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.

J WILSON
Director

Royal Commonwealth Society for the Blind
Commonwealth House
Haywards Heath
West Sussex RH16 3AZ

INTEGRATION OF LEPROSY INTO A BASIC HEALTH CARE SERVICE

Sir,

In the former Belgian Congo (now Zaire), following successful campaigns against trypanosomiasis and yaws, the charismatic personality and vision of Dr (now Sir) Clement Chesterman has full scope under the government policy to respond to appeals from chiefs
and notables to inaugurate a community health service based on dispensaries established in the chief towns of each agglomeration. The area concerned was the medical sector of the Baptist Mission Hospital at Yakusu, covering about 10,000 square miles with a total population of some 105,000 representing 7 tribes, each with its own language and culture. The health authorities invited Dr Chesterman to develop a public health programme covering the whole area, and such were the good relations with the local population as the result of campaigns against trypanosomiasis and yaws that the hierarchical leaders in villages and chefferies asked for an extension of the developing health care programme into the districts they controlled. By the early 1940's health centres had been built by the people themselves in 18 strategically-situated villages so that nine-tenths of the population were within easy walking distance of medical help. Ten of these centres were eventually supplied with a binocular microscope and the usual stains for blood, lymph, urine, dermal scrapes, lymphatic node puncture, sputum and cerebro-spinal fluid. Both the lengthy training of the infirmiers (5 years) and the standard of knowledge and skill expected of them exceeded the standards now being advocated in the average Primary Health Care programme, and were those of good basic health care. Each health centre was responsible for the supervision of two to four subsidiary treatment centres. For the latter, the local community chose a suitable candidate — usually a senior schoolboy who had shown some interest in health matters — and the local infirmier undertook to train him for a 3-months' apprenticeship at his health centre. When the trainee had given evidence of competence and suitability, he was sent back to his village to take charge of an aide-post, which the villagers had already built. He was supplied with a few medicines and some dressings. On market days, the infirmier would cycle in to visit him and give treatment for leprosy, etc., and examine and prescribe for patients whose trouble was beyond the competence of the local aide. The area of activity of the latter was that of a well-organized Primary Health Care worker. Doctors from 3 agricultural companies in the area subsequently developed the statutory medical services required for contracted workmen and their families, and also assumed responsibility for the medical care of the people living in adjacent villages.

In 1935, Yakusu became 1 of 2 non-government schools for Medical Auxiliaries to receive official approval for a 5-year course for the diploma of Infirmier. The first 3 years were spent at the Central Hospital, in class and ward-work, with periods of practical work in the district interspersed with clinical work at the hospital. Amongst transmissible diseases in the area were trypanosomiasis, yaws, tuberculosis, onchocerciasis and leprosy — the latter far commoner than early investigations had suggested. With the help of infirmiers diplômés and in training, leprosy survey teams discovered all clinically diagnosable cases of leprosy, and took eight slit-smears from each patient. These were fixed on the spot, and subsequently stained and read at the central hospital. In this way a complete record of all cases of leprosy was made, and kept up-to-date by annual whole-population surveys. Biopsies were taken of typical and of doubtful cases, to be examined by Dr R G Cochrane at the Leprosy Study Centre in London.

During this period, because of its medical and social importance in the community, leprosy assumed a greater prominence in clinical teaching, in the examination of skin and peripheral nerves and in microscopy. At first, treatment consisted of chaulmoogra oil by intradermal and intramuscular injection; then sodium gynocardate and proprietary preparations of derivatives of chaulmoogra oil were used. A plantation, 2 1/2 acres in extent, of Hydrocarpus wightiana was developed.

The sulphones were used initially at the central leprosarium, whose patients increased from 118 to 1,025 as news of the success of the new treatment spread. When adequate supplies of drugs became available, 5,349 leprosy patients were undergoing treatment at the all-purpose dispensaries, and 2,749 registered patients with indeterminate or minor tuberculoid leprosy were kept under observation and did not receive treatment; their lesions were resolving spontaneously.
A decline in the numbers of new cases of leprosy infection began to be observed within a few years of the installation of treatment for everybody suffering from leprosy, and coincident with the reduction in infectivity of patients with multibacillary disease and heavily infected nasal mucosa in this area of prevalence. After 8 years of leprosy treatment completely integrated into a Primary Health Care service covering the whole district, leprosy could be considered as being controlled. In the light of modern knowledge, it may be thought that dapsone monotherapy gave a false optimism to the programme, but in a country where over 82% of the diagnosed cases of leprosy give evidence of some degree of cell-mediated immunity, such optimism is not entirely misplaced. In 1958, 2,092 patients had been discharged from treatment, ‘disease arrested’, and the whole attitude of the people towards leprosy and its victims had been transformed.

The main purpose of this letter is to draw attention to an example of ‘Primary Health Care’, in which leprosy was completely integrated long before the current wave of enthusiasm. The secret of its success was the extremely careful selection, training and supervision of auxiliary staff. Wherever leprosy is concerned, I consider that there is a need for a high level of competence in diagnosis, treatment, the recognition of reactionary states, the management of nerve damage and eye complications — and that it is a short-sighted policy to rely on less well-trained workers than those described, albeit briefly, in this communication.

S G BROWNE

16 Bridgefield Road
Sutton, Surrey SM1 2DG

References


LEPROSY AND PRIMARY HEALTH CARE: EXPERIENCES FROM MALAWI

Sir,

Attempts to integrate the anti-leprosy work into the general health work have been mooted and tried for many years under different guises. All have been unsuccessful and it is only recently that WHO have urged governments, where leprosy is a problem, to seriously consider, once again, the integration of leprosy treatment into the general health services and set the year 2000 as a target date for the total, successful, integration. As a starting point, in Malawi, as elsewhere, Ministries of Health were urged to complete, by 1980, a plan to achieve this goal.

With the present treatment regimens which call for the regular attendance of the patient at dispensaries, or where mobile treatment is available, for long periods of time special consideration must be given to the problem of the integration of leprosy work within the general framework of the general health service. To do this it would be useful to recapitulate the experience of the original LEPRA project when, at the end of its 10-year life, it handed back to the care of the Ministry of Health, Malawi, the residue of patients still receiving treatment in that area.

Two years prior to the handing over date, 1st January, 1976, a series of meetings with the Ministry of Health was begun to discuss the anticipated problems and to prepare the way