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DISCUSSION GROUP REPORTS ON THE ROLE OF THE LOCAL HEALTH SERVICES IN LEPROSY CONTROL

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REPORT OF GROUP I

Chairman : Dr. John Lewis

Rapporteurs : Dr. E. Ferron
Dr. Haji Abbas bin Haji Alias

I OUTLINE OF DISCUSSION

The Group discussed the subject under the following headings:

(1) Should the infectious case be treated in isolation?

(2) Case-finding.

(3) Rehabilitation.

II SHOULD INFECTIOUS CASE BE TREATED IN ISOLATION?

1. Every case of infectious leprosy should be isolated either in an institution or in his own home.

2. Institutional isolation is considered necessary in some countries where control of the patients is difficult and where it is difficult to provide education, diagnosis and treatment in their own communities.

3. There was general acceptance that segregation of patients in institutions has serious disadvantages:

   (a) it is very expensive;

   (b) it tends to force patients into hiding;

   (c) it causes psychological dependence;

   (d) it deprives other health personnel of the opportunity to learn about leprosy.

   In one country with fifty years experience, the institutional care of leprosy patients is being abandoned in favour of domiciliary treatment. The result has been the

discovery of cases unknown before and at a reduced cost.

4. In domiciliary treatment, the leprosy patient should be isolated in a room separate from the rest of the family.

More research on leprosy should be undertaken to determine its mode of transmission.

III CASE-FINDING

1. The examination of household contacts of leprosy patients is very important.
2. Referral by physicians and other health personnel should be encouraged.
3. Patients have been used successfully to find and refer other patients. In one country discharged patients who meet basic educational qualifications have been employed to work with mobile leprosy teams.
4. The examination of schoolchildren in places where leprosy is prevalent has uncovered many cases.
5. Mass examination, except in endemic areas, is probably not worth while.
6. Health personnel who visit for other programmes in the homes of people, should be given training in leprosy so that they can recognize cases early and make referrals.
7. The leprosy control programme should be integrated with local health services and the maximum use made of personnel in these services in the finding of new cases

IV REHABILITATION

1. A complete rehabilitation programme will include physical restoration, social adjustment and psychological preparation to enable the leprosy patient to return to his family and community and function to the best of his ability.
2. Rehabilitation should start as soon as the disease is recognized.
3. Attention should be given to the welfare of the family while the patient is incapacitated.

REPORT OF GROUP II

Chairman : Dr. D.A. Russell

Rapporteur : Dr. E.L. Villegas

I ISOLATION OF LEPROSY CASES

The group considered the necessity for isolation of leprosy cases. It was felt that the decision on whether infectious cases were to be isolated or not would depend on actual situations obtained in any given area. It is desirable to isolate infectious cases in special institutions or in general hospitals in some situations. In other situations, however, this may not be suitable and therefore domiciliary care or home treatment would be preferable. The important point to recognize is that the leprosy programme to be adopted in any country should be related to the extent of the problem and the available resources of that country. The group felt that it was very important, however, that leprosy patients should be advised to avoid unnecessary intimate contact with children.

The treatment of cases should be done regularly and, whenever possible, closely supervised. Clinical and bacteriological examinations of all cases of leprosy should be conducted at least every six months.

II CASE-FINDING

Emphasis was placed on the importance of early diagnosis of leprosy, particularly in countries of high endomicity. The local health service can assist effectively in the detection of leprosy cases in the following ways:

(1) follow-up of all contacts of known patients brought to the attention of the authorities;

(2) routine examination of special groups, such as schoolchildren, recruits for labour force, prisons, etc.;

(3) detection of cases in medical patrols as they are applicable in certain areas;

(4) mass examination of the population for other diseases, such as treponematoses, tuberculosis, filariasis, etc.;

(5) conduction of surveys for leprosy case-finding in the following ways:

   (a) preliminary investigation,

   (b) case-finding programme,

   (c) epidemiological survey.

Case-finding can be done at the village level, at the rural health centre, at district hospitals and through special services, such as leprosy clinics, travelling skin clinics, etc.

The need was stressed for increasing activities on the part of the local health service in every phase of leprosy work, especially in case-finding and follow-up.

It is important to collect precise information of the location of cases wherever they are diagnosed. This information, when collated, will be valuable for further epidemiological studies.

Countries should not depend entirely on government services, but must also make use of voluntary agencies, e.g., missions, etc.

III LEGISLATION

There was unanimous agreement in the group that there should be no special legislation for leprosy but it should be considered just as any other notifiable infectious disease under the health ordinance. However, the group also realized that this might not be acceptable to some countries but recommended that the laws relating to leprosy should be framed with the greatest humane consideration of the patient.

IV RESEARCH

It became apparent that the problems met in any leprosy control programme stemmed from gaps in the present knowledge of the disease. The group, therefore, strongly recommended that active research in leprosy should be encouraged. Assistance for such research programme might be obtained, if necessary, through international agencies or organizations, such as WHO, etc.

