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EDITORIALS

Editorials are written by members of the Editorial Board, and occasionally by guest editorial writers at the invitation of the Editor, and opinions expressed are those of the writers.

Present Perspectives in Leprosy Control[1]

Control of leprosy remains an illusion. The most optimistic appraisals do not suggest that the incidence of the disease is less today than it was twenty years ago. When we become willing to face this fact with realism and integrity, progress will be better served. Although the incidence of leprosy may have been influenced favorably in some areas, this fact does not alter the overall picture.

Neither lack of knowledge of epidemiology, immunology, or pathology, nor the availability of therapeutic armaments is the primary obstacle. *What we do know is not being applied.* The reasons for this failure of application are many. They include inadequate human and financial resources, administrative failure to make efficient use of available resources, and apathy resulting from decades of indifference in the medical and paramedical professions. Leprosy patients and their families do not pound on hospital doors for attention, or, if they raise a voice, it is lost among the acutely ill, whose needs are vociferously made known. Not infrequently compassion becomes profaned and is used as an exceedingly poor substitute for good medicine.

Another obstacle stems from the fact that governments and voluntary agencies are often burdened with costly but static ghetto types of institutions, which only minimally, if at all, affect the incidence of leprosy. Many such agencies make no attempt at leprosy control. The maintenance of these institutions may absorb almost the entire amount set aside for leprosy work, even though, in the case of governments, this amount may represent a generous share of the total budget for public health.

Similarly, it is not unusual to find as much as 80 per cent of the budget of an individual institution being spent on the support of the 20 per cent or less of the total census of patients, who are totally dependent and not rehabilitable. Long institutionalization is socially and economically crippling, and this intensified dislocation may be harder to cure than the

[1]Guest editorial.

disease itself. At the same time, social welfare and good medical work often become confused when attempted in the same institution. The totally disabled and socially handicapped must have care, but leprosy control work that could prevent this relentless waste of human resources should not be vitiated for the sake of the few. Fortunately, with planning, institutions can also engage in the kind of control work that can make a difference.

Obsolete activities, such as preventoria for children and leprosy settlement villages suited to a bygone era, continue to dissipate resources. They add nothing to leprosy control. Even more important, they impede progress toward enlightened social attitudes.

It is alarmingly true. We are not applying what we know.

No one involved in any aspect of leprosy work can be permitted to forget that the primary consideration in all activity must be directed to control of spread of the disease. Leprosy control involves: prevention (including available chemoprophylactic and health education technics); early detection of every new case; regular treatment, particularly of the "open" case; prevention of deformity; and treatment of complications promptly when they arise. The research worker cannot exclude himself from concern with questions of control. How is leprosy transmitted? What constitutes an infectious case? What type and what percentage of cases must be controlled to affect the incidence of leprosy? What ecologic factors influence the spread of leprosy? Do genetic factors influence susceptibility, and, if so, what are they? The social scientist has yet to tell us clearly the reasons for high absentee rates in most leprosy control programs and the factors that cause a leprosy patient to be threatened and insecure long before disfigurement or deformity occurs. The explanations are repeated year after year, without sufficient authoritative scientific investigation of these and many other problems having to do with social attitudes. Few factors affect the success of leprosy control work more seriously.

The first objective of a leprosy control program is to discover the maximum number of new patients at the earliest possible time. What is the most efficient and least expensive method to accomplish this end? Mass surveys of populations or population groupings have been tried. Experiments have been made using public education as a substitute for surveys. Skin clinics not identified with a leprosy control program have been used to good advantage, attracting patients on a voluntary basis. All have their merits when used selectively under certain circumstances. The cost-benefit ratio has not been clearly evaluated, although in some countries it has been estimated that it costs as much as $400, on an average, to find a new case through use of such methods. Certainly there needs to be intensified effort toward refinement and coordination before these methods fulfill their potential role in leprosy control.

One method is available to every worker, and not to use it is to be guilty of serious negligence. Working from the known case to the unknown is a method within reach of all. The skill and understanding of a sensitive social worker may be required to prepare the way for examination of household contacts of a known leprosy patient by a physician or paramedical worker. It is an exception even to find institutions keeping a register and spot map of inpatients and outpatients with a follow-up program to search out new cases among contacts. Checks need to be made at regular intervals to be effective. To wait passively for the unknown case to make itself known is usually to wait until crippling deformity creates a crisis and the patient resorts to what he considers a last remaining alternative, admission that he has the disease. Although their value has not been finally established, BCG vaccine and chemoprophylaxis are available, and give encouraging evidence of value in the protection of healthy contacts. More rigorous case-finding is necessary before this protection can become widespread. Failure to take positive action working from the known to the unknown, is to avoid taking the first step in leprosy control.

Hospitals, health centers, and mobile and stationary clinics, all of them concerned with general public health and welfare, are rapidly proliferating in most

countries. Progress has been made in providing rehabilitation services for those disabled by a variety of causes. Public health education programs, literacy programs, and mass media technics, have all made progress. Leprosy work has shared little benefit in such progress. The failure rests with the leprosy workers who have not moved horizontally into cooperation with these agencies, institutions, and programs. Most efforts have been concerned with increasing the services meant for leprosy patients alone. This is vertical movement, while the problem calls for dynamic horizontal movement. Improvement in general public health and welfare resources will not become available to leprosy patients unless we relate their needs to what already exists. A climate receptive to the horizontal approach often is present among these wider community agencies. Using logic and tact, fortified by scientific knowledge, leprosy workers must take the initiative in creating this climate where it does not exist. The needs of leprosy patients can be integrated into other community concerns; this is better than initiating the establishment of new facilities, including rehabilitation, for leprosy patients only, a procedure which is expensive and impractical. Business men with resources readily accept the logic of horizontal movement that lessens the likelihood of duplication with more and more calls upon their public-spirited reservoirs. It is the medical and paramedical professions which must be persuaded to yield in their attitudes toward leprosy. Judgements based upon scientific objectivity rather than inherited, emotionally charged prejudices will open new doors of opportunity. No amount of public education can overcome prejudices as effectively as one hospital, rehabilitation center, skin clinic, or private physician into whose concerns leprosy has been integrated. Quite obviously this process of emancipation from rigid attitudes inherited from the past can best be started in colleges of medicine as well as in all allied branches of paramedical training.

Leprosy control will be nearer a reality when we begin using what we do know, when we begin working from the known toward the finding of the unknown case, and when concern for the leprosy patient involves us in determined horizontal movement.

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