Editorial

INTEGRATION—PRESENT PROSPECTS

A recent editorial in this journal (1971, **42**, 1) commented on certain trends in the relation between leprosy control programmes and the health services of developing countries. The provocative, controversial, idealistic watchword "integration" is fast becoming more than a talking point in many circles.

The Fourth Report of the World Health Organization (WHO) Expert Committee on Leprosy (1970) observed that "the need for integration of leprosy control programmes into the structure of the general health services is widely recognized", but pessimistically concluded that "full integration will be attained only as a result of a long drawn-out process". Lukewarm support for the theoretical desirability of integration was given by the WHO Regional Office Seminar in Kampala, but at a more recent meeting held in the same town (East Africa Leprosy Working Conference, April 1970), the principle of integration was "generally accepted" and some of the difficulties encountered at supervisory and local level were realistically faced and discussed. The responsibility of governments to plan national health programmes in the interests of all citizens has been urged and admitted by the World Health Organization, and also by such meetings as that convened by the United Nations at Geneva (September-October, 1971) on "National programmes for rehabilitation of the disabled in developing countries". Many governments have in principle accepted these various recommendations, but many face difficulties in their attempts to pay more than lip-service to them.

On another page of this issue (p. 255) we publish *in extenso* a valuable account of discussions held in Bhopal at the 12th All-India Leprosy Workers' Conference and 9th Biennial Conference of the Indian Association of Leprologists. The understandable prudence and circumspection of this account will commend themselves to those acquainted with the Indian scene. Local knowledge and sympathy should prevent precipitate action that would leave the leprosy sufferer worse off than he is. Over-rapid and ill-considered attempts at premature integration of a functioning leprosy programme into an unwelcoming rural health service could all too easily result in a return to the *status ante quo* of neglect. There might be some initial reduction in the number of leprosy patients receiving treatment, which, in these circumstances, would indicate failure rather than success.

In this matter, the social milieu and climate are factors just as important as the coverage of the health services. Such non-medical factors affect the speed and even the possibility, at the present time, of full integration of leprosy into the health programme. In some countries prejudice against leprosy and the leprosy sufferer still appears to be as strong (and as groundless and irrational) as ever, while in others gradual erosion of age-long beliefs is making gratifying headway.

The quality of the basic health services, the resources available in men and means, the apportionment of effort between curative and preventive measures, and between prestigious central hospitals and rural health centres—all have a bearing on the gravity of the leprosy endemic and the forces actually deployable for meeting it. When a specialized campaign of leprosy control has achieved a notable degree of success, the thorny and inescapable question arises: how can the residuum of patients still needing treatment be adequately cared for? It is possible that leprosy could insidiously and silently re-establish itself in such a community if existing medical services were too thin on the ground, or were otherwise unable or unwilling (for diverse reasons) to cope with this extra load.

Voluntary organizations have a continuing responsibility in this business: with their history of dedicated and competent service, their present resources, and their capacity for local initiative, they can influence policies and practices in many ways.

The debate continues.