drug therapy makes it necessary to have specially trained staff.
- Leprosy being a chronic disease there is need for long term follow-up and maintenance of records and reports.
- The multipurpose workers (MPW) and Community Health Workers (CHW) are not adequately trained in leprosy. Medical personnel in general health services are also not given adequate training.

5.3 MAIN LIMITATIONS REGARDING THE IMPLEMENTATION OF LEPROSY CONTROL THROUGH A VERTICAL PROGRAMME (WHO, 1986)

- Insufficient coverage of the population by vertical programmes.
- Inefficiency with regard to the use of resources (finances, equipment, manpower)
- A disproportionately high amount of resources for vertical leprosy control programmes is often used for institutional care of patients.
- Relatively too much attention is given to methods of active case finding.
- Lack of comprehensive health care.
- Staff of vertical leprosy control programmes often have sporadic contact with the community due to the fact that clinics are conducted only periodically (no continuity of services).
- A vertical approach, separating the leprosy services from the general health services, increases the stigma related to leprosy among the community and the general staff.
- Managerial weakness of some vertical programmes.
Vertical programmes are often more dependent on donor agencies than integrated programmes. (Integration reduces the danger of a collapse of the programme if donor agencies withdraw their assistance).

- Lack of job satisfaction for specialized leprosy field workers.
- Lack of career opportunities for peripheral specialized leprosy workers.

Practically all of the limitations listed above justify the integration of leprosy control into the PHC system. Vertical programmes still exist in most countries; usually throughout the whole country; however in some cases, certain programmes are still vertical in some parts of the country and integrated in other parts (i.e. leprosy control programme in Thailand has been integrated in 67 provinces and is still vertically organized in 6 provinces). (WHO 1986).

5.4 DISADVANTAGES OF VERTICAL PROGRAMMES FOR LEPROSY CONTROL

- Size of the problem is so much that the staff in vertical programme is not enough.

- Health information is more confined to vertical programme and does not diffuse to general health services.

- Since there is vertical programme for leprosy most of the community health programmes do not cover leprosy in their programme. Inspite of these disadvantages it is difficult at the moment the PHC to give adequate coverage. The endemic areas will need MDT implemented without much delay and regularity of treatment is very important and fairly long time treatment and follow-up is needed. MPWs have multiple responsibilities (Thangaraj, 1987).
5.5 PROBLEM OF INTEGRATION OF LEPROSY INTO THE GENERAL MEDICAL CARE

Leprosy had always been isolated from other diseases in most places where it was endemic in the past. Today it is still the case in many places. It is a very expensive disease to treat and control. It is extremely expensive to train staff just for the treatment or the care of a single disease; build institution, to set up surgical units and rehabilitation units, shoe and limb making industry for a single disease. The actual cost of drugs for the treatment may not be very high in comparison to other diseases.

Because of the cost of running a separate service for a single disease, integration of its care is very essential and need urgent consideration. Caution need to be exercised however to determine at what level-as to avoid its being absorbed and then neglected to deteriorate. It should also be noted that integration does not mean there should be no specialisation as we have for other disciplines of medicines (Michael, 1988).

It has not been very easy, however, to change the attitude of the public and medical personnel towards the disease as to make integration an easy procedure. Most countries, especially the developing countries, where the disease is endemic, have adopted Primary Health Care System. This is the area where serious efforts should be made to effect integration.

One of the important issues which is soon likely to come up is how and when to integrate leprosy with primary health care. MDT will no doubt bring down the prevalence rate to the tune of 1 per 1000 but it may be tremendous task to bring it down still further. The situation is not encouraging with incidence rate, which is a very slow declining indicator. Though no authentic figures of incidence would be available, it is still 1.5 or more per 1000
in majority of MDT districts (Tare 1989). Theoretically, switching over of leprosy work to primary health care should depend on the minimum incidence rate to be fixed for such a switch over. But this may take a very long time and programme officers may not have patience to wait. The compromising criteria needs to be decided for switchover.

One of the important concepts of PHC is community participation. It will be interesting to see results, if the community is involved and leprosy is integrated at a lower point of prevalence rate with primary health care system.

The need for integrating leprosy control work with general health services of the community, and the appropriate time has been receiving the attention of the W.H.O. expert committee on leprosy.

