Leading article

Integrating leprosy services into the general health care system in Sri Lanka

Sunil Settinayake[1]

Sri Lanka Journal of Dermatology, 2001, **5**, 3-5

By applying a social marketing strategy, Sri Lanka has made tremendous progress in eliminating leprosy during the last ten years[1]. By 1995, the country had already reached WHO's target of having less than one leprosy case per 10,000 inhabitants. This means that leprosy is officially "eliminated" in Sri Lanka. Nevertheless, there are still some regions in the country where the disease is still endemic and there are high rates of leprosy. Since the prevalence rates are very low in other parts of the country, specialized and vertically organized leprosy services are no longer cost-effective. For these reasons, the Sri Lankan government – through its Anti-Leprosy Campaign – and the Novartis Foundation are attempting to integrate the specialized leprosy clinics into the general health-care services, in order to consolidate the successes achieved so far and eliminate leprosy in every area of the country.

Initial successes through networking leprosy clinics and preventive health services

The prevalence rate of leprosy in Sri Lanka dropped below 1 per 10,000 population in 1995, meeting the WHO definition for the elimination of leprosy as a public health problem. This was the result of major efforts to change the public image of leprosy and to improve access to diagnosis and treatment.

In 1990 the Ministry of Health's Anti-Leprosy Campaign and the Novartis Foundation launched a major social marketing initiative aimed at reducing the stigma and anxiety associated with leprosy and encouraging those affected to seek treatment. Health messages on leprosy were communicated via radio and television. Serials and popular 'soap-operas' were used to get the message across to the masses. This was complemented by a print campaign using posters, bus-shelters and bill boards carrying positive slogans and images. Orientation sessions for opinion leaders, grass roots organisations and village women were carried out, for them to reinforce the message within their communities. School teachers were a special target group in order to reach children. Special programmes were conducted in remote areas beyond the reach of radio and television which combined training and health education activities and concluding with "skin camps", which offered free treatment for all skin ailments. Awareness of the first signs of leprosy and the availability of a cure is now widespread in Sri Lanka – the image of leprosy has moved from one of 'fear and loathing' to one of 'hope and cure'.

The national initiative also aimed to improve access to care. The network of specialized leprosy clinics was significantly extended – today it consists of 150 field clinics run by 24 Public Health Inspectors (PHII), trained on leprosy control activities (who rotate around the clinics). Links were also developed between these clinics and the country's preventive health services. The entire staff of the preventive services (providing basic health, mother and child care for the general population) received training to enable them to detect leprosy cases and refer patients to the specialized clinics. At the same time, this led to reducing the existing prejudices and anxiety among the health care workers.

More than 20,000 cases were detected and treated as a result of the measures, and Sri Lanka was able to reach the WHO target in 1995. But while leprosy is officially "eliminated" in the nation as a whole, in some regions the prevalence is still very high (balanced by other areas in which the prevalence is very low), and this has required a reorganization of services to overcome various problems. Because leprosy services have not been available in general curative health institutions, the disease is often not recognized and treated early enough, and the infection risk for the population is unnecessarily prolonged. For example, about 10% of the new leprosy patients only reach the appropriate institutions when visible deformities have already occurred. The average time delay between initial symptoms and demand for treatment is three months, but in some cases it can take a patient as long as three years, to make his or her way to a leprosy clinic.

[1] *Director, Anti Leprosy Campaign, Ministry of Health, Sri Lanka.*

Involving curative health services in leprosy treatment

In the final phase that Sri Lanka has reached, it is therefore extremely important for both public and private curative health services, as well as traditional non-medical practitioners, to become involved in the diagnosis and treatment of leprosy. Due to the relatively low numbers of leprosy cases, the staff of the curative health care system can now incorporate leprosy treatment into the services they offer, without any substantial additional effort. However, precisely because of the low numbers of leprosy cases in several parts of the country, many of those working in the health care system never come into contact with leprosy, and they consequently do not feel affected by the disease. Nevertheless, new cases can occur anywhere, and the local health care staff must be prepared for it. Integrating leprosy care into the general health care system improves access to diagnosis and treatment, because it makes these available at local level. The ultimate hope is that this will lead to a more cost-effective and sustainable system of leprosy care.

Another effect of this integration approach is that the special status of leprosy as a complicated disease will be further reduced. Patients no longer have to visit a leprosy clinic far from home, staffed by specialists. They can simply go to the nearest local health centre for treatment. In the past, despite all the successes achieved, the existence of a specialized Anti-Leprosy Campaign also meant that leprosy was seen as a 'special type of disease'. In addition, all of the other health care personnel regarded themselves as having no responsibility for diagnosing and treating leprosy.

Integrating leprosy treatment – a strategy

Actively involving all health authorities at the national, provincial, regional, district and community levels in the planning process was crucial if these agencies were to take ownership for eliminating leprosy. To implement this integration approach successfully, the Anti-Leprosy Campaign and the Novartis Foundation conducted a series of workshops and field trips to develop the blue print for the integration strategy that would take account of the interests and concerns of all of the stakeholders involved, so that potential problems could be anticipated and solutions developed. This culminated in a goal oriented planning workshop at which the detailed plan for the integration process was developed, which was presented to the National Steering Committee for approval.

