Lessons for Integration of Health Programmes

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The experience gained by the integration of the leprosy eradication programme with the general health services has many lessons to offer in the context of the National Rural Health Mission's objective to combine the national health programmes for various diseases.

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The programme for leprosy control in the country started in 1955. However, recent developments in the programme call for a critical analysis. The initiative to integrate leprosy control activities with general health services gained momentum with the popularisation of the National Rural Health Mission (NRHM). With the introduction of multidrug therapy (MDT) in 1983, the programme was renamed as an initiative to eradicate the disease completely by 2000 (Pandey et al 2006). Elimination of a disease is defined as the stage when its prevalence reaches less than 1 per 10,000 populations. A significant decline in the number of cases has been reported since then. In 2001 the second phase of the National Leprosy Eradication Programme (NLEP) started with the objective of decentralising its activities and which ultimately initiated the process of integration with the general health services (ibid). The need to integrate various disease control programmes with the general health services has been voiced from various quarters for more than three decades now. It is important to learn from the experience of leprosy control in the current context when one of the major objectives of the NRHM is to integrate various national health programmes with the general health services. The current article is an attempt to examine the issues and challenges involved in such integration in the context of the leprosy control activities and the NRHM.

Evolution of the Programme

The leprosy control programme was centrally aided and its pace was slow until the introduction of MDT in 1983. The strategy then was based on the endemicity of the cases with vertical structures like survey education and treatment centres, leprosy control units and urban leprosy centres. In each of these, paramedical workers were given the primary responsibility of surveillance (active) carried out through house-to-house visits. The strategy for case identification was survey, education and treatment (SET) that involved identification of the cases from the field, providing awareness of the disease to those affected and making sure that they continued the treatment (Banerji 1985: 118). The non-governmental organisations (NGOs) have also been playing a vital role all through the history of leprosy control in the country. Around 290 voluntary organisations are presently actively engaged in leprosy relief services with 127 of them involved in SET activities and of which 50 are covered by the SET grant from the government of India.[1] Earlier, the NGOs were involved in almost all aspects like case detection, treatment, public awareness creation, training, disability prevention and so on. Once the programme took off, only those areas where the government was not able to provide services were covered by these NGOs, thus keeping their role to a minimum. Despite this, the contribution of the NGOs must be acknowledged for its strong component of training rooted in experience and an efficient system for disability prevention (Lockwood and Suneetha 2005). Three is thus a need to redefine and situate the role of NGOs in the programme after integration.

Integration: Some Concerns

Integration implies that leprosy control activities become the responsibility of the general health services as part of routine day-to-day activities. Integration was influenced by the international acceptance of primary healthcare approach, the World

Health Organisations (WHO) campaign for elimination and more importantly the introduction of MDT (Feenstra and Visschedijk 2002). Thus equity and sustainability, the major components of primary healthcare approach also became the major justification for integration. Equity implies comprehensive care as well as care-specific to leprosy patients. This is in contrast to the vertical services that are provided otherwise on specific days and separately for leprosy patients. Here the challenge is to ensure quality and specialised services to those affected with leprosy but as a responsibility of the general health services. Second, the question of sustainability gains prominence as the reliability and support towards general health services is higher than towards those services provided by a vertical setting. Moreover, integration expects to improve access to leprosy control services through which it reduces stigma and the gender bias attached to it. The experiences with integration of leprosy control services in various countries reveal a mixed trend. The positive element identified by some countries was the decentralised, health services system that could address the uneven distribution of leprosy cases whereas inadequacy in planning the integration process was identified as a major shortcoming; particularly the processes of training and monitoring (ibid).