5.6 PRE-REQUISITES FOR INTEGRATION

Though a specialised service for any disease is a temporary phase, the length of this temporary phase of specialised leprosy service will depend mainly on two factors.

1. The degree of success obtained by the specialised service,

2. The preparedness of the general health services, especially at the periphery to take over the added responsibility and to discharge it satisfactorily.

Several factors make it imperative for us to consider the advisability of integrating leprosy into the general health services of India and other countries (Browne, 1971a), these may be brought together under the following headings.
Medical

Thanks to research into leprosy to the evidential findings of the best leprosy control programmes and the results of epidemiological investigations, leprosy cannot be regarded other than a slightly contagious mycobacterial disease that should be amenable to the medical measures applicable to the control of similar infections. There is no medical reason for treating leprosy in a special, different or unique way. On grounds of infectivity, curability, direct transmission without the need for an intermediate host or insect vector-leprosy does not require any separate service for its treatment or control.

Economic

Poor developing countries faced with widespread killing diseases, and diseases treatable or preventable at no great expense, with malnutrition and over population as ever present risks, cannot face the prohibitive cost of organising separate services for each of the chief endemic diseases. This is economically unjustifiable, and logistically impossible.

Operational

The population has a right to health and medical care, and will not for long tolerate lack of facilities for themselves while disproportionate funds are allocated to the favoured few. The only way of delivering comprehensive medical care to the masses is by means of a chain of all-purpose dispensaries manned by polycompetent medical auxiliaries, trained and provisioned and supervised. Investigation and surveys conducted by successive teams for purposes of individual diseases, and not accompanied or followed by treatment, leave the average villager bewildered and disappointed. And if treatment is provided for one disease, which may not be serious or fatal or widespread, he becomes frankly puzzled.
Social

In this modern world, there is no longer any justification for singling out leprosy as requiring its own organisation for diagnosis, treatment and control. Granted that circumstances and attitudes vary within extremely wide limits from country to country; but the time is surely ripe to initiate this desirable integration.

Administrative

In some respects, leprosy has been overemphasized as a disease, a stigmatizing condition, and as a neglected and ostracizing stage. It has attracted funds and sympathy. In some ways, the leprosy patient makes disproportionately demands on the budget of the voluntary organisation, and the government. From being neglected, he tends to be financially pampered, compared with his fellow villager suffering from a less publicized condition. If we can ensure that he gets a fair deal, and a square deal, from doctor and paramedical worker, in general dispensary or hospital in vocational training course or sheltered workshop, then we can assume that the special categorization of leprosy and its victims may well come to an end. Integration is already in practice in some countries where the stigma and the historical connotations were never as strong or as deep as in India. With increasing emphasis and education at all levels, and with the example of successful practice, we must try for the complete integration of leprosy into the general health services enlisting the co-operation of voluntary agencies and Government in the great and commendable task.

The present concept of primary health care as defined at the International Conference on primary health care, Alma-Ata, 1978, calls for an integration of leprosy control into the general health system. It would be too simplistic to say that specialized leprosy control, as practiced in many countries
for many years and still practiced in some, is in opposition with the primary health care approach. Treatment was delivered to the patients in their community. A large role was conferred to education and community participation, involving local leaders, schools and other community resources for detection, and relying on self-treatment in remote areas of difficult access. If leprosy control was not integrated into primary health care, the reason is that in many areas there were simply no other health services and no primary health care of any sort to integrate into.

The present development of primary health care offers a great opportunity for leprosy control. In areas where a well-organized primary health care delivery system does exist, integration of leprosy control will, most likely, increase the efficiency of services. Moreover, since leprosy will not be singled out as a special disease requiring special services, integration will reduce the psychological and social stigma of the disease, which constitutes an additional advantage. Controlling leprosy through primary health care is, however, not an easy matter, and will not necessarily be cheaper. It requires discrimination, expertise, time and money. It is not that obvious that multiple drug therapy, with its technical requisites, will be easy to translate into the context of primary health care. It needs careful preparation.

Primary health care requires some kind of recording and reporting systems for all types of health problems. This could be called "appropriate information" similar and parallel to "appropriate technology". An appropriate information system to be used with in the context of primary health care implies the definition of relevant indicators, as well as the design of a simple information system, possibly computerized for field use wherever appropriate and feasible. The WHO-recommended OMSLEP recording and reporting system for leprosy is one example. It can be easily adapted to local contexts
and expanded to include follow-up of patients treated with MDT. Integration of leprosy control into primary health care offers a great opportunity, as well as a challenge, for developing such systems.