Successful integration of the leprosy services requires actively generating demand for diagnosis and treatment – for example through new media campaigns to reinforce the "normality" of leprosy and to indicate that treatment is now available at all health facilities. In addition, it also requires training and educational programmes for local healthcare staff, to enable them to cope with the increased demand. It was decided initially that the Anti-Leprosy Campaign and dermatologists should jointly develop the education and training programmes and carry them out. Training materials already available, developed by the WHO, were used for the purpose. For example, complicated cases such as early nerve damage, are precisely defined, so that the local services know when to refer patients to the leprosy clincis or specialist dermatology clinics. This is why the staff also receive basic information about early recognition of disabilities and about how to treat these. Experienced staff; for example, the medical officers at the central leprosy clinic and dermatologists, also provide on-the-job support during field visits. The Anti-Leprosy Campaign's 24 specialist leprosy staff (PHII) are working with local epidemiologists to ensure the supply of MDT and materials, as well as to keep information flowing.

A number of important administrative steps have been taken to anchor the integration process institutionally. Official circulars specified that leprosy treatment and diagnosis should become an intergral component of the job description for curative health care personnel; the private medical practitioners should be entitled to request free MDT for their patients; and the leprosy treatment should be included in routine monitoring at health care institutions.

The integration approach in Sri Lanka represents an immense organizational and logistical challenge. Various technical details had to be worked out – for example, a supply system, for MDT, a simplifield reporting system, monitoring procedures at local level, and role definitions for the most important partners involved. Collecting information about curative health-care institutions in the field of general practice, such as staff numbers and average numbers of patients which was indispensable for assessing requirements for MDT and other materials, proved difficult, due to a lack of statistics.

Finally, an easily applied monitoring system is important for supervising the integration process throughout the country (regarding the supply of MDT drugs, etc.) and for ensuring the quality of the leprosy treatment. The aim of this is partly to ensure the flow

of information from local health care institutions to the health authorities at district level and to the Anti-Leprosy Campaign, so that epidemiological indicators can be used to monitor developments and identify problems at an early stage.

Implementation problems

Implementing any strategy, no matter how carefully prepared, involves imponderable elements. A variety of problems also emerged in the course of the intergration efforts in Sri Lanka. The process of converting a vertically structured leprosy service into a horizontally structured system during decentralisation revealed complex problems and obstacles. The Anti-Leprosy Campaign had for decades been accustomed to working directly only with the 24 Public Health Inspectors (PHII) with a supportive role from the general health services. It had to abandon this approach and collaborate on a broader basis with provincial health directors, epidemiologists, dermatologists, pharmacists and directors of local hospitals and motivate them to provide the necessary services without the necessary "authority" to ensure that the services are provided. It became clear that skills in the areas of team building and teamwork, conducting negotiations, and monitoring were needed. In addition, integrating leprosy services into the local health care system also involves sharing power and a change in the roles played.

Moreover, the integration efforts also meant a certain loss of influence for the 24 leprosy workers who had previously been responsible for leprosy treatment. For them, the fact that medical officers were now to diagnose and treat the disease involved a change in their role they became 'consultants' at the local level.

Finally, there was little cooperation in the provinces between the large, centralized, state-run hospitals and the local health services, so that the Anti-Leprosy Campaign had to introduce team building methods to ensure, for example, that new patients registered at local level were reported to the dermatologists in the large hospitals.

Progress so far

In spite of these difficulties, the integration process is in full swing. Staff at the curative health care institutions, including 7,000 doctors and 1,500 pharmacists, have received their training. MDT, illustrated information leaflets, patients' records and patient registers are now available at all the health-care centers. At the provincial level, all medical officers in the public health authorities have established adequate MDT stocks. Patients can now turn directly for diagnosis and treatment, to one of the 1,000 curative health-care services run by central or local government.

Monitoring continues to be one of the important elements of the programme. Teams from the central leprosy clinic in Colombo are regularly visiting small and large health-care institutions throughout the country. With the establishment of local monitoring teams consisting of epidemiologists, dermatologists, and the 24 PHII responsible for leprosy, conflicts and tensions are gradually dissolving. The leprosy specialists have transferred the patients who were previously receiving treatment from them to the local hospitals taking over their care. After two months, 100 new cases have already been identified, and the patients are receiving appropriate care through the integrated system.

All of the activities involved in integrating the leprosy services are being followed by the Ministry of Health, in order to lead another of the Anti-Leprosy Campaign's forward-looking projects to successful completion. In integrating its leprosy services, Sri Lanka has passed another milestone on the way to sustained elimination of leprosy.

Acknowledgements

I acknowledge the continued support rendered to Anti Leprosy Campaign by Novartis Foundation for Sustainable Development (NSFD), Switzerland in all activities related to the final phase of elimination of leprosy (Integration) in Sri Lanka. I also acknowledge the contributions of Ms Penny Grewal, Head, Sector Health Care, NFSD, Switzerland and Dr. Nimal Kasturiarachi, Director, Medical Education Unit, Faculty of Medicine of University of Peradeniya, who is also the Project Consultant to Anti-Leprosy Campaign preparing this document.

References

1. Salgado S. Eliminating leprosy from Sri Lanka - the launch of a social marketing campaign. *Ceylon Medical Journal* 1993; **38**: 95-97.