Experience In The Leprosy Control Programme

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A. Goal And Objectives.

In a Leprosy Control Programme the goal is to eliminate the reservoir of bacilli in n and thus breaking the chain of transmission.

From the epidemiological aspect the following objectives are essential:

1. Case Finding.

- a. to find all cases ideally, but at least all infectious ones.
- b. to find these cases in an **early stage** before they have been able to infect others.

2. Case Holding.

To keep them under **regular treatment** to avoid relapses and thus re-establish the chain of transmission.

From the aspect of individual care two objectives are the same, but for different reasons.

1. Case Finding.

to find patients **early** before physical or social disability has occurred.

2. Case Holding.

to treat them **regularly** to avoid further damage and reach, ideally, complete healing.

How have these 3 objectives been realized in the different approaches so far done in this country ?

B. The Institutional Approach.

Before the Leprosy Control Programme was established, few specialized Units only offered care for Leprosy patients, demanding from them to travel mostly long distances.

The effect on the stated objectives were:

1. **Case Finding.**

Patients came voluntarily or were sent in e. g. by local officials

- a. depending on the distance only a **few cases** came, and
- b. those who were mostly in an **advanced stage**, physically and frequently also socially disabled

2. **Case Holding.**

The **regularity** of these patients was mostly **good** because they presented voluntarily and because of their greater medical needs. The attendance of socially disabled patients--and these applied particularly to the group sent in by the local officials--was poorer in general.

Good case holding of relatively few patients does not make up for insufficient and delayed case-finding, thus making this approach ineffective in controlling the disease.

C. **The Control Approach**

1. **Case Finding.**

Since this 5-year plan the National Leprosy Control Programme (N. L. C. P.) has been extended over the whole country with one mobile team for every region, doing active case finding. In the West and Far West region, for example, 1.2 million population has been covered and more than 350,000 people examined. Case finding has been very difficult depending on the area and was in the Far West Region about 3 times higher than in the Western Region.

Areas of high prevalence rates are particularly in the Far West Region in the hills of the Rapti Anchal, in Rolpa and Rukum where there are now 1,000 patients treated in the Health Posts and in the Western Terai and Banke and Bardia With nearly 900 patients. High prevalence rates are also known from the Central and East Terai e. g. in Bara district with more than 2,000 and in Siraha with more than 900 patients.

Since the survey has been completed there has been a steady stream of new voluntary presentations from these districts, proving that **survey doesn't identify all patients of that area.**

To find cases in an early stage has certainly been made possible by the survey activity.

2. Case Holding.

- a. New patients found by survey activities have primarily **no motivation to go for regular treatment**. Why should a person take the trouble to walk for many hours to the H. P. because of having an anaesthetic patch only? He needs to be motivated after being diagnosed, and this is difficult. In fact, 50% of our survey findings need to be contacted again and some will never go for treatment.
- b. The quality of care given at H. P. level may hardly be sufficient in fully integrated district with a limited case load, but prove to be very difficult in areas like Ro. where, on one hand, integration is in a developing stage and, on the other, the case load is very high. In Libang for example, more than 200 patients are treated. Assistance for the Control Programme is essential to handle this case load. Other difficulties are added, like frequent movement of personnel and untrained staff etc. As far as our observations in the West and Far West Regions are concerned, case holding is **not sufficient**. W. H. O. standard is not reached, even not in integrated districts.

Without effective case holding one main objective of Leprosy control is not fulfilled thus making the Programme unsuccessful.

In fact a serious problem of developing **D. D. S. resistant strains** of mycobacterium leprae is added. This is dangerous for the patient and the community as spreading of these strains leads to primary drug resistance. In Ethiopia this problem is already obvious because of poor quality care given to Leprosy patients for decades.

From these facts it can be concluded that **case finding without the facilities for case holding is dangerous**.

D. Alternative Approach.

Is there any other method to fulfil all 3 objectives essential for Leprosy control?

1. Case Finding.

Let us consider one example. A patient was sent by the community to our hospital in Pokhara because people had observed the effect of treatment of another patient who had been with us for some time.

The same process may happen between two patients, one referring the other after experiencing help, or even in the mind of one individual only after having seen others improving or having heard about Leprosy and that is curable. In these examples, the community and/or the patient are convinced by their own observation and motivated to act. Case finding is directly linked to effective treatment in any survey activity. Patients detected by this method are far more willing to continue treatment regularly.

The motivation of the community to send a patient for treatment may still be dubious. It may not just mean to help the patient only, but also to segregate him for the security of the community.

To channel this activity in the right direction, active steps from the Health Service are possible and required.

Let us consider one example of the Siraha district which Dr. C. B. Karki shared.

The **Community Leadership Training** involves panchayat officials and socially interested people, together with medical personnel on the H. P. base. Amongst other teaching related to health problems, Leprosy is not only included, but patients are demonstrated showing the effect of treatment. Participants are requested to send any person they know, or get to know, with these symptoms, to the H. P. for examination. The community is thus encouraged to do their own survey.

This type of training and health education activity could be assisted by the Leprosy Control Programme in various ways.

2. **Case Holding**

It is obvious that **good quality care** is the backbone of this approach. In the first stage, the increase in the number of patients registered is almost an indicator for the effective treatment. It is remarkable that in Bara district about 2,000 patients have been registered now and most of them after the survey activity had been completed. Good quality care involves:-

a. **Training of Medical Personnel.**

Leprosy should have a fixed part in any training programme, preferably **block studies** at an Institution where Leprosy patients can be demonstrated and examined. Training has proved to be one of the best motivators to care for Leprosy Patients.

To **Quality in Trained H. P. Personnel.**

2. Off untrained in Leprosy and moved into an area where Leprosy patients are, should undergo a short course of about 3 days as it is available in several places, preferably before being posted. This demands good co-ordination between B. H. S. and N. L. C. P.

c. **Reliable Drug Supply.**

This does not only apply for D. D. S. only, but also for the treatment of other complications like provision of anti-reactive drugs, eye ointment, bandages, probably even shoes for patients with anasthetic feet.

It is very discouraging for a patient to walk to a H. P. only to hear that D. D. S. has run out of stock.

d. **Referral Units.**

Quality care does also involve specialist units, preferably attached to General Hospitals to deal with complications, surgery and other means of rehabilitation.

The care for advanced cases should not be neglected in any Control Programme not only because of the benefit of the patient, but also for the impact of the public opinion. Disabled and disfigured patients, for example, having improved by surgery can be a tremendous demonstration of effective treatment. This will further reduce the prejudice and boost voluntary presentation.

e. **Social Services.**

e. g. by N. E. L. R. A. (Nepal Leprosy Relief Association). People never think in medical terms only. Assistance from any possible source to avoid debilitation and to make rehabilitation possible will help patients and increase the effect of the Programme.

To summarize, effective care must be concerned with all aspects of the Leprosy patient, taking into account his particular physical, psychological and social needs.

The best line of this approach would be high quality care established and maintained at a decentralized and integrated level and made known to the community by demonstration and underlined by Health Education. Case finding will regulate itself as a dependant factor, leading to the control of all patient in the course of time and ensuring other regular treatment. Survey activities would be confined to investigate the prevalence rate in different areas on a random sample basis.