REPORT OF GROUP III

Chairman : Dr. C.H. Gurd

Rapporteur : Dr. C.J. Ross-Smith

I MAIN POINTS CONSIDERED BY GROUP

(1) Should the infectious case be treated in isolation

Desirability, duration under different conditions, domiciliary treatment

(2) Case-finding

Available techniques and methods

(3) Health education and training

Patient and family, lay public, health personnel

II GENERAL COMMENTS

The group was of the definite opinion that local health services had a very important part to play in a leprosy control programme with particular respect to health education and training, case-finding and domiciliary treatment. Attention was drawn to the fact that a totally specialized leprosy service isolated knowledge of the disease from the main body of health workers who, at all levels, could make a significant contribution to leprosy control.

III BASIS FOR DISCUSSION

Prior to commencing discussion on the particular points allocated, the following premises were agreed upon:

(1) Leprosy is a contagious disease

Of all its various forms, the lepromatous form is the most contagious and therefore requires special attention.

(2) The disease is treatable

1. <u>Should the infectious case be treated in isolation</u>

The group considered this aspect and was of the opinion that:

(1) it was desirable to treat infectious cases in isolation;

(2) children up to fifteen years of age should be kept apart from infectious cases and babies at birth should be separated from infected mothers;

(3) isolation of infectious cases should ideally be maintained until there had been two or more consecutive negative smears at six monthly intervals;

(4) domiciliary treatment should be carried out for the following categories of patients:

(a) non-infectious cases from the beginning of their treatment;

(b) arrested cases discharged from leprosaria;

(c) infectious cases under favourable home conditions.

It was noted that no statistical data were available to the group on the comparative results of hospital and domiciliary treatment for infectious cases and accordingly, in this respect, the following proposals were made:

(1) an effort should be made to collect and collate any relevant information on this matter and to make it available to all countries in the Region;

(2) if satisfactory data could not be obtained, consideration should be given to the setting up of a project aimed at the relative evaluation of these two types of treatment, as had been done for tuberculosis.

Comment

Local health services have a major responsibility:

(1) in the overall supervision of domiciliary treatment of all types of cases;

(2) in seeing that favourable home conditions of patients are maintained during domiciliary treatment.

2. Case-finding

The relationship of local health services to the various forms of case-finding was discussed and the following comments noted in respect of each method:

(1) Examination of contacts of known leprosy cases

This was certainly the most important and fruitful type of case-finding and it should be the prime responsibility of the local health services. However, there should be guidance from the regional or central office and use of the regional or central registry should be made. Examination of the contacts would need to be made over prolonged periods and the local health services were well suited for this activity.

(2) Patients presenting to clinics for advice

The diagnosis of leprosy in such patients should be made at the local health services level, with the possible assistance of special personnel such as those found in the travelling skin clinics in the Philippines.

(3) Incidental finding of leprosy during:

(a) routine MCH visits,

(b) routine school examinations,

(c) examinations during special campaigns such as yaws, malaria, tuberculosis, etc.

Local health services should be entirely responsible for these various forms of examinations.

(4) Patients referred to clinics for examination by:

(a) other leprosy patients,

(b) lay administrative personnel conversant with the disease.

Local health services should be responsible for the examination and diagnosis of such patients.

Registry

It was agreed that a registry of leprosy cases, apart from any records kept at the treatment level, should be maintained at the central or district level.

3. Health education and training

(1) Health personnel

In view of the vital role to be played by staff members of the local health services in case-finding, it is of paramount importance that health personnel at all levels be fully informed and trained on the various aspects of leprosy control. It is stressed that instruction should not only be at the undergraduate, but also at the post-graduate level. Also, it is necessary that every

opportunity be taken to refresh the knowledge of such personnel at conferences, meetings of societies, prior to taking registration, etc.

In areas such as Papua and New Guinea where patrol officers come in close contact with a large number of the population, elementary instruction on leprosy control is desirable.

The actual training of health personnel should be the responsibility of the senior staff of the local health services assisted by regional or central advisers.

(2) Patient and family

Undoubtedly this group must be made fully aware of all aspects of leprosy control. The nursing staff, in particular, at the local health service level, have the greatest opportunity of contact with the group and so as mentioned in (1) above, such personnel should be adequately trained.

(3) Lay public

The aim here should be to effect a change in the attitude of the general public towards leprosy to vanish the stigma surrounding the disease and encourage patients to come forward for treatment. Treatability of the disease should be emphasized and employers in industry informed on the employment possibilities of arrested and cured cases.

Although a regional or central authority, such as health education section in a department, may design and assist in a general health education campaign for the public, the participation of the personnel at the local level is vital in such a programme.

This participation can be effected by lectures, meetings, personal contact with community leaders, as well as approaches to voluntary organizations in the community.