

INTEGRATION OF LEPROSY CONTROL WITH PRIMARY HEALTH CARE: THE NIGERIAN PERSPECTIVE

* Udoh N. B. , **Umo A. N. , *** Ikorok M. M.

*Senior Registrar, Department of Community Medicine, University of Nigeria Teaching Hospital, Enugu, **Tb/L Control Programme, Qic Leprosy Hospital Ekpene Obom, Etinan. ***Department of Health Education And Human Kinetics, University of Uyo, Nigeria.

Summary

Arguments have been advanced that with declining prevalence and shortened duration of treatment, leprosy could, and should be integrated into the primary health care system. This paper examines the feasibility of such integration from the Nigerian perspective. Emphasis is placed on retraining and re-orientation of existing staff in the primary health care department and the use of locally available and acceptable technology especially in the area of supply of equipment. The need for continuous supply of drugs is also stressed.

Keywords: Leprosy, multidrug therapy, Primary health care, Nigeria,

INTRODUCTION:

In September of 1978, an international conference on health attended by representatives from 134 countries was convened in Alma-Ata, Russia. This was in practical response to findings a solution to the nagging problem of health inequalities that plague different communities in the world.

At the conference, the overwhelming view was that a system of health care that best serves the needs of individual communities must be organized from the grassroots and woven into the fabric of the community through community participation. This system must integrate preventive, promotive, rehabilitative and curative services using the types of technology the community will accept, at a cost it can afford, and with an efficient and effective system of supervision and referral¹

The conference viewed the gross inequalities in the health status of peoples, particularly between developing and developed countries as politically, socially, and even morally unacceptable, and therefore recommended the system of primary health care for adoption by all countries of the world as a matter of urgent importance. The declaration defined Primary Health Care² as:

..."essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".

Primary health care was to be the vehicle through which the various peoples of the world were to work to attain by the year 2000, such a level of health as to enable them to lead socially, economically and politically productive live(s)³.

Primary health care has several components which are basic to its implementation. These include Health education, food supply and nutrition, maternal and child health services including family planning, environmental sanitation, immunization against prevalent childhood diseases, mental health, appropriate treatment of common diseases and injuries, and prevention and control of locally endemic diseases³. Absent from this list is leprosy control and prevention. Were it to be integrated into primary health care, it would come somewhere into the last two items.

The Nigerian Primary Health Care System Background:

Since Nigeria became independent politically in 1960, health policies and structures have been enunciated in various forms, either in National development plans or as government decisions on specific health problems. The nation's health system itself is divided into three levels: Primary, Secondary and Tertiary health care delivery systems⁴.

The Primary Health Care System is the responsibility of Local Government Councils (equivalent of countries elsewhere) while the State and Federal Governments are responsible for overseeing implementation of the secondary and tertiary health care systems respectively. Primary health care has already been defined. Secondary health care, by the Nigerian definition is based in general Hospitals across the country and takes referred cases from the Primary Health Care System. Tertiary health care is based in such health institutions as Teaching Hospitals, most of which are located in large cities

and in some designated tertiary health institutions owned by the Federal Government. These receive referred cases from the secondary health care system. Tertiary Health Care is supervised by the Federal Ministry of Health.

Evolution and Structure of Primary Health Care System in Nigeria

The first serious attempt to put a Primary Health Care service in place was in 1975 when the Federal Government announced the basic health service scheme as part of the Third National Development Plan (1975-80)¹. The aim of the scheme, among others were to "increase the proportion of the population receiving health care from 25 to 60 percent and to correct the imbalances in the location and distribution of health institutions and between preventive and curative medicines." For reasons of poor administration and lack of understanding of the scheme by the implements, the scheme failed.

The present system of PHC in the country took firm roots in 1986, and was developed on the basis of Local Government Areas¹, this being adopted in 1987 as the National Health Policy.

Structurally there are 774 Local Government Councils in the country each of these Councils has a Primary Health Care Department. Each of the primary health departments has, at its apex, the Maternal and Child Health Centre, which serves as the operational base of primary health care for the Local Government Health Department. Under this operational base are units or departments that cater for all the components of PHC. In each LGA are a number of primary health centers which are scattered in different political wards and serve as the first contact point of entry into the National Health Care System. Referrals are made from these primary health centers to the operational base at the Local Government headquarters, both in terms of patient management and administration.

Staff Disposition

Each Local Government PHC department is encouraged to assign a medical officer of health who should be a qualified medical doctor to be the head of the PHC department and the Local Government PHC co-ordinator⁵.

