

LEPROSY AND PRIMARY HEALTH CARE IN BANGLADESH

Sir,

LEPRA sponsored me on my elective to Bangladesh, July–September 1981 to investigate the advantages and disadvantages of incorporating leprosy control into Primary Health Care. There is a popular call for integrated ‘horizontal’ health care delivered in a decentralized manner instead of ‘vertical’ health projects such as family planning or leprosy control. If, however, stigma, ignorance, and lack of resources still hinder leprosy control, it may be asked if integrating the care of leprosy patients into the general health services will put this subject at the bottom of the list?

Bangladesh is the second poorest country in the world, consequently with one of the highest aid inputs. It has a population of 85 million at a density of 1,414 people per square mile with a growth rate of 2.8% (which means the population will double in the next 25 years). 95% of the population is rural, and 40% of these are landless. The illiteracy rate is 80%.

Some health indices: infant mortality rate 140/1,000

maternal mortality rate 25/1,000

prevalence of anaemia 92%

prevalence of diarrhoeal disease 80%

prevalence of malaria 13/1,000

prevalence of TB 5/1,000

prevalence of leprosy 2.6/1,000

From these figures and from the pressurizing of some 120 voluntary health agencies it was considered Primary Health Care was essential. The national plan, therefore is now to have village level health care and advice about preventive medicine provided by voluntary village health workers supervised by paramedical workers.

Certain factors will influence the outcome of primary health care:

- (1) It must be realized socioeconomic conditions have a much more profound influence on the health of a population than the health service.
- (2) In the hierarchical society that exists throughout the Indian subcontinent (regardless of religion) the village is not a homogeneous, harmonious community. Disease is related to poverty and injustice. An ‘effective’ health service cannot be neutral. The health worker will be co-opted by vested interests or blocked (and sometimes violently).
- (3) Because there is an existing, self-perpetuating medical profession disseminating the health budget to lower levels away from the cities requires a strong, motivated government.
- (4) Health care is also disseminated by non-qualified allopathic ‘doctors’, drug store owners, homeopathic doctors and various other indigenous practitioners and spiritual healers. The government health centre is often the last port of call for the sick.

Leprosy registered patients number 40,000 out of a potential 200,000; that is only 20% have been located at some time and started on treatment. There is a wide geographical difference in prevalence ‘leprosy occurs in pockets’ unlike TB which has a much more general incidence in Bangladesh. Rangpur district in the north has an estimated prevalence rate of 10–15/1,000, whereas in the areas in which no leprosy services have been provided as yet the estimate is < 1/1,000.

The government leprosy services have 4 mobile clinics and 3 inpatient facilities; 2 of the latter I found to be virtually redundant as the patients in need went to the nearby voluntary hospitals. Currently the leprosy and TB paramedical workers are learning each others fields so that a greater number of them can disseminate information to general Paramedical Workers

(PMW), who can then facilitate more case finding.

The 7 voluntary leprosy agencies (of different denominations and sponsorship) together with the government services send their statistical returns to Dr I M Dadul Islam, Asst. Director Mycobacterial Disease Control. The following are some of my impressions as I visited 'Primary Health Care' and 'leprosy control' projects around the country:

- (1) Most projects are covering enormous areas with difficult communications so that presentation of a patient to a clinic depends on him/her having heard about the clinic by word of mouth, and being sufficiently motivated to travel far (1 new patient I saw had come 240 miles taking 3 days on the roof of a train). The patient's regularity at the clinic therefore depends on his/her perception of the need to receive treatment, and the ease of getting there.

One project was attempting domiciliary care. There is 1 leprosy PMW per 100 general PMW's per 200,000 population. The general PMW finds the leprosy patient, the leprosy PMW then classifies the disease and organizes treatment. The general PMW delivers the medicine regularly and reports back with any problems.

- (2) Close to the hospitals or clinics where control schemes were being carried out, even in the most conscientiously surveyed area 20% of the population remained unexamined which is sufficient to hide people with the disease if the stigma is high.
- (3) Purdah of women and their seclusion, restricts them from travelling to clinics, and being examined by anyone other than another woman. Examination in the sunlight is very difficult. This restriction on women also limits the number of women who work, and what they do and where they can go.
- (4) The humidity and the sanitary arrangements make ulcer care and plaster of paris immobilization difficult if not impossible in the monsoon.
- (5) Where space is at such a premium, isolation of an infectious patient away from the 1 room where everyone lives and sleeps, is difficult.
- (6) Treatment of the same classification of the disease in different centres varies widely (dose of dapsone by a factor of 4 in an equivalent case). There is no nationwide drug policy, nor equal accessibility of drugs.

At the end of my stay I went through the statistical returns, analysing the percentage of patients registered as lepromatous, tuberculoid, borderline, indeterminate, unclassified and 'irregular', but regretfully came to the conclusion that there are so many variations in terminology and records that there is an urgent need for rationalisation of the whole system before helpful conclusions can be drawn.

Advantages of incorporating leprosy control into Primary Health Care

The rationale for the government leprosy services to expand into Primary Health Care is to find all cases (remember only a possible 20% are registered, if the original leprosy prevalence rate calculation was correct). If all local general health workers were case finding leprosy they could also do absentee check-ups, and perhaps eventually, delivery of drugs under supervision.

Primary Health Care and stigma? If general health workers can be educated so as to reduce their own fear of leprosy, then they can convince their clients. This in turn could be vastly more convincing if leprosy treatment could be shown to be more effective; at the present time, the regimen of drug treatment used in Bangladesh is of long duration, according to conventional advice in recent years, but if the recent WHO recommendations on combined therapy for leprosy are accepted and applied, this could make an enormous difference, particularly as all paucibacillary cases would require only 6 months treatment.

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Disadvantages

At best above I have discussed the ideal situation. Primary Health Care does not exist in Bangladesh nationally, nor is leprosy a priority health problem. If leprosy aid organizations supply funds for government Primary Health Care there is a possibility that it may be put into water supplies, sanitation, latrines, nutrition education, and population control. At the moment, the direct care of leprosy patients is best accomplished by the voluntary leprosy centres. Their effectiveness and the future success of leprosy control generally in this country may depend crucially on whether or not short-course combined chemotherapy can be safely applied.

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