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LEPROSY CONTROL IN SRI LANKA

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Early Control Efforts

The history of leprosy control in Sri Lanka dates back to the eighteenth century when the Dutch who were in control of the maritime provinces established the Lepers Asylum (now the Leprosy Hospital) in Hendala for the segregation of patients suffering from leprosy. It is probable that this asylum was the first of its kind in the East. With the British taking control of the maritime provinces in 1798, the administration of the asylum came under the British military administration and later, in 1868, under the Civil Medical Department, which was established in 1858.[1] The main mode of leprosy control was the segregation of patients, which was made compulsory, in 1901, by the enactment of the Lepers Ordinance No. 4. A second leprosy asylum was set up on the island of Mantivu off the eastern coast of the island, in 1920.

First Leprosy Survey

In 1930, the Director of Medical and Sanitary Services drew attention to the need for conducting a survey to determine the magnitude of the problem of leprosy, in view of its growing importance as a socio-economic problem. In 1931, the Executive Committee of Health approved a proposal to send two medical officers to India for training in leprosy control to Chingleput, India. On their return to the island they carried out a survey of the known cases of leprosy and formulated a scheme for leprosy control in the island.[1]

Review of Leprosy Situation

In 1933, the services of Dr R.G. Cochrane, the Medical Secretary of the Empire Leprosy Relief Association was sought by the Executive Committee on Health to review the leprosy situation in Ceylon and make recommendation on its control. Dr Cochrane visited Ceylon in the same year and recorded, amongst other things, that the care of the arrested cases and those needing surgical attention was inadequate and that there was a dire need for palliative surgery to remove necrotic bones and deal with other conditions so common in deformed cases. He also commented on the reluctance of patients to permit even the most elementary surgical interference, but that these obstacles could be overcome by providing the necessary facilities and demonstrating the benefits of surgical intervention to alleviate trophic conditions in advanced nerve cases.[2] Dr Cochrane visited the island again, in 1936, during which visit he observed that more patients were ready to have trophic conditions treated surgically. This new attitude was attributed largely to the untiring efforts of Dr Milroy Paul[3] (a future Professor of Surgery of the University of Ceylon). Dr Cochrane paid his third visit in 1951 to assess the further progress of the leprosy control programme and to ascertain the possibility of introducing bacteriological, pathological, and orthopaedic and other treatment techniques in the campaign against leprosy. His recommendations included the institutional segregation of only infective cases, the rehabilitation of discharged patients, a special children's home for leprosy patients, a special home for crippled leprosy patients, employment of suitable infective leprosy cases in leprosy hospitals in place of attendants, lepromin testing, BCG vaccination and the treatment of suitable patients in local hospitals and dispensaries and in their homes.[1]

Establishment of the Anti-Leprosy Campaign

In 1954, the World Health Organisation agreed to assist Sri Lanka in implementing Dr Cochrane's recommendations by providing a leprosy specialist, a pathologist with experience in bacteriology and an occupational therapist. In July 1954, Dr B.C. Malhotra, Senior WHO Officer in the Leprosy Project arrived in Sri Lanka as a consultant; an occupational therapist arrived towards the end of the year. In the same year the Anti-Leprosy Campaign was established as a centrally controlled campaign to plan, implement, coordinate and evaluate leprosy control activities in the island. Domiciliary treatment of non-infective leprosy patients began with the establishment of the Anti-Leprosy Campaign.

Leprosy Colony for Rehabilitation of Patients

A Leprosy Colony was set up at Uragaha in the Southern Province for the rehabilitation of able-bodied patients by engaging them in agricultural work. A textile centre at Uragaha and a sandal-making centre at Hendala were other occupational activities set up, in 1955, by the occupational therapist to further expand facilities for occupational rehabilitation. Dr Malhotra, who served in Sri Lanka for three years, stressed the importance of rehabilitation and occupational therapy in his final report. He observed that whilst some progress was made in providing facilities for occupational rehabilitation, little progress had been made towards improving facilities for physical rehabilitation.[4] The Uragaha Colony was closed in 1963 due to the villagers objecting to its further continuance in the area.

