ASSESSMENT OF EFFORTS TO INDUCE MEDICAL PRACTITIONERS TO PARTICIPATE IN URBAN LEPROSY CONTROL PROGRAMMES*

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The cooperation of private practitioners in the urban leprosy control programme in India is considered essential. Doctors are subject to the inhibitions and prejudices of the general population. Methods adopted to encourage the participation of doctors are described. An individual approach, the provision of literature, and in particular, refresher courses have been shown to lead to changes in attitude, while informal group meetings have also proved helpful.

The urban leprosy control programme differs in approach, though not in aim, from the leprosy control programme in rural areas, mainly because the people are more educated and the environment more sophisticated. The social structure is such that the privacy of the family is something that cannot be violated, and any measures to bring about leprosy relief or change in attitudes must be designed against this background.

When the Gandhi Memorial Leprosy Foundation introduced health education on an experimental basis in 1961 its prerequisites and objectives were in tune with the social psychology of the urban community. The objectives were to make people aware of leprosy, suspect it in the early stages, consult the family physician and take treatment if necessary.

While the whole community was our concern, there were two groups in it which we felt had to be tackled as a priority. The first consisted of school teachers, a large, homogeneous and highly relevant group. The second consisted of the doctors, also a priority group because they were directly concerned with the health of the community, and it is to the family physician that most people in cities go with their medical complaints.

If doctors participated in the leprosy control programme there would be distinct advantages:

1. Patients would not normally hesitate to go to their family physician because this would not reveal their identity as leprosy patients.
2. This would avoid problems created by ostracism and fear.
3. Many patients who would otherwise have remained undetected and untreated would be put on treatment.

There are more than 100,000 doctors working in leprosy endemic areas in India. If each doctor treated 10 cases of leprosy, 1 million patients, or nearly one third of the estimated total of leprosy sufferers in India, would get the benefit. Not only this, but the quantum of infection in the community would correspondingly be reduced.

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Personal Approach

The method adopted to enlist the cooperation of doctors was to approach each doctor individually, and try to convince him of the need and importance of his participation in leprosy work as part of his routine medical practice. It soon became apparent that doctors had certain inhibitions regarding the diagnosis and treatment of leprosy patients. At one stage of our health education campaign we asked people to approach their family physician if they saw signs simulating leprosy on their bodies. Naturally, these persons expected their doctor to be as competent to treat leprosy as he was with their other ailments. The doctor's dilemma was that although he had some theoretical knowledge of leprosy, he did not feel confident enough to say whether a patient was or was not suffering from the disease. Another predicament was that if he labelled the case as leprosy, the patient might suffer from psychological trauma. In order to escape from this embarrassing situation, many doctors who were contacted by the Foundation suggested that if the Foundation brought out some handy literature and arranged refresher courses on leprosy, they would welcome it. They expected answers to their problems to be elicited during refresher courses.

Literature

As a result of the first suggestion the Foundation brought out a booklet entitled *Hints on Diagnosis and Treatment of Leprosy*. At about the same time the Foundation also prepared a film, suitable for medical and paramedical groups with the title *Diagnosis of Leprosy*. Both the booklet and the film turned out to be very useful.

Refresher Courses

The Foundation then worked out a methodology for organizing refresher courses. The Paramedical Officer of the Foundation would visit a town and make a complete list of the doctors with the help of the local Secretary of the Indian Medical Association. The doctors were then approached through 3 letters. The first gave the doctor an idea of the leprosy problem in India and the need for his participation; the second gave information regarding refresher courses; the third letter in the series requested a personal interview with the doctor. Then in consultation with the doctors and the Secretary of the Indian Medical Association refresher courses would be organized. Originally the course consisted of four lectures each of 1½ hours' duration and spread over a period of 4 days. Later on the course was condensed to 2 days to suit the convenience of doctors.

The Foundation has so far conducted 83 refresher courses for 2810 doctors in six States. Details are on opposite page.

Evaluation of Refresher Courses

We sought to assess the usefulness of these refresher courses by sending questionnaires to doctors in two places, Midnapur and Poona. The first information sought was, how many persons came to the doctor with suspicious skin lesions during the previous 2 years; it was not how many cases did he detect among his clientele. The letter was sent to 50 doctors at Midnapur, of whom only

Refresher courses

Name of unit	Number of courses	Doctors attending
Poona (Maharashtra)	20	905
Midnapur (West Bengal)	31	748
Khurda Road (Orissa)	10	342
Kottyam (Kerala)	13	365
Wardha (Maharashtra)	2	76
Dharwar (Karnataka)	4	218
Tiruchirapalli	3	156

9 responded by giving information. Eight doctors out of the 9 who responded were approached by their clientele for diagnosis of suspicious lesions. At Poona, according to the answers we received, 11 out of 23 doctors were approached by their clientele for diagnosis of suspicious lesions. The overall impression gained by this method of analysis was that the questionnaire method was unsatisfactory for the purpose of evaluation. All the same some encouraging trends in changes of attitude among doctors could be discerned.

