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Editorial

LEPROSY AND PRIMARY HEALTH CARE

Well over a year ago, the Editorial Board of this journal decided to devote a special number to the subject of *Leprosy and Primary Health Care*. This decision was taken partly because of increasing international interest in Primary Heath Care (PHC) as an important element in health services, particularly in developing countries, but also because it was thought necessary to look very carefully indeed at the limitations of such an approach in a disease with the inherent difficulties and complications of leprosy. We therefore informed our colleagues of this venture and wrote letters to many parts of the world, requesting original articles and observations on the subject, particularly from those who were known to have experience of PHC in countries with a leprosy problem. At the same time a search of the literature was made for publications dealing specifically with leprosy and PHC, covering as best possible material from the Far East, India, Africa and South America. In this special number of the journal we present the results of these endeavours, together with a selected bibliography of books, booklets and other publications which deal with some aspects of PHC which may contribute to leprosy control.

It must be immediately obvious that our assembly of material is neither large nor generally representative of those parts of the world were PHC and leprosy might be considered most important. Indeed a significant discovery from the editorial point of view has been that there are very few projects indeed, anywhere in the world, who can submit a written account to show how PHC in the World Health Organization sense of the term is working in association with leprosy or vice versa. The definition of PHC, from the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978, reads as follows:

> Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.

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The full text[1] which accompanies this definition should be studied in the original by those interested in any aspect of health care delivery, but early on (page 3) there is a supporting paragraph of particular importance to the potential of PHC in leprosy – 'Primary Health Care is likely to be most effective if it employs means that are understood and accepted by the community and applied by community health workers at a cost the community and country can afford. These community health workers, including traditional practitioners where applicable, will function best if they reside in the community they serve and are properly trained socially and technically to respond to its expressed needs'.

Some of the original articles in this number of the journal draw attention to the way in which such workers have been identified and trained, with varying degrees of success, for work in leprosy. It must however be emphasized that for various reasons, these excellent contributions represent only a fraction of the total experience to date. In conversation, correspondence, meetings and workshops, a considerable number of doctors, supervisors and leprosy control officers have described projects in various parts of the world, notably India, in which the village or community health worker has already contributed significantly to improvement in compliance, regularity of attendance, and in the detection and referral (not diagnosis) of possible new cases of leprosy. Timidity, or lack of time in an exceedingly busy day-to-day commitment to field work, have probably accounted for the fact that much valuable information has not yet been reported. In view of the well known constraints in the diagnosis, treatment and management of this disease, it is however perhaps just as well that we should proceed with extreme care in reporting or publishing preliminary results either at meetings or in print. It must be acknowledged that a number of experts in the field of leprosy have expressed reservations about any change towards PHC which is not preceded by a carefully planned programme of training and re-training for all health personnel concerned, and which is not backed by an effective system for referral of cases for confirmation of diagnosis and the treatment of complications. In this context it is important to note that some confusion has arisen between PHC and 'integration' – the latter term being used in a variety of different ways, but usually to indicate that a specialized or 'vertical' control programme should be abandoned or phased out, in favour of the 'horizontal' insertion of leprosy, together with other similar health problems, into the general health services. It is our view that such a step should not generally be taken in the case of leprosy, until the most careful plans have been made and implemented to educate all members of the health service who will encounter and treat leprosy patients. With extremely few exceptions, this process will cover a period of years, not months, and there is in fact already evidence to show that where the change to 'horizontal integration' has been made almost overnight, leprosy services have been amongst the first to suffer.

The positive side of PHC, and its great potential benefit to the patient with leprosy, is brought out well in this number of the journal by the contributions of Antia from Bombay and Hogerzeil from Dichpalli, who describe the role of the PHC worker with emphasis on the benefit to leprosy control at community or domestic level. This element of PHC activity – at least for the immediate future – may prove to be the most important from the leprosy point of view, for chemotherapeutic regimens have now been defined better than ever before by WHO[2] and yet we continue to face problems, in common with our colleagues in tuberculosis, in compliance and regularity of attendance for suffient periods of time. The message of PHC for those working in maternal and child care, nutrition, immunization or contraception may also contain something important in the way of personal cooperation and regularity of attendance by the individual, but for the successful application of adequate chemotherapy to a larger number of patients with leprosy, it is probably no exaggeration to say that this element is absolutely crucial. It is a delusion to think that the mere purchase and supply of drugs, some of them at high cost, or their issue from a hospital, clinic or mobile team, will cover this vital area in the chain of events leading to success. Provided we approach the concept of PHC keeping in mind a number of safeguards for the patient and maintain what Rouillon – in the case of tuberculosis – has termed an 'aggressive identity',[3] it is indeed possible that the PHC concept may go far to providing a solution, better than any which has so far been proposed, to the problems of drug compliance and attendance, which are inseparable from the use of both self-administered and supervised medication in leprosy.

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References

1 WHO Primary Health Care. A joint report by the Director General of the World Health Organization and the Executive Director of the United Nations Children's Fund. WHO, Geneva, 1978.

2 WHO Chemotherapy of Leprosy for Control Programmes Report of a WHO Study Group. Technical Report Series 675. WHO, Geneva, *in press,* 1982.

3 Rouillon A. Introduction to centenary of the discovery of the tubercle bacillus by Robert Koch 1882–1982 *Bulletin of the International Union Against Tuberculosis,* 1981; **56**: 83–85.