Role of Public Health Inspectors in Leprosy Control

In 1970, trained Public Health Inspectors (PHIs) were appointed (one for each district) to implement the field programme of the Campaign. They were actively involved in conducting clinics, village surveys, contact surveys, default retrieval and educational programmes. From this time onwards, the Anti-Leprosy Campaign functioned with three medical officers working at the centre and 25 PHIs working in the districts.

Domiciliary Care of Non-infectious Patients

Compulsory admission of patients to the leprosy hospitals under the provisions of the Lepers Ordinance was discontinued from 1977; from then on non-infectious patients were treated at home.

Introduction of Multi-drug Treatment

Financial and material support granted by Leprosy Relief Work Emmaus, Switzerland, from 1983, enabled Sri Lanka to introduce the multi-drug treatment (MDT) regime. Sri Lanka achieved 100 percent coverage of all her registered patients the same year. However, it was evident that transmission of the disease had not been effectively interrupted as 19 percent of new patients were found to be children and 20 percent of new patients were found to be suffering from multi-bacillary leprosy.

Social Marketing Campaign

In her Administration Report for 1988, the Director, Anti-Leprosy Campaign remarked, 'A change in the attitude towards leprosy is required to make a real difference to the leprosy situation in Sri Lanka. Consequently the only viable option is to launch a social marketing campaign in order to de-stigmatise leprosy, create an

awareness of the early signs of the disease and encourage patients to seek treatment'.[5] This expectation was realised when the Ciba-Geigy Leprosy Fund, now Novartis Foundation for Sustainable Development (NFSD), joined Leprosy Relief Work Emmaus, in 1989, in support of leprosy elimination activities. NFSD funded a highly successful Social Marketing Campaign, launched in 1990, aimed at educating the population on leprosy and removing the stigma attached to the disease. As a consequence, case detection dramatically increased by 150 percent, and self-reporting increased from 9 percent in 1989 to 50 percent in 1991.[6]

Elimination Target Achieved

With increased community awareness achieved through the social marketing campaign, a large number of undetected cases presented themselves for treatment, and Sri Lanka was able to reach the WHO Elimination Target of less than one case per 10,000 population, in 1995. Although the target has been achieved at national level, there remain a few health divisions, particularly in the Western and the Eastern Provinces, where the elimination target has yet to be achieved.

Integration with the General Health Services

On January 1, 2001, leprosy control activities will be integrated with the general health services. The final objective would be to sustain the achievements gained so far, and to eliminate leprosy in the few remaining health divisions where the target has not yet been achieved.

Conclusion

Sri Lanka's achievement in the elimination of leprosy can be attributed to the dedicated service rendered by a group of committed workers. It is noteworthy that the district programmes were implemented by Public Health Inspectors specially trained in leprosy control– a feature unique to the Anti-Leprosy Campaign where the services of medical officers were available only at central level. The financial and managerial support given by two international non-governmental agencies– Leprosy Relief Work Emmaus and Novartis Foundation for Sustainable Development– and the technical assistance given by the World Health Organisation over the years helped in no small measure in achieving success.

References

1. De Silva, DM. Health progress in Sri Lanka: a survey. Colombo Ministry of Health, 1956
2. Cochrane, RG. Sessional Paper II of 1934. Leprosy survey of Ceylon 1933. Colombo: Ceylon Government Press 1934
3. Cochrane, RG. Sessional Papers XX of 1936. Leprosy in Ceylon. Colombo: Ceylon Government Press 1936
4. Malhotra, RL. Final Report of Leprosy Control in Ceylon. WHO Project Report 1957 (Unpublished)
5. Anti-Leprosy Campaign. Annual Administration Report 1988
6. Fishlock, D. Conquering leprosy through social marketing. Biologist 1994 41(4): 146-148