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INTEGRATION INTO PRIMARY HEALTH CARE

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INTEGRATION OF LEPROSY CONTROL INTO PRIMARY HEALTH CARE

1. INTRODUCTION

When this subject was discussed at the 1st Regional Meeting on Leprosy also held in Mogadishu in 1980, some proposals were made concerning a few activities which could have been integrated into the Primary Health Care scheme at various echelons.

We would have been glad to be able to evaluate now the progress achieved in the two-year interval since the 1980 meeting.

Primary Health Care remains a subject much spoken about and actual field progress seems to be slow.

Leprosy control is one of the most difficult subjects which can be integrated as it continues to suffer from the "isolation" problems faced by the patients themselves. On the other hand, the progress of the countries in developing a viable primary health care scheme meets considerable difficulties, mostly financial, along with difficulties of operational, logistic and methodological nature.

Under the circumstances we did not expect much progress in this aspect of leprosy control for which there is a firm Government commitment sanctioned by the World Health Assembly. The expression of interest to implement the Primary Health Care programme and the established goal to achieve Health for All by the Year 2000 make us feel that we are approaching fast the target date without much progress. In few words, time is running short.

2. ACTIVITIES

As mentioned on the previous occasion two aspects of the LEP control programme need to be taken care of by the primary health care scheme at the most peripheral level: (1) the curative activities, and (2) the epidemiological surveillance.

The first aspect becomes more and more urgent since the Expert Committee on Leprosy has proposed a time-limited multidrug therapy for all cases of leprosy with the objective of drastically reducing the reproductivity of the disease by reducing the sources of infection.

The combined treatment, the details of which are given elsewhere, requires a supervised intermittent treatment concurrent with a non supervised self-administered daily therapy. It is clear that this regime of treatment requires neither specialized institutions, nor isolation, nor long-term hospitalization of patients. It is therefore fully the responsibility of the community and of all echelons of primary health care. For this purpose, the plan for integration of the Leprosy Control Programme curative activities would imply the following actions:

1. Definition of responsibilities of the primary health care scheme at all levels.
2. Training of primary health care personnel on the most recent techniques for diagnosis and combined drug treatment.
3. Training of primary health care staff on the appropriate delivery of health education to the public to ensure community participation.
4. Establishment of the logistics of drug procurement, distribution, and administration to patients.
5. Establishment of a system of specialized laboratory, clinical, surgical, and rehabilitation services at the appropriate intermediate or central levels of the primary health care scheme.
6. Establishment of a mechanism for continuous reporting and follow-up including evaluation of the programme
7. Ensuring a system for full community participation and collaboration in the implementation of the programme

3 BASIC REQUIREMENTS

The above are only some of the most important activities expected for the effective integration of the leprosy programme into the Primary Health Care scheme. Conditions and priorities may vary from country to country and within the countries themselves. We may have, for instance, special problems posed by nomadic and semi-nomadic population groups where the organization of a primary health care scheme may present great difficulties in the patterns envisaged, considered feasible in other countries. There are nevertheless some constants which have to be respected.

a) appropriate planning and resource allocation for the integerated leprosy programme,
b) strict adherence to the concept of combined drug therapy ensuring continuity and regularity of administration,
c) adequate follow-up of patients,
d) continuous evaluation of the patients and of the programme.

4. COMMITMENT

The actual implementation of the leprosy control programme will start when a firm commitment has been made to the policy of combined therapy on as wide a coverage of foci as possible.

We know that coverage of the combined therapy programme will depend on the extent of the Primary Health Care coverage but the most important element is the allocation of adequate resources for the procurement of the necessary drugs and their distribution to ensure sufficient and regular availability and administration

The firm commitment to the combined treatment therefore implies:

a) a commitment to the primary health care coverage in the focal or endemic areas,

b) a commitment to the continuous and regular supply of the drugs required,

c) a commitment to the continuous evaluation of the programme.

Should the resources for the combined treatment be obtained from donors, the agreement with such agencies should therefore include the commitment to the continuity of supply of the drugs.

5. CONCLUDING REMARKS

5.1 Time is running short for the achievement of the objective of Health for All by the Year 2000.

5.2 Primary Health Care is considered to be the approach to the delivery of leprosy care at the most peripheral level.

5.3 The combined drug therapy advocated by the experts convened by WHO is expected to be conducive to an effective control in a relatively time-limited programme.

5.4 Community participation is an essential component of the combined programme.

5.5 A firm commitment to the implementation of the suggested strategy of control by combined therapy through Primary Health Care network is necessary before embarking into the programme.

5 6 Sufficient resources have to be secured for the continuous and regular procurement of the drugs required throughout the control programme.