

THE CAMPAIGN AGAINST LEPROSY IN VENEZUELA

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Campaigns which have long been carried on against infectious or contagious diseases have evolved systematically as new knowledge has been acquired of their pathogenicity, epidemiology, immunology, etc. The use of modern antibacterial drugs against the sources of infection, the destruction of vectors, and the immunization of susceptible persons are effective methods which have replaced former prophylactic measures. In the case of leprosy, it is evident that recent advances in the classification of the clinical forms, in therapeutics, in epidemiology, and in biologic immunization, as well as the promulgation of sanitary information, have given a wider scope to antileprosy work and radically changed the outlook for the future.

It may be permissible to draw a comparison between two entirely different diseases as regards the basic concepts involved in the efforts that have been made to eradicate them. As an example, let us look at malaria. The fight against this disease has mainly been centered on breaking the cycle of transmission, involving the malarial person, the vector, and the healthy person, by efforts to eliminate the vector. We have a clear example here of how sanitary technique has been applied effectively to the gradual eradication of a disease.

On the other hand, when we look at leprosy we have a different situation in that the leprosy problem involves a serious social factor which cannot be changed by any simple sanitary technique, but must be met with adequate social measures. In general the transmission of the disease requires, besides a focus of infection and a susceptible healthy person in close and prolonged contact, an environment of poor hygienic conditions together with nutritional deficiencies and a low cultural level. In other words, something more than the coming together of a susceptible person with a carrier of the bacillus is necessary to continual spread of the disease. The contributing factor is a low level of cleanliness in poor overcrowded dwellings, and this makes leprosy what it really is—a disease of the home. Its control and eventual eradication is dependent on a program of advanced sanitary technique together with social uplift and education.

Not long ago the fight against leprosy was thought of principally as a matter of hospitalizing the patients. The simple procedure of isolation or hospitalization was thought to be a sufficient measure of con-

trol. The Philippines and Brazil are examples of countries where the policy of isolation was enforced—as fully as circumstances permitted—for a long time. The results obtained were disheartening, as the statistics showed that there was no decrease, but rather an increase, in the yearly numbers of new cases.

Something new and of far-reaching importance was the demonstration by Faget in 1943 that treatment with certain sulfone derivatives was effective in leprosy. When it had been shown that it was possible to reduce substantially the bacteriologic index of the patients, it was evident that the physician had a new and very useful tool.

In Venezuela an intensive campaign against the disease was started in 1946 with a policy of increased hospitalization in the leprosaria maintained by the government. In the same year a Leprosy Division was created within the Ministry of Health to investigate the size of the problem and to apply the necessary measures of control.

In the first stage of its activities, the Division trained the necessary technical personnel that was to carry out the work of recognition. This brought about the organization of the special antileprosy service, with a permanent staff of full-time workers. Full-time employment was considered absolutely necessary, if the organization was to do efficient work.

An epidemiologic investigation of the prevalence of the disease was then begun. The first leprosy center was established in Trujillo in 1947, followed immediately by one in Táchira, and not long after by one in Mérida. The work was gradually extended until there are now 24 such leprosy centers in the country.

The field surveys carried out by these centers soon revealed that the disease was prevalent on a scale which made it impossible to consider the isolation of the cases in hospitals. It became necessary to adapt the work of the centers to other manners of combating the disease, in whatever form. We were soon engaged in the treatment and control of the majority of the cases in the rural foci themselves, when previously such work had been carried out within the walls of the leprosaria.

This new orientation brought with it new prerequisites, namely: (a) dissemination of information on hygiene and sanitation; (b) search for new cases, preferably in the incipient stage; (c) ambulatory treatment of the cases by the administration of sulfones from dispensaries; and (d) control of contacts.

Following the lead of the eminent Argentinian leprologist José M. M. Fernandez, who first proved that persons negative to the Mitsuda test could be made reactive by BCG vaccination, the Leprosy Division began in 1950 its first trials with the vaccine in leprogenic foci and was able to demonstrate in practice its prophylactic effect. The results seemed important enough to warrant the use of BCG vaccination by

all of the leprosy centers, and they soon applied it to all contacts and to all other persons from 0 to 15 years of age in the leprogenic areas.

