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Reports

Summarized Papers from the All Indian Leprosy Workers Conference, Madras, 29-31 January, 1965.

(After an inaugural address by Sir A. L. Mudaliar, Vice-Chancellor of the University of Madras and a presidential address by Dr. R. G. Cochrane).

(**1**) *Team Approach in the Rehabilitation of Leprosy Patients*, was a paper delivered by MR. H. D. PAVRI, which demonstrated that more practical results are achieved by a team approach. Such a team in the author's experience has been studying such varied projects as assessing the effects of social ostracism, moulded footwear in the welfare of the feet, heat resistant points in limb trauma, moulded tool handles to suit the needs of hands, evaluation of jobs and tools to prevent trauma, choice of a suitable job in which to be placed for the best progress of rehabilitation.

(**2**) *Occupational Therapy in Leprosy*, by PAUL REGIS. This paper is not concerned with specific treatment ideas but with leading the deformed patients to his highest capacity in living. Each patient is evaluated for his physical disability, functional status, and mental condition. The aim is to concentrate on occupational therapy goals of developing independent skills and pre-vocational therapy. Every effort should be made to improve the working capacity of the patient in his own profession, along with his handicap.

(**3**) *Effect of Leprosy on the Work Life of Patients* by MISS N. B. SHAH. The author analysed the out-patient register of the Acworth Home in Bombay, and of 2,507 patients recorded January to October 1960 noted that 14% were women doing household work, 12% were children below the age of 15 years, 5.5% were above the age of 55 years, 4% were mendicants, 8.9% were young adults with advanced deformity and 55.6% were young adults without deformity. Of the patients without occupation or without means of support, 90 persons were young adults with deformity and 199 persons young adults without deformity. The young adults are the special concern of rehabilitation and educational facilities should be provided for children with infectious leprosy.

(**4**) *The importance of Social Assistance and Rehabilitation in Leprosy Control.* DR. V. P. DAS emphasizes that patients hesitate to leave hospital for home and family not only because of the stigma of leprosy, but because of economic and personal reasons.

The patient is gradually displaced as an economic unit as physical weakness advances, and ostracism develops to him. In many cases the relatives have used the ostracism to alienate the property of the patient in one way or another. Such relatives are the core of resistance to the return of the patient. Strangely enough, ostracism is more predominent in the educated section of the community. This is becausa the social excommunication is aimed at the whole family. Explanation, and further education, can be assisted by the family doctor.

On the economic side there are several suggestions, (a) improving the general economic condition of the common man in India; (b) teaching the patient an extra trade while he is under treatment, perhaps a better trade; (c) allowances for graded assessed disability; (d) explaining the leprosy problem to those in charge of the department on which the patient works or has worked; even the idea of rehabilitation centres at district level may be inspired in them; (e) in hospitals occupational therapy can be linked with the organized programme of rehabilitation; (f) sheltered industries outside the leprosaria should be arranged for the disabled, and help a non-mendicant morale; (g) every child patient should be found a place in a leprosarium, where they can be taught trades.

With early detection, deformities need not occur. A panel of lawyers, giving honorary service in the way of advice to patients to save many being ill-treated by the public on account of the disease, will be very helpfu! in a community. Re-assuring the public should also be done by doctors and social workers, and a special effort is needed by doctors to convince educated people.

(**5**) *Vocational and Psychological Rehabilitation*, by SRI D. V. KULKARNI, deals with present efforts in India in rehabilitation and social adjustment. The basic concept is of total rehabilitation. This includes physical as well as psychical means. The author considers that institutions are not out-moded but should be given special tasks, such as a supportive psychotherapy as well as specialised vocational training, therapeutic occupations, reconstructive surgery, and suitable medical treatment. The author makes several suggestions; (a) total rehabilitation should be a wider aim beyond physical; (b) the regular framework of therapy should be streamlined; (c) examine how anti-mendicancy legislation could be used for social adjustments of mendicants who have leprosy; (d) some kind of social insurance should be interwoven; (e) such as some kind of grant-in-aid; the leprosy programme needs help; (f) training for workers should be extended; (g) top priority should be given to emotional rehabilitation in any leprosy programme; (h) treatment centres should have specific and purposeful objectives towards social adjustment, with help of a team of specialised personnel, and encouragement of the corporate sense of the patients by themselves having a corporate sense.

(**6**) *Attitudes of leprosy patients to Their Rehabilitation*, by MISS O. PEREIRA. This paper deals with the response and active participation of the patients. Complete faith in the therapy is essential for its effectiveness. Studies show that most patients have faith in a complete cure with good treatment. This faith is stronger in women than in men, and more in the literate than the illiterate.