The primary health care co-ordinator maybe an experienced community health officer where a doctor is not available, as it often happens. The PHC co-ordinator reports to the supervisor in charge of health, who is a political appointee, and who in turn reports to the Council Chairman.

Each of the units under the Maternal and Child Health Centre is manned by an Assistant PHC Co-ordinator, who oversees the activities in his/her unit and reports directly to the PHC Coordinator. Thus we have an Assistant PHC Coordinator-Nutrition, Assistant PHC Coordinator-disease control, Assistant PHC Coordinator-NPI (National Programme on Immunization) who is variously called NPI Manager, and so on.

Primary Health Centers are manned by Nurses, most often with some qualification in public health, or public health officers trained for that purpose. All these report and refer cases to the operational base at the Local Government headquarters.

Brief Review of Leprosy and Current Leprosy Services

Leprosy was first recorded in China in 400 B.C. in the Mediterranean region between 326 - 327 B.C. in Europe at the beginning of the 13th century and in Africa during the middle ages⁶. Caused by the bacterium *Mycobacterium leprae* which was discovered by Hansen in 1873⁷, leprosy continues to be a serious public health problem. It contributes to a great extent to the mental, physical and social disability of its victims.

A 'case' of leprosy is regarded as a person showing clinical signs and symptoms of leprosy with or without bacteriological confirmation of the diagnosis but yet requiring chemotherapy⁶.

The incubation period is between 1 -30 years, though a case that occurred within seven months has been reported⁶.

Clinical presentation of leprosy varies from a small, solitary nodule to wide spread hypopigmented patches which are usually symptomless but hypoparaesthetic, and can be made into indeterminate leprosy, tuberculosis leprosy, lepromatous leprosy and boarderline/dimorphous leprosy⁶.

Laboratory diagnosis is made by smear from the most active lesions and from skin biopsy which are examined microscopically to reveal the acid fast bacilli.

Apart from the clinical presentations and the physical deformities that have been associated with leprosy, in no other disease do social and psychological factors loom so large². These are more a result of the attitude of the patient to his disease as well as the attitude of the society towards it. Traditional beliefs

as well as guilt feelings may result in apathy, resignation or aggressiveness towards society. Leprosy in the present 'incarnation' may be looked upon as retribution for misdeed in the previous one, so that nothing should be done to ameliorate it². This encourages the spread of the disease.

For patients with leprosy, tolerance by the society is the exception rather than the rule, so that the patients try in many instances to conceal the ailment as long as possible to escape the concomitant shunning of the whole family by the community².

Integration of Leprosy Control with Primary Health Care

The World Health Organization has estimated that as at the end of 1997, the prevalence of leprosy worldwide was 1.15 million cases⁸, and in areas with low socio-economic conditions like third world countries with heavy debt burden, prevalence of 5/1000 are common. Some of the places, for instance where outbreaks have been reported in the past include Eastern Nigeria⁶. All these underscore the need for sustained control of leprosy, since it is still very much a public health problem.

Currently, leprosy has traditionally been managed by specialized vertical services in most endemic communities⁸. since the WHO Expert Committee on leprosy has concluded that the length of fixed duration multidrug therapy (MDT) for multibacillary (MB) patients could be shortened to 12 months without greatly increasing the risk of relapse for the majority of such patients⁶, there is a ground swell of opinion that general and particularly primary health care staff should be oriented to manage leprosy.

In this country specialized centers for the treatment and control of leprosy, mostly established by Missionaries early on their arrival are the most popular treatment outlets for leprosy cases. These are few and far between, and for the country's population estimated at 140 million people, grossly inadequate.

Integration of leprosy services into Primary Health Care services is the easiest means of meeting these needs, and should take the following form:

1. Advocacy
2. Staff retraining and re-orientation
3. Provision of basic needed equipment
4. Provision of an uninterrupted supply of drugs.

1. Advocacy

The main aim of advocacy is to impress upon policy makers both at the Federal, State and Local Government levels the need to support the little extra

expenditures that may be incurred by the government on purchase of minimal number of equipment, particularly for laboratories. Expenses may also be incurred on the training and re-orientation of the staff of the primary health care department to effectively perform this additional role. It is customary for policy makers to be apprehensive, if suspicious of new policies, particularly those not formulated from within their respective systems.

Gentle persuasion by knowledgeable health staff on the need for the various governments to support the integration programmes is a sine qua non for success to be achieved.