Uneven Distribution

Prior to the introduction of MDT, leprosy was found more among the southern states of the country. According to a recent report, however, the burden is more among states like Bihar, Jharkhand, Chhattisgarh, Uttar Pradesh and West Bengal (Joshi et al 2007). This could be due to the improved surveillance mechanism prevalent now in these states as compared to earlier times. As per 2006 estimates, around 50% of new cases of leprosy detected worldwide were from India, and of these two-thirds were confined to the above mentioned five states (ibid). Bihar, Chandigarh, Chhattisgarh, Delhi and Jharkhand have a prevalence rate between 1 and 2 per 10,000 populations while in Dadra and Nagar Haveli the rate is 2.11 per 10,000 populations. These together contribute to 25% of the country's recorded caseload (ibid). Reports also indicate that there has been a drastic decline in prevalence rate due to the introduction of MDT for leprosy.

Scholars have been sceptical about using prevalence rate as an indicator for the magnitude of the problem and there is a controversy over whether elimination is a virtual phenomenon or a reality (Lockwood 2002). The decline is attributed to the reduction in the treatment period with the new regime, when prevalence is calculated on the basis of those who take treatment. This is only reported prevalence (iceberg) submerging the real prevalence. The two major indicators that reveal the burden of leprosy, namely, case detection rate and reported prevalence are predominantly dependent on the surveillance mechanism prevalent and treatment regimen followed as well as the access to treatment. This being the case, the burden of leprosy cases can appear to decline if there is a failure in the mechanism for diagnosis and treatment. This was the situation in India when the case detection rates became stagnant with high rates among children (about 17%), an indication of the fact that leprosy is being transmitted in the community (Lockwood and Suneetha 2005). Moreover when disability due to leprosy is on the increase, it indicates that the disease is spreading. Thus, any approach to control leprosy must put a system in place that can ensure prevention of the disease at the primary, secondary and tertiary levels of prevention. These in the context of leprosy can be active surveillance for new cases, effective provisioning of treatment to the patient as near to his/her home as possible with an equally vigorous mechanism to follow-up cases to ensure patient adherence and, last but not the least, prevention of disability and rehabilitation. It is in this context that the call to integrate all national health programmes becomes relevant both as an opportunity as well as a challenge since any programme once integrated will "sink" or "sail" with the general health services (Banerji 2005).

Possibilities within NRHM

The NRHM acknowledges the need to integrate health programmes since it recognises limited synergism of disease control activities at the operational level. It further calls for decentralised services that give ample scope to address the regional inequalities that are relevant as far as the problem of leprosy is concerned. Besides, the overall strengthening and effectiveness of general health institutions, the major focus of NRHM, has positive consequences for the leprosy control programme as it is already integrated. The Common Review Mission of NRHM aims to build in the preventive, promotive and curative care for communicable diseases into the definition of fully functional health facilities thereby providing for promotive and preventive services within the general health services (GOI 2007). This is accomplished by developing standard treatment guidelines, essential drug lists, referral systems, support systems for capacity building, logistics, and monitoring, and behaviour change communication (BCC) interventions. This, along with the bringing together of district health societies of tuberculosis, malaria and leprosy under state health societies is already in the process (Pandey et al 2006). In order to ensure horizontal integration sharing of laboratory infrastructure, equipment and technicians amongst various control programmes has been recommended. Developing multiple skills is recommended by NRHM for pharmacists, laboratory technician and other support staff. The mission also guarantees full coverage of curative and restorative services related to leprosy. In addition to these the mission also offers space for NGOs/civil society organisations especially in the field of training, monitoring and evaluation.

NLEP within NRHM

Thus in the current scenario integration provides a new outlook when seen through the lens of the NRHM. Its approach on integration of leprosy control activities appears to be to provide Accredited Social Health Activists (ASHAs), the central component of NRHM, the major responsibility for case detection of leprosy. The central role of case detection/surveillance both in terms of administrative and technical competence, in effective implementation of leprosy control programme has been identified by many scholars earlier (Lockwood and Suneetha 2005). Here the context in which ASHAs work becomes crucial as incentivisation (cash) of their work and its setbacks in Reproductive and Child Health

(RCH) Programme cannot be forgotten. However, incentivisation and "social activism" are contradictory not only conceptually but in practice too. The existence of contradictions shows the need to revisit the work constraints of the ASHAs while keeping in mind the experiences of the auxiliary nurses and midwives (ANMs) with the health service system.

