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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.

The Management of Leprosy in Comprehensive Community Health Planning[1]

Has the point in experience been reached when it is practical to design programs for the control of leprosy to be included in Comprehensive Health Planning? As early as 1953, the WHO Expert Committee on Leprosy stated, "Leprosy is not a disease apart; it is a general public health problem in countries where it is endemic." Time and again various international meetings have confirmed this conviction. The proper question now is not whether integration is practical but rather, is there a viable alternative? None is evident.

Community medicine has been described as "medicine of man in the aggregate. It goes beyond the discussion of care of total man to care of total men."[2] Dr. John Bryant states, "Every apparent medical success must be measured against the needs of all," and "every effort and every cluster of resources must be divided by the total number of people"[3] Again, "The great obstacles and the great challenges to providing health care in the developing world revolve around problems of quantity. While we must be deeply concerned about quality of programs and personnel, it is the quantitative issue that guides us to the form and action that a health system must have if it is to provide care at a cost these countries can afford."[4]

Some will argue that since we can not treat everyone we will treat a few in depth. The difficulty of this thesis is finding a basis for deciding who shall have health and life and who will perish. The concepts of care for total man and total men are not in conflict.

The control of leprosy now and in the foreseeable future cannot be other than a long hard struggle. Few countries can afford the luxury of a vertical health delivery system for each disease that constitutes a major threat to the welfare of a particular community. Costs become prohibitive when duplicate facilities including hospitals, rural health centers, surgical theaters, x-ray equipment, laboratories, communication facilities, etc., are provided separately for leprosy. Countries in transition have heavy burdens in financing health services. There is no reason to expect any substantial changes with respect to human and financial resources for health delivery services.

[1] Guest editorial.
[2] Foege, William H. *Community Medicine.*
[3] Bryant, John, *Health and the Developing World.*
[4] Ibid.

While the gross national product increases rapidly in many countries, the proportion available for health is not likely to improve. It behooves us then to determine methods which will permit us to work effectively within the limitations imposed by circumstances. In leprosy this appears to demand the use of more auxiliary personnel with multi-disciplinary training; personnel who could, under supervision, manage more than one health problem. It will also require that leprosy be treated in the available general medical facilities including hospitals and peripheral health units.

Leprosy will never become a "disease like any other" so long as it is treated in isolation. All the health education to be generated can never overcome the stigmatizing attitudes with which the community regards leprosy, so long as the medical profession denies by methodology of management all we attempt to teach the public. Change will come when medical students will diagnose and treat leprosy in patients who are normally present among other patients clinically studied. The inclusion of theoretical lectures in the curriculum will not produce change. Nor will attitudes be improved when the specialist brings in a few "interesting cases" to demonstrate to the curious. On the contrary, it makes the patient under study an oddity or museum piece.

For the patient and his social milieu the advantages of adding leprosy within the context of comprehensive community health planning appears to be great. This is the real test of his acceptance in society. It is often forgotten that the patient is in *relationship*, that he can not be cared for in isolation without generating massive dehumanizing forces as harmful as his disease. He is in relationship to family, friends, employer, community, and fundamentally to himself. Not only is it important how others regard him but how circumstances force him to regard himself. The community in which the patient lives may be as sick, or more so, than the patient. Indeed, those who treat him may be the sickest of them all. In their method of management they may be forcing the patient to conform to a set of behaviour patterns that society expects of him. Is the community not sick, whose attitudes toward leprosy are conditioned by fear, myth, ignorance and superstition, making it impossible for the patient to get well whether he stays home for treatment, holding on to the tenuous thread of social and economic security, or goes to a leprosarium? It is truly said that *Mycobacterium leprae* causes leprosy but only his fellowmen make him a "leper."

We must insure that leprosy control programs are not waging war against bacteria in abstraction. We are dealing with people, people who are likely to be less concerned about the effect of a handful of pills upon bacteria, about which they know nothing, than about painful neuritis, the insidious development of paralysis of hand or foot, progressive anesthesia with its frightening sense of disassociation, sore eyes with gradual loss of vision, the crippling and evil smelling plantar ulcers, etc. These are among the "felt needs" of the patient. Equally important are the "perceived needs" which the objective worker can not fail to take into consideration. Such needs take into account the concern of the patient because of discrimination, loss of employment, his children not being permitted in school, his family being hungry, the water supply being polluted and causing chronic dysentery for him and his family, etc. The four or five most important health problems which threaten the welfare of the community as a whole must be identified and resources made available to correct them. Leprosy then becomes an integral part of the total health needs. Comprehensive community health planning requires that leprosy is seen in the context of total need. In applying resources to their solution, the leprosy patient must not be isolated from other community needs, singled out for special attention while his other needs and those of his community are ignored. I believe that problems of case-holding, loss from control and others will gradually diminish with this approach.

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