2. Staff Retraining and Re-Orientation

For a successful integration of leprosy into the existing PHC system, there should be a re-orientation of all staff of the entire PHC unit in each Local Government Area towards this new and additional role. Apart from the fact that most staff in these departments cannot recognize cases of leprosy in their present state of knowledge, there is the added disadvantage that the stigma hitherto attached to leprosy by the general population still lingers, even among health workers. Health workers, for instance should be made aware that leprosy is no more dangerous or contagious than measles or pneumonia which they see and treat as a matter of routine, particularly when the cases are recognized and treated early.

Generally, all staff should be taught the early signs and symptoms of leprosy and how to recognize a case, and the system of referrals.

Some key staff of the PHC department should be selected for special attention. These should include the Medical Officer of Health and Primary Health Care Coordinator for the Local Government, the Assistant PHC Coordinator-essential drugs, Assistant PHC Coordinator-disease control unit, the Laboratory Technologist and the Assistant PHC Coordinator-Monitoring and Evaluation. These are the key officers on whom the success or otherwise of the integration programme will rest. Special short-term courses should be designed to train them on the diagnosis, treatment, control and documentation of leprosy as a disease.

3. Provision of Basic Equipment

Reference is not made here to equipment that are out of tune with the basic needs of the simple laboratory of the PHC system, or that are too sophisticated for use by its laboratory technologists. Simple

equipment that can enable an accurate laboratory diagnosis of leprosy to be established locally are what is required. Such equipment should be at a cost that local establishment can afford at all times and should be such that local artisans should be able to maintain. For instance, it is not germane to insist on 'Seward' tables and chairs when the local artisans can fabricate and deliver functional ones at cheaper rates. The philosophy of self-reliance espoused in primary health care should be the watchword.

4. Provision of Drugs

Multidrug therapy was recommended by WHO for use in all endemic areas primarily because of drug resistance associated with single drug therapy. This regimen is effective in preventing drug resistance provided full doses are taken for an adequate period on a continuing basis⁶. Fortunately, it has been determined by the same WHO Expert Committee that a period of 12 months is adequate for proper recovery without greatly increasing the rate of relapse⁴.

Implementation of this decision requires that a continuous supply of antileprosy drugs be maintained. This should be ensured by proper communication and supply channels maintained between Local, State and Federal Governments as well as international donor agencies. Interruption of supplies means that patients could default in the treatment. Every effort should be made therefore to ensure an uninterrupted supply of the drugs from the inception of the integration programme.

Conclusion

Even though the prevalence of leprosy worldwide has been declining⁸, leprosy continues to pose a formidable challenge to public health practitioners and governments. Simple measures aimed at integrating the management of leprosy into the primary health care system such as enunciated herein should ensure that this is done successfully.

Integration of leprosy into primary health care is a plausible move since this, if done successfully, will further ensure that the prevalence of leprosy is further reduced. The argument that this will further strain the existing staff and facilities in the PHC system, though plausible, is untenable since leprosy is not an every day occurrence, like malaria or gastroenteritis. The merits of integrating leprosy into the PHC system, especially in the endemic areas, far outweigh such arguments.

REFERENCES

1. Ransome-Kuti O.; *Introduction In: Strengthening Primary Health Care at Local Government Level: The Nigerian Experience* Academy Press, Lagos, 1991: 10-14.
2. Lucas A. O. and Gilles H. M.; *A new short Textbook of Preventive Medicine for the Tropics.* Ewdward Arnolds, 1998: 271 278.
3. Akinsola A. H.; *A to Z of Community Health and Social Medicine in Medical and Nursing Practice with special reference to Nigeria.* 3 AM Communication, Ibadan, 1993: 99-108.
4. Sorungbe A. O.; *Strengthening the National and State PHC Capacity In: Strengthening Primary Health Care at Local Government Level: The Nigerian Experience: Academy Press, Lagos, 1991: 1-13.*
5. Oyegbite K. S. *Strengthening Management for PHC at the Local Government Level In: Strengthening Primary Health Care at Local Government Level: The Nigerian Experience* Academy Press, Lagos, 1991: 27-34.
6. Smith E. A.; *Leprosy in developing Countries In: Principles and Practice of Public Health in Africa. (Eds) Sofoluwe, G. O., Schram, R. and Ogunmekan, D. A. University Press, Ibadan, 1996: 370-380.*
7. Curtis R., Blower S., Cooper K. et al.; *Leprosy research in the post-genome era. Leprosy Review 2001, 72: 8-22.*
8. Chin J.; *Control of Communicable disease Manual. 17th Edition. An Official report of the American Public Health Association, 2001: 289-292.*