Thus, the need of facing the country's vast leprosy problem gave origin to a dynamic policy of prevention, one which was a radical departure in its methods and scope from the time-honored custom of hospitalization—which, while not abandoned, was relegated to a complementary status. At the end of 1953, the Madrid congress went on record as considering that methods of prevention such as those mentioned could properly form the basis for modern antileprosy campaigns.

The antileprosy service in Venezuela had come into being through the influence of a central organization, to which the field units were at first directly subordinate. With rapid development of the work, and in order to consolidate its results, it became necessary to join these field units with the Ministry of Health's regional medical centers, which, in effect, received them by progressive steps into their organization as specialized services. The individual medical center received into its organization not a static unit with merely local activity, but a dynamic one with a great capacity for penetration in the outlying rural areas of greatest need. It formed a permanent contact between the Leprosy Division and the rural medical centers as regards the leprosy problem. The participation of the rural medical centers in the antileprosy work was the logical manner of meeting the situation that the primary surveys had revealed, and the delegation of work to them has gone forward steadily.

It is the policy of the Ministry of Health to leave the control of all public health problems to the medical officers in the localities where a particular situation exists. As regards the special problem of leprosy control, the integration of the specialized antileprosy units into the regional medical centers and their dependent rural services made it possible to direct toward it a double force of correlated, effective action. This teamwork, in which every member of the technical staff does his part, has been a source of success in sanitary education, in the treatment of known leprosy cases, and in the finding of new ones. At the same time it has given the trained leprologists more time for attention to the worst foci and to the control and protection of contacts. A most vital part of their work has been the education of rural dwellers in matters of sanitation, and the training of personnel. They keep the rural physicians up-to-date on methods and practices of leprology.

We expect that this harmonious sharing of the work, and the future participation in it of all rural medical centers in the country, will make the campaign against leprosy increasingly effective.

SUMMARY

After the success of the sulfones in treatment gave promise of providing an effective tool for use in the leprosy control effort, there was created, in 1946, a Leprosy Division in the Ministry of Health of Vene-

zuela. This leprosy service, with full-time personnel, gradually established throughout the country a system of leprosy centers, of which there are now 24.

The surveys made by these centers revealed that the prevalence of the disease was such that most of the treatment work would have to be carried out in the rural foci themselves, relegating hospitalization in leprosaria to a complementary status. Results of experiments with BCG vaccination led to the use of this measure of protection in all of the leprosy centers, with vaccination of all contacts, and of all other persons in the 0-15 age group in leprogenic foci.

As the work developed, the field units—at first subordinate to the central leprosy organization—began to be integrated into the Ministry's regional medical centers, with appropriate relationships with the Leprosy Division continuing. This integration and the resulting teamwork have had material advantages.

RESUMEN

Después que el éxito de las sulfonas en el tratamiento ofreció promesa de suministrar un instrumento eficaz para empleo en los esfuerzos encaminados al dominio de la lepra, se creó en 1946 una División de Lepra en el Ministerio de Sanidad de Venezuela. Este servicio de lepra, con personal de a tiempo completo, ha establecido gradualmente por todo el país un sistema de centros antileproso, de los cuales ya hay 24.

Las encuestas realizadas por estos centros revelaron que era tal la frecuencia de la enfermedad que habría que llevar a cabo la labor terapéutica en los mismos focos rurales, relegando la hospitalización en las leproserías a un puesto complementario. Los resultados de experimentos con la vacunación BCG condujeron al uso de esta medida de protección en todos los centros antileproso, vacunándose a todos los contactos, y a todas las demás personas del grupo de 0-15 años de edad en los focos leprógenos.

A medida que proseguía la obra, las unidades en campaña—al principio subordinadas al organismo central de lepra—comenzaron a ser integradas con los centros médicos regionales del Ministerio, continuándose relaciones apropiadas con la División de Lepra. Esta integración y la consiguiente colaboración han tenido ventajas decididas.