Lepr Rev (1982) **53**, 230–239

Letters to the Editor

BLINDNESS AND PRIMARY HEALTH CARE

Sir,

The concept of Primary Health Care, though obviously not a universal panacea to all the health needs of the developing world, has since its enunciation in the Alma-Ata declaration been broadened to the point where I believe it has a significant relevance to many causes of disablement, and certainly is the basis of any attack on avoidable blindness.

Of the four priority causes of blindness which are now the main thrust of our prevention of blindness programme, 2 – trachoma and xerophthalmia – can certainly be tackled effectively at the level of primary health. The other 2 causes – cataract and onchocerciasis – do require secondary or tertiary care and, in the case of onchocerciasis, environmental control.

As I understand it, and I may well be over-simplifying the problem, the primary difficulty in leprosy control is identification at a sufficiently early stage to arrest the disease. In discussions at the Leeds Castle International Seminar on the Prevention of Disablement, November 1981, the opinion was expressed that control of leprosy was possible at the Primary Health Care level. This could be achieved through the identification of leprosy patients, in well-equipped primary health centres, possibly by the treatment of straightforward cases, and of course by the referral from the primary health level to other levels of the health services of people requiring more sophisticated treatment.

It is this basic ability of a competent primary health system to know its community, identify what it can do and refer what it cannot, which is generally regarded as its most important characteristic. Encouraged by the attention which has been brought to bear on disablement by the recent International Year of Disabled Persons, and by support from the World Health Organization, the important thing now is to get long-term action, and the centre of that strategy must be an effort of *prevention* of the major causes of disablement, including leprosy.

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