1. LEPROSY ELIMINATION AND REHABILITATION IN INDIA: CRITICAL ISSUES

*Dr. Ashok Sahni

This paper presents critical issues for professionals, administrators, and policy makers for effective Leprosy Control and Rehabilitation in India.

1. The 44th World Health Assembly in May 1991 adopted a resolution calling on member states to intensify efforts to attain elimination of leprosy as a public health problem by the year 2000, through effective implementation of Multi Drug Therapy (MDT). Elimination of leprosy as a public health problem was defined as a prevalence rate of less than one case per 10,000 population. On January 30, 2006, India announced the elimination of leprosy as a public health problem at the national level. This is truly a significant achievement for India. Currently, 76 of the 412 districts, the prevalence rate exceed 10/10000; in 125 districts, it ranges between 5-9.9/1000. About 430 million people live in these 201 endemic districts.

2. The National Leprosy Control Programme (NLCP) started in 1955. It received priority only after 1980 when it was renamed as National Leprosy Eradication Programme (NLEP). The Central Government financially supports 100% to all states / UTS since 1980. Now that Central Government has declared Leprosy being eliminated and integrated, how would the States/UTS continue to sustain the programme to sustain essential leprosy services?

3. The WHO Global strategy for 2006-2010 states as follows.

- Adequate tools and resources for prevention of disability and rehabilitation
- Strengthened partnership and collaborative working arrangements with all partners.

   How does the Government of India wish to implement this Global Strategy? What changes would be made at national, state, and district levels to implement the strategy?

4. Dr. Dharmendra, former Editor, Indian Journal of Leprosy (1988), stressed that for leprosy control, it was necessary to raise the socio-economic conditions of the general population. Also he emphasized for removing some insanitary habits which help in the transmission of the disease, like indiscriminately spitting and blowing nose in the public places, wherever these habits exist. What have been the efforts in this direction since 1980? How can we control, eliminate, or eradicate leprosy without increasing the socio-economic status or changing the insanitary habits of large section of the people?

5. In countries, where leprosy has been eradicated from their indigenous population, the strategies have been as follows.

   (a) In Japan, Norway, and other European countries, leprosy cases were isolated under Leprosy Prevention law.

   (b) Socio-economic development made notable contribution to reduce the transmission of infection and thus reducing leprosy in these countries. These countries stressed on the importance of good nutrition and improvement of social welfare and living conditions.

   (c) To minimize the hardships for the family, the State provided monthly allowance and a domestic servant.

*Professor, and Hony Executive Director, ISHA, Bangalore - 560 070*
How can a developing country with enormous load of leprosy cases can afford to provide social welfare activities of this nature?

6. The programme structure for implementers has changed from vertical to general health care services. Whenever, we have changed the organizational structure, there have been set backs of accountability, motivation and availability of staff, and receptivity (eg.Malaria programme). What system would be established to ensure effective implementation and practice of integrated leprosy services without compromising quality services?

7. Leprosy was never considered as a “disease” like other diseases. It was recognized as a condition caused due to wrath of supernatural forces or sins committed. Therefore, more than leprosy, we are faced with the disease of “stigma” – social death at family and work place. The patient is deprived of bio-psychic needs of affection and belongingness particularly due to deformities caused by Leprosy as compared to other diseases. How can we educate the people, the members of the family, community and public at large about eradication of stigmatization? In India, there are several types of discrimination - caste, religion, language, statehood. What social change strategies would be initiated for integration of treated Leprosy patients and eradication of stigma?

8. In case of Multi Drug therapy, the main purpose is not only to cure the patient’s disease but also to reduce the infectivity in the community. Keeping in view the delay in case finding or delayed self reporting, how is it possible to forestall nerve damage and reduce deformities?

9. According to Lobo (1988), every patient who is displaced or becomes a destitute and thereby qualifies for rehabilitation signifies many failures:

   (a) Failure of early detection of Leprosy
   (b) Failure of early detection of nerve involvement
   (c) Failure of prompt and proper management of nerve involvement
   (d) Failure of prevention of nerve damage
   (e) Failure of prevention and treatment of secondary infection
   (f) Failure to give the benefit of reconstructive surgery to the patient
   (g) Failure of health education of the patient and his/her family.
   (h) Failure of community awareness and community support.

   How can we reorganize the systems at various levels to minimize the failures and optimize successes at various levels?

10. International Leprosy Congress at Bergen in 1973 observed as follows:

    If the patient is not sought and discovered, how should we take care of him? If the patient is not cared for psychologically due to the stigma and prejudices, how will he/she react to medical care? Finally, if the cured Leprosy patients are not reintegrated into the society, has the medical care obtained full effectiveness? How do we answer these questions?

11. According to World Health Organization, “by rehabilitation is meant the physical and mental restoration, as far as possible of all treated patients to normal activity so that they may be able to resume their place in the home, society and industry. To achieve this, treatment of physical disability is obviously necessary, but it must be accompanied by the education of the patient, his family and the public, so that not only can he take his normal place, but society will also be willing to accept him and assist in his complete rehabilitation. Can this goal be achieved in India? What initiatives are needed at various levels by various agencies?

12. For effective Leprosy control and rehabilitation, accurate, timely and essential information system is required. According to Revankar (2006), though municipal/government and NGOs sectors provide required information on leprosy to the district/municipal authorities, information from private doctors and hospitals treating leprosy cases is not forth-coming easily. Therefore, there are likely to be errors in the
reported prevalence and disease trend. How can we improve the existing health information system?

14. Eradication means zero disease, zero transmission and zero disease agents in the community. Is it possible to eradicate leprosy from India? If yes, when? We should not confuse elimination as a public health problem with eradication otherwise there would be complacency on the part of all partners in the programme.

15. Excepting few Voluntary organizations, there is hardly any rehabilitation work going on in the country. Due to lack of funds and right personnel, the country is forced to place the problem of rehabilitation low on the list of priorities in leprosy work. What would be the magnitude of funds, personnel, and time period required for rehabilitation of patients who are in need?

References
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