Many of the patients go home for shorter or longer periods, and there is benefit in this. The strongest fears in the patient concern social status and this fear affects relatives. Reconstructive surgery, artificial aids and adaptive devices are hard to find for cured patients, and their future seems insecure. Whether a patient wants his old job or is willing to find a new job is important.

Recreation is important. It goes a long way in building up a positive attitude to rehabilitation.

(**7**) *Control of Leprosy Among Students*, by SRIMATHI INDUMATI S. RAU is a paper recording a study of progress of the patients in clinics at the Victoria Hospital, Bangalore. Most patients are under 30 years of age and a great number about 13 years of age. Out of 650 patients registered as out-patients in 15 months 25 were below 10 years, 112 were between 10 and 9 years, and 194 were between 20 and 28 years. The group of young people contained 81 who were students in the schools and colleges of Bangalore, but none was sent by schools medical officers, and their diagnosis seems to be by chance. Many teachers suffered from leprosy. Efficient periodical medical examination is essential, as well as general and special health education.

(**8**) *Social Obstacles in Combating Leprosy*, by DR. Y. K. SUBRAHMANYAM. The paper poses the problem of instilling in the mind of the patient the understanding of leprosy and courage to come forward for treatment. It might help if the leprosy worker approaches the leprosy patient as one suffering from mental anxiety as well as physical disease. In all cases special love and care are needed, and the worker himself should be fearless. The leprosy paramedical worker, on whom control depends so much today, should realise this.

(**9**) *Health Education in Leprosy in Urban Areas*, by SHRI M. S. MEHENDELE. The author indicates various groups in each community such as leading persons, doctors, government and municipal officials, heads of institutions and clubs. These should be indoctrinated and given a task to do, as well as the teacher, the patient and relatives, and the man in the street. Various methods are suitable for tackling each group. Certain suggestions are the individual approach, short term courses for doctors, approach through voluntary workers, group discussions and meetings, newspapers, radio, pamphlets, films with lectures, integration with general health work. The author also suggests revision of text-books.

(**10**) *Health Education in Leprosy*, by DR. RANJITH RAO. The author who is in Health Education in the Research plus Action projects in Poonamallee, Madras, relates his experience in 2 villages. In these the main difficulty was the reluctance to come early for treatment and to maintain regularity. A large amount of success followed the formation of village health committees among influential village leaders, and the practical help of the Research cum action Committee. Local health committees have been found active. Regular treatment of the patient over long periods is helped by these local health committees.

(**11**) *Leprosy Eradication in the Villages*, by DR. R. VEDABODAKAM. The author gave an account of health education of the villages adjoining St. Luke's Leprosarium in Tirunveli District in Madras State. When a village is selected the panchayat president is informed a week in advance. The party arrives at the village at 7 p.m. in a van fitted with loudspeakers and gramophone, and the van moves round the entire village and gathers crowds successfully. Slides are shown and speeches made.

(**12**) *Health Education About Leprosy*, by DR. V. EKAMBARAM. The author thinks that public meetings and wall posters are not enough, and that health education about leprosy should be integrated into general health education and planned for urban and rural populations. He suggests that all students of the higher secondary and college classes should be given a course of instruction about general hygiene and about communicable diseases, including leprosy. The subject should culminate in a general examination, and in this subject all students should be required to get a class mark. He suggests that all officials and municipal and government employees should pass a first aid and general public health examination before being appointed to services. Traders might well be expected to pass such a course. Rurally, village committees should participate, and the efficiency of a panchayat should be judged by their active knowledge of such a health programme. The press, radio, and journals could help in the spread of health education.

(**13**) *Integration of Leprosy with General Health Services*, by DR. N. JUNGALWALLA. The author points out that the national leprosy campaign has not achieved the status of a mass campaign, for in 1963 the total registered was 530,000, whereas treated reached 496,000. Of these there were 394 'S.E.T.' or official treatment centres which covered 50,000 patients and voluntary agencies 20,000 patients.

The organisation of leprosy control work through S.E.T. centres is already in process of integration with basic health services, based on the primary health centre. With hospitals only partial integration has been attained. The separate leprosy treatment institution seems to be the pattern. It is debatable whether it should be increasingly favoured. The teaching hospital still needs to develop community consciousness. It is found that some self-sufficient institutions can find and treat fairly large numbers of patients and treat them, e.g. Polambakkam covered 570,000 population and registered 23,500 patients in $3\frac{1}{2}$ years; the Danish Mission covered 680,000 population and registered 23,000 in 3 years against 87,500 registered in the whole state. In Uttar Pradesh 13,000 patients were registered in 1 Taluk in 3 years by a similar voluntary organisation.

