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# Letters to the Editor

## A LESSON FROM THE DECLINE OF TUBERCULOSIS AROUND THE WORLD

Sir,

I was interested to see a report (*Lepr Rev*, 1987; **58:** 1–5) relating to operational problems in leprosy programmes in the event of a decline in endemicity. The editorial has rightly emphasized its concern for the proper placement of staff with specialized training in leprosy, who will be underutilized as their load is reduced. Often health planners hold the optimistic view that these facilities now available only for leprosy sufferers, can be utilized to meet other public health needs of the future.

In this regard we have another lesson to learn from similar problems faced by tuberculosis centres and sanatoria when the need for the specialized institutions for that disease was declining. At the same time in India and other countries in South East Asia, the rate of infection and prevalence of the disease remained static and the absolute number of cases have increased as a result of the population explosion.[1] Nevertheless, as in leprosy, highly effective regimens and short courses of treatment made hospitalization unnecessary in most cases of tuberculosis. The need for thoracic surgery declined rapidly. WHO recommendations for domicilliary treatment of this disease have been adopted widely. All these measures have drastically reduced the need for sanitoria and specialized centres in India and in various parts of the world, despite the fact that the incidence is still remarkably high. In such a situation the health planners felt that the specialized staff and the facilities can be used to meet needs such as converting the sanatoria into general hospitals with thoracic surgery units or as referral centres for TB and other chest diseases.

I would like to share my observations seen while visiting some of these 'converted' centres in India. All of them were run by voluntary organizations. The outcome was not encouraging for reasons such as the following:

1 Most of the centres were situated away from towns and cities. Therefore very few people used these facilities.
2 There was a lack of confidence among the public about the capabilities of specialized staff to handle other conditions, however similar it may have been to their original area of specialization.
3 There was a reduction in input from donor agencies and the donors.

This shows that in the wake of the continuous decline of leprosy rates already being observed,[2] leprosy institutions should plan and set their priorities ahead of time. Needless to say that in any such planning, priority has to be given to the strategy of maintaining a static workload when the leprosy caseload decreases. Implementation of such policies in different stages will avoid unforeseen setbacks, e.g. increasing the ratio of the caseload of other conditions in proportion to the reduction of caseload of leprosy to maintain the workload.

It takes some time to build up the liaison and confidence necessary among the public where leprosy centres function, if integration of leprosy with other primary health case programmes, has to be initiated. It also takes time to retrain and enhance the skills of the personnel. Finally, it may adversely affect the monetary support to leprosy programmes, if the over optimistic impression is created among the masses that there is a rapid decline in leprosy after MDT, and by not mentioning the need to take care of complications among cured leprosy patients with residual disabilities.[3]

## References

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[2] Irgens, LM. Secular trends in leprosy; increase in age at onset associated with declining rates and long incubation period. *Int J Lepr*, 1985; **53:** 610–17.
[3] Askew AD. Managerial implications of multidrug therapy. *Lepr Rev*, 1985; **56:** 96.

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