5.7 RECOMMENDATIONS

In order to enable integration with PHC to become an effective reality for leprosy case-finding and case-holding in countries where leprosy is endemic:

1. All grades of health personnel likely to be engaged in the clinical management of patients should be able to (i) recognise leprosy and its complications (ii) refer recognised cases to an appropriate facility and should (iii) practice and teach a positive and supportive attitude toward leprosy patients.

2. All health facilities with responsibility for leprosy patient care should have sufficient staff competent to diagnose, classify and manage cases of leprosy coming to them for help. To maintain and update their competence, provision should be made for the continuing education of these staff particularly in view of changes in leprosy policy and advances in the technology of patient care.

3. Medical Students and all other categories of health staff in training should receive appropriate training in leprosy including, if at all possible, a period of field experience.

4. Appropriate information on leprosy should be included in countrywide programs of health education beginning with primary schools.

5. Private and voluntary organisations should be encouraged to provide more resources for the development, production and distribution of teaching material on leprosy.

6. Private and voluntary organisations should be encouraged to support faculties of medicine and schools of public health in their efforts to prepare suitable members of staff to meet the training needs outlined above.
An Expert Committee (GOI, 1988) consisting of Senior Administrators, NLEP Consultants, Leprologists, State Leprosy Officers, Public Health Experts and Programme Managers met in February, 1988 in Madras to discuss and evolve a suitable strategy for integration of NLEP with Primary Health care in the districts which are under MDT for over 5 years. The conclusions and recommendations of the Expert Committee are as follows:

Irrespective of the stage reached by the NLEP in either monotherapy or MDT Districts, it was unanimously agreed that the totality of the PHC system should be sensitized and prepared for progressive involvement in leprosy eradication as early as possible.

The involvement of PHC should be meticulously planned and developed gradually to be realistically suited to the roles and functions of each category of PHC worker available at each level, from the village, sub-centre PHC and other institutions and services falling under the total district management. In the pursuit of smooth transition and absorption of NLEP specialised approaches into the overall PHC infrastructure, integration should not at any time abandon or reduce the significance of any of the principles and approaches of MDT strategy.

Accordingly, the critical issues of overcoming constraints of participation of PHC through more purposeful motivation, with change in attitudes to leprosy work will depend on the degree of determination pursued in overall manpower staffing, their training and reorientation for a better perception and practice of NLEP as an integral component of their PHC tasks and responsibilities falling within their areas of competence. Since leprosy eradication is to be achieved in 196 endemic and 239 low-endemic districts, all of which present epidemiological variations and varying degree of
infrastructural and organisational development of PHC, it was crucial to develop a general plan of action for leprosy eradication for states taking into account the specific situation analysis, the realistic approaches to be followed locally, and the extent of technical, logistics and financial requirements, within the policy pattern of the NLEP. The general plan of action agreed upon by each state will be developed into specific plans of action for individual districts as soon as possible.

Without such planning and preparatory work, the State and its districts' needs will remain unclear about the process of eradication leprosy, and the required tasks, efforts and inputs needed at State and Central levels should all be spelt out in clear and definite commitments by the respective parties concerned. In this preparatory and planning phases at State level, the Government of India/NLEP Consultants have an indispensable role to fulfill.

5.8 CONCLUSION

It is high time to consider questions related to improving the effectiveness and efficiency of both PHC and the vertical control program, and the co-operation between the two from the point of view of integration in the long-run.

It is reasonable to conclude that MDT programme, if implemented efficiently, can control and perhaps ultimately eradicate leprosy. It is also seen that the case load had become very low as a result of MDT which result is likely to happen in other areas also after MDT is worked for a few years. Hence there will not be enough work for the field staff after about 10 years of MDT. But still case detection and surveillance has to be carried on for a few more years after such a situation is reached to be certain that control has been achieved. Later on, it will be necessary to think of integrating leprosy work with
general health services keeping specialised personnel only at the District Headquarters to act as consultants and also with Temporary Hospitalisation Wards and Rehabilitation centres for aftercare of patients. The present Para Medical personnel in leprosy may have to be trained as multipurpose workers.