Analysis by Social Scientist

At our request a social scientist of Poona University undertook an analysis of the results of refresher courses held at Poona. This step was taken because however much we may try to be objective in our self-evaluation, we are likely to be very biased because of our own involvement.

The social scientist undertook his study at two comparable towns, namely Poona and Jalgaon. At Poona refresher courses had been conducted. At Jalgaon no refresher courses had been conducted. The sample was selected by a statistician by the method of stratified random sampling without replacement. The universe in Poona consisted of 475 doctors who had attended the refresher courses. In Jalgaon the entire medical population was taken as the universe. In each town 47 doctors were selected. The doctors from both towns had graduated from medical colleges where the teaching of leprosy had been similar. Both groups had been exposed to the same information regarding leprosy through medical journals, the press and other sources. Further details are as follows

	Poona	Jalgaon
Doctors selected at random	47	47
Male	40	39
MB BS	17	12
Post Graduate Diploma and Degree	23	22
General practitioners	87.2%	74.4%

The main points of similarity were:

(i) The samples showed a preponderance of degree holders in both towns

(ii) At both places there was a preponderance of general practitioners in the sample.

INSTRUMENT OF EVALUATION RESEARCH

The interview schedule was designed and used with a view to test awareness of the facts of leprosy, to note the prejudices, practices and opinion about leprosy. The schedule was not designed to test the knowledge of the doctor.

The results of the enquiry are interesting.

(i) At both places the doctors examine suspicious skin lesions for leprosy, 74% in Poona, 76% in Jalgaon. In Poona this may be due at least in part to refresher courses (and health education). In Jalgaon this may be due to the proximity of the town to leprosy centres at Amraoti and Wardha, whose influence cannot be ruled out.

(ii) In Pona 81% of patients are treated openly, as against 45% in Jalgaon, where they are treated confidentially.

(iii) In Poona more patients are treated in private dispensaries and less are referred to skin specialists as compared with Jalgaon.

(iv) 21% of doctors at Jalgaon feel that the disease will spread to others if patients are treated at their clinics, as compared with 0.5% at Poona.

(v) 25% of doctors at Jalgaon believe that all leprosy patients should be sent to leprosy colonies in order to check the disease, as compared with 4.4% in Poona.

(vi) At both places doctors were of the opinion that refresher courses in leprosy are essential.

The social scientist commented that he could not ask technical questions for obvious reasons, even though he was aware of areas of ignorance and prejudice. "Moreover there are no universal truths available in leprosy" he adds.

It becomes clear that health education has a definite impact in changing the outlook of doctors on leprosy. It may be commented that in stating this health education has been equated with refresher courses. It must however be understood that preceding the refresher course the Paramedical Officer had spoken to the concerned doctors a number of times, and this was also true subsequently to the refresher course. Thus the refresher course was a part of the educative process.

Those medical men who have been exposed to health education and have undergone a change in attitude in consequence definitely assist in urban leprosy control work. It cannot be surmised at this stage to what extent their cooperation will influence leprosy control. This is material for further assessment in the years ahead.

In terms of cost, it may be mentioned that on an average the cost per doctor attending refresher courses is around Rs 40/- (*c.* £2). This includes expenses incurred by the Paramedical Officer in organizing the refresher courses and those incurred in sending a leprologist from Wardha to conduct the courses.

Group Meetings

The Foundation has conducted a large number of group meetings for doctors. These are on opposite page.

These are not refresher courses in the sense that the subject was not covered according to a pre-determined method. The subject was nevertheless covered in all its essentials, including the projection of slides and wherever possible showing the film *Diagnosis of Leprosy* in the time that was available. Such gatherings were subjected to post-lecture analysis by the speaker and the Paramedical Officer who

Group meetings for doctors

Unit	No. of meetings	Attendance	
		Doctors	Students
Poona	44	1333	395
Midnapur	20	655	–
Khurda Road	16	295	1010
Kottyam	9	149	294
Wardha	6	168	–
Bardoli	28	985	3550
Dharwar	5	101	–

organized the group. The criterion to determine whether a group meeting had been successful or not was the number and range of questions put to the speaker at the end of his talk. By that criterion the impression gained was that such gatherings were beneficial. A number of the doctors who attended such group meetings were practitioners from rural areas.