The Wallajapet scheme has tried to use the staff on a vertical mass campaign basis and tries to forge a link between the medical institution and the groundwork of primary health centres.

Co-ordination will progress when funds are available to strengthen district and subdivisional hospitals and peripheral services. The control of leprosy may yet achieve a mass campaign as in malaria and tuberculosis. Considerable experience has been built up in other campaigns, and integration and consolidation of the leprosy campaign should be planned now, with a pilot phase as soon as possible.

(**14**) *Review of Leprosy Control Programme in India*, by DR. P. N. KOSHOO. The author recalls the recent estimate of 1,500,000 leprosy patients in India and that a quarter of these patients are of infectious type. The 8 states which have a big problem are Andhra, Madras, Bihar, Maharashtra, Mysore, Orissa, Uttar Pradesh, and West Bengal. Other states have a rather low prevalence. Of the 450 million population of India there are 300 million people living in zones of high and moderate endemicity.

The national leprosy control programme has been in existence since 1955. Up to the end of the second plan a population of over 14 million people was covered and 6.6 million persons physically examined and 180,000 patients registered. In the third plan the concept of the S.E.T. Centres introduced, established in less endemic areas, and form the first step towards the integration of leprosy work with general public health and medical institutions. Leprosy subsidiary centres were reformed into leprosy control units. During the period of the third plan so far a population of 24 million has been covered and out of 12.2 million persons examined 250,000 more patients have been registered.

There have been financial and administrative difficulties, but now there are 166 leprosy control units, 487 S.E.T. Centres, and 32 voluntary organisations.

Training programmes have gone on for medical and non-medical personnel, and a rehabilitation training programme has not been forgotten.

The draft fourth plan envisages the establishment of 110 more leprosy control units, and 4,490 S.E.T. Centres in rural and urban areas, and 11 more training centres: 21 additional voluntary organisations may receive grants-in-aid, and a handsome amount will be spent on health education, reconstructive surgery, and a training programme for rehabilitation.

(**15**) *Voluntary Institutions and Changing Pattern of Leprosy Control Work*, by DR. R. V. WARDEKAR. The main burden of leprosy work since Swaraj has shifted from voluntary institutions to Government. In the same period sulphone therapy has shifted the emphasis from in-patients to out-patients. Voluntary institutions need to re-orientate their policy so as to contribute to the national programme by sharing their knowledge, and make practical field investigation of special problems, and especially if their institutions have 4 wings such as hospital, vocational training, settlement, and infirmary. If they are interested in out-patient treatment centres, they can take up S.E.T. work, if necessary helped by Government grants. Voluntary organisations can take up health education in urban areas, or establish referral centres.

(**16**) *An Approach to Leprosy Control and the Achievements of the Pogiri Control Centre*, by DR. KEJA. The Danish Fund started a leprosy control project with the approval of the Government of India and the interest of WHO, the Gandhi Leprosy Memorial Foundation and the Hind Kusht Nivaran Sangh. Soon construction of a headquarters building is to begin at Pogiri near Rajam, Palakonda Taluk of the Srikakulam District, which is a hyperendemic area. The approach to the problem on the advice of WHO has been ambulatory treatment through static control units, with visiting supervisory staff. The plans for 1965 are to extend the project to 2 adjacent taluks, and later to begin a similar project in Orissa. The Palakonda taluk project covers an area of 1,500 square miles with a population of 798,391. The prevalence rate is 18 per thousand, child rate 24.5% and lepromatous rate of 21.5% and the total number of patients is 20,884.

(**17**) *A Review of Anti-Leprosy Campaign in Gaya*, by DR. R. S. SHARMA. This anti-leprosy work in Gaya developed under the auspices of the Gram Nirman Mandal, led by Shri Jaya Prakash Narayan. There are many out-patient clinics spread over the area. The author points out from his experience that sulphones are not the last word in therapy, for there are baffling relapses: nor distribution of tablets through paramedical workers is the last word. There is need for suitable doctors. All Government dispensaries and hospitals should take more interest in anti-leprosy work and should treat leprosy and make special arrangements for reconstructive surgery. There should be more co-ordination of funds and supervision of voluntary institutions, and the allotted funds should be available in time. All leprosy workers should be one in spirit and devoted to the common cause.

(**18**) *Integration of Leprosy Relief with General Medical Relief Measures*, by DR. V. EKAMBARAM. The author stresses the importance of integration and suggests how the difficulties can be overcome by sufficient coaching of undergraduates in leprosy, by training house-surgeons in leprosy for 15 days, by asking questions about leprosy in the M.B., B.S. exam, by training medical officers in service as well as general practitioners by the State Leprosy Officers, by making a record of good leprosy work as one of the qualifications for promotion of Medical Officers.