

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 Malaŵi, 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 LEPRO project when, at the end of its 10-year life, it handed back to the care of the Ministry of Health, Malaŵi, 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

for the health units in the project area to assume responsibility for the treatment of the patients. During the run up period visits were made by the project staff to each unit to discuss with the officer in charge the take over and to explain what would be involved. Basically the District Medical Officer would resume responsibility for the patients in his area, as he had been prior to the project assuming this task. Under him the health unit would be responsible for the treatment of the patient and the provision of the necessary anti-leprosy drugs. The keeping of adequate records and the submission of returns was explained. To enable the handover to be made smoothly LEPRO undertook to maintain two supervisors, seconded Medical Assistants with considerable experience of leprosy work, who would visit the health unit when the unit was treating the patients. To this end, and in consultation with those concerned, a programme was drawn up whereby each unit would set aside at least $1\frac{1}{2}$ each lunar month for the exclusive treatment of the leprosy cases. This was in order that the treatment did not clash with other specialized programmes held at the unit (ante-natal, under 5s, TB etc.). A trial area was chosen and the hand over made 4 months before the main hand over date. This enabled any snags to be ironed out before 1 January 1976.

Despite the arrangements which had been made, however, it became increasingly obvious that, without the continual visits by the supervisors, there would have been a drift back to the situation which existed prior to the introduction of the specialized service; haphazard treatment to those patients who presented themselves, an inadequate supply of drugs and the absence of any case finding or holding by the health branch of the unit. One example suffices: the District Medical Office had to pay for the drugs used in the district and this included anti-leprosy drugs. He, therefore, had to balance his requisitions with the funds available to him and the anti-leprosy drugs, previously supplied free of charge by the specialized service, became an unwelcome extra to his already strained budget. Consequently anti-leprosy drugs, to say nothing of dressings for ulcers, suddenly were in short supply alleviated only by the limited stocks carried by the supervisors from the store of the specialist unit.

Record keeping, too, became an added chore to the officer in charge of the dispensary so that up-to-date, accurate, figures were not readily available. Attempts to persuade the health branch of the unit to trace absentees and, at the same time to undertake case finding in the villages, usually met with the explanation that this was not possible as there were no funds available to undertake the travelling involved.

Inevitably these experiences led the specialized unit to view the development of the project with some concern and wonder what could be done to overcome the problems which have been described. Those Medical Assistants who had received intensive training in the recognition and treatment of leprosy returned to their dispensaries with great enthusiasm. Inevitably those who were hard working in all their pursuits were swamped with patients of all complaints and, by virtue of their diligence, were unable to give sufficient time to the many special tasks they had to perform. Those whose approach was one of indifference soon made their feelings apparent to the people they were sent to serve and the empty clinics were stark testimony of this.

The lessons of the past must provide guidelines for the future integration; the most important of these is the acceptance of the Ministries of Health that leprosy is not something special requiring specialist services, that it is an illness, as are others, and that it should be treated in exactly the same manner as any other. For too long health authorities have assumed that leprosy is the responsibility of a body whose sole role is the treatment of the leprosy patient. Once this fact has been genuinely accepted then the implementation can be put into practice. Following acceptance by the authorities the next important step is to persuade individuals of its necessity. Instruction in the treatment and recognition of leprosy must be increased; in a 3 year training course in Malawi for Medical Assistants only 2 or 3

lecture sessions were devoted to leprosy. Suggestions were made that the pupils be sent to one of the leprosy hospitals for an at least 2 weeks intensive period of instruction were received with little favour. But, providing the will is present and instructions are passed on from the Ministries, then training can be expanded. Thus, as each cadre is posted to their stations, well trained personnel become available for the treatment of the leprosy patient within the overall medical service.

With the best will in the world, however, the satisfactory treatment of leprosy will not be achieved unless those in charge of the primary health unit are made aware of their responsibilities and are motivated to continue the regular treatment of the patients with consideration and understanding. Without this motivation successful integration will never be attained.

Whilst the necessity of treating leprosy within the context of the general health service is accepted the large numbers that have to be treated require that special sessions should be held so that the person responsible for the treatment can devote his whole attention to their needs which must include the admission of new cases, review examinations, laboratory examinations and a 'general complaints' clinic. If this is done then ample time can be provided for accurate record keeping.

Unfortunately for some time to come it must be necessary to retain certain specialized personnel with adequate training in all facets of leprosy control to advise those running the rural health units. The discharge from treatment must be made by experienced staff; the consequences of premature discharge from treatment are only too familiar and, until sufficient experience is gained, the treatment of the complications of leprosy must be in the hands of skilled personnel. To this end the retention of chosen, skilled, men from the specialized service should be made. These could be posted to strategic health units within an area so that they could be available to visit the primary health units when the treatment session is held. In addition, on these visits, they could advise on dermatological complaints referred by the health unit.

This would need transport and the next stumbling block would have to be overcome. The ever present problem of funds for transport must be answered. But with careful planning this can be reduced to a minimum. No impressive vehicle is required for motor cycles are satisfactory.

The final requisite for integration is the supply of the necessary drugs to the health unit. On too many occasions the success of a scheme has foundered on this point with, as has become apparent, the tragic consequences of drug resistance. The necessity of continued international provision of drugs and dressings may have to be negotiated for all too often the budgets of the countries most concerned with the problem of leprosy control are not sufficient. In this context WHO must use its influence on the richer nations to provide the essential requirements. Not a particularly difficult task if adequate planning goes into the requisitions.

With the implementation of this programme must come a greater awareness of the problem of health education and this must go hand in hand with the health authorities and social welfare departments. The prejudices of the people to leprosy must be overcome – a very real problem in Africa. The public must be made aware of the facts of leprosy not the fallacies. All too often schemes put forward for some form of integration of treatment or improvements in the efficient running of existing schemes have come to naught against the hostility of the general public. Every opportunity should be taken to get the message across that leprosy is just another sickness without sinister origin.

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