

## Reports, News and Notes

### LEPROSY AND PRIMARY HEALTH CARE: A MEETING HELD AT THE ROSS INSTITUTE OF TROPICAL MEDICINE, LONDON WC1 ON 2ND FEBRUARY 1981

Professor D J Bradley invited members of the Evaluation and Planning Centre in his Institute to meet Ad de Rijk (Royal Tropical Institute Amsterdam), Tim Lusty (OXFAM, Oxford) and Colin McDougall (Slade Hospital, Oxford) to discuss some of the problems in the handling of leprosy within the context of Primary Health Care (PHC), as defined by WHO. The discussion began with a position paper outlining some of the main clinical features of leprosy and its adverse immunological reactions, with particular reference to diagnosis, treatment and case-holding. It was suggested that whilst some relatively simple activities, such as ensuring patient attendance and encouraging compliance in the ingestion of prescribed drugs, could be considered as suitable for the peripheral worker, others were far too complex to be considered at this level. There was a need to define, probably at country, or at least regional level, what such peripheral workers might reasonably be expected to do for PHC in leprosy. During the ensuing discussion, it was soon pointed out that it would also be necessary to limit and control the number of duties these workers were called upon to perform; there were already signs that their workload was becoming impossible. Drawing on reports and experience from those areas of the world where PHC is being practised methodically (and they were very few), participants at this meeting found data on their success or failure to be conspicuously lacking. This was true for their activities in general, and more so for leprosy. It was also reported incidentally, that 2 such schemes (both in Africa) had not taken leprosy into the programme at all, and that leprosy control was still being carried out by special services, covering the same area. Whilst this might have been due to the 'special' or 'segregated' aura surrounding this disease, the possibility was also considered that leprosy, like tuberculosis, is intrinsically a more difficult subject to handle at primary health care level than maternal and child care, immunization, hygiene, contraception, clean water supplies, and so on.

After considerable discussion about duties, Ad de Rijk suggested that the village health worker might reasonably be asked to be concerned with the following:

- (1) Regularity of collection of anti-leprosy drugs and encouragement of patients to ingest the prescribed dose, regularly and for long enough.
- (2) Reporting on patients who (a) move out of the area, leave the country, travel, etc., or (b) arrive in the area for the first time.
- (3) Early recognition of complications, including damage to anaesthetic limbs and adverse reactions, with referral if indicated.
- (4) Case finding, including contact examination, with referral for all suspicious cases for further examination and diagnosis.

The methodology of training or instructing such workers in these simple duties was felt to be a matter for planning and execution at regional or perhaps district level, in view of the enormous differences in various countries of transport and suitable teaching centres.

Instruction on the spot, with a minimum of transport to centres where the conditions and facilities might be far superior to those of real life in the village, was thought to be important, but it was recognized that there might be difficulties in teaching the basic clinical signs of leprosy and its adverse reactions, in the absence of a suitable group of patients.

On the matter of leprosy in relation to other diseases, it was thought that leprosy should usually be brought into PHC after it had been established and shown to work for various other diseases or services, and that – with some exceptions – it was unlikely that leprosy could initiate PHC. The importance of supervision was discussed at some length, with the conclusion that its most significant component would probably come from ‘district’ level, but that it might be necessary to enlist personnel devoted almost exclusively to the supervision of PHC, in view of the usually heavy workload of those already working in district hospitals. Participants agreed that some element of vertical or specialized expertise would be needed in leprosy for many years to come, probably from district level upwards, and that there would be a continuing need for referral centres, able to diagnose, treat and generally manage all aspects of complications in leprosy.

The meeting ended with a discussion on the magnitude of the task created by the aim of health for all by the year 2000, in the area of medical and para-medical education and the provision of suitable health learning materials. It was thought that appropriate education, together with the necessary change of attitude, might well take 10 years. Meanwhile, it was important to collect a great deal more data on the integration of leprosy, and other diseases of similar importance, in those areas of the world which are practising, or claim to be practising, PHC. Indeed, perhaps the most important upshot of this meeting was the realization that there should now be available much more information on the effectiveness (or otherwise) of some aspects of PHC, including experience with leprosy.