If the task of leprosy surveillance is handed to the ASHAs, especially in the high leprosy prevalent regions of Bihar, Jharkhand, Uttar Pradesh and Orissa, it is bound to fail due to their already heavy workload. Health problems in these regions are numerous, especially those related to reproductive and child health and the ASHAs have to deal with them on a priority basis. Also, since the ASHAs are expected to work for a meagre amount (given as honorarium) it is possible that programmes with incentives get higher priority. During initial stages of the disease leprosy patients do not get much attention from healthcare givers (Lockwood and Suneetha 2005). This neglect is worse in a situation where the felt need for RCH related services is much higher as compared to leprosy. It must be noted that ASHA training does not cover leprosy and even if it is included, will such training be sufficient enough for effective diagnosis is a question that needs to be seriously looked at. This is based on the concern that it is fundamental to distinguish between cases with skin lesions and cases of nerve involvement for which hands-on-experience with diagnosing leprosy patients was found to be crucial (Lockwood and Suneetha 2005).

The second aspect of leprosy control that finds a place in NRHM is provision of information, education and communication (IEC) through the village health and sanitation committee (VHSC). Here the challenge will be to find ways by which IEC activities can address the issue of stigma towards leprosy as it is a necessary condition for effective integration into the general health services system.

The third aspect is the strengthening of primary health centres and pharmacies within the general health services as part of the NRHM. This can improve provisioning of drugs thereby improving treatment. This calls for overall improvement of service delivery of general health services that should also address the issue of access to healthcare. If that is ensured then the challenge will be to ensure follow-up and supervision of relapsed cases. This is because patients with high bacterial load who are probably responsible for maintaining infection were found to have greater relapse rates despite 24 months of MDT (Lockwood and Suneetha 2005). The rehabilitative measures to support disabled patients are another feature. The approach could be that of a public-private partnership with support from the civil society. This can take the form of a technical and advisory body to the general health services. The details need to be worked out meticulously with both the partners functioning together for a common goal. This will also have the scope to retain civil society/NGOs that have been doing a commendable job in the field of leprosy treatment. Experts have pointed out that maintaining these groups as a support system can gain from their invaluable experience (Lockwood 2002). Again it is important to note that the role of civil society/NGOs should always be supplementary and cannot be a substitute to the general health services.

Conclusions

An attempt has been made to examine the possibilities and challenges within the leprosy control programme in India in the context of the NRHM. The experience with leprosy is an opportunity to learn from the integration of a disease control programme with the general health services a few years before the introduction of the NRHM. The concept of integration in leprosy control has evolved in the backdrop of primary healthcare approach thereby carrying forward the notions of equity, sustainability and community participation. The NRHM also considers these values as the core through which health services need to be strengthened. Here it becomes imperative to ensure a degree of specialisation, quality of services, sustainability and communitisation. This becomes relevant as the two-year review of the NRHM identifies that a basic minimum in terms of manpower, resources and services need to be ensured before additional resources are poured into it. In other words a system for monitoring, governance and service delivery needs to be ensured at every level so that more resources can be effectively utilised.

The major task of leprosy control like that of any other disease control is morbidity control for which active surveillance is crucial. Relying on ASHAs for this is not an encouraging option given the constraints with which they work. It is high time that we develop a reliable and systematic case identification mechanism both in terms of technical and administrative efficiency that can rule out the dilemmas on the number of leprosy cases. Though the NRHM conceptually offers ample scope to build leprosy control into its activities the task here is to ensure that the programme "sails" with the general health services. This can only be accomplished by efforts that can strengthen the health services system thereby ensuring that the components of leprosy control is knit into the general health services system as a responsibility on a regular basis.

NOTE

1 See http://mohfw.nic.in/National_Leprosy_Eradication_Programme/LEP_SET_SCH.htm accessed on 10 October 2008.

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