Original article

The involvement of the general health service staff in the management of leprosy in the Southern Region, Ethiopia

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Abstract: A qualitative study to examine the involvement of the General Health Service (GHS) staff in the management of leprosy patients was done between January and March 1997 in the Southern Nations Nationalities and Peoples Region (SNNPR). The aim of the present study was to get qualitative information on the status of the leprosy control program, the possibility of managing leprosy in the GHS, their willingness and future vision. The study used an in-depth interview with key informants and Focus Group Discussion (FGD) with leprosy field workers and GHS staff as an instrument.

The result showed that information related to the program is lacking at the woreda and zonal health department levels. The involvement of GHS staff in the leprosy control program was limited to suspecting and referring leprosy cases. The increased availability of the service to patients and better relationships among vertical program and GHS staffs were raised as major advantages of involving the GHS in leprosy work. Decreased attention given to prevention of disability, the occurrence of stigma and the threat to leprosy technical staff of losing incentives, were some of the disadvantages raised, if the program is integrated into the GHS. In general, there was a positive attitude from all participants of the discussion towards integrating leprosy into the GHS. Therefore, all stakeholders should give due attention to promoting the involvement of the GHS staff by gradually integrating the program into the GHS system. [*Ethiop. J. Health Dev.* 1999;13(3):187193]

Introduction

The social picture of leprosy has changed over the last decades, it being regarded more and more as any other public health problem that can be managed in any general health service. All countries have officially adopted the outpatient clinic as the base for treating leprosy, while old stigmatising leprosaria are being phased out. This optimistic approach deserves strong support from health personnel and others at all levels in order to guarantee patients' adequate treatment as well as self-respect (1).

After considerable progress has been made in the control of leprosy through the implementation of multiple drug therapy (MDT) during the last decade, the prevalence of the disease decreased dramatically. As a result of the very encouraging results from MDT within the last decade, the World Health Assembly (WHA) in 1991 resolved to eliminate leprosy (prevalence below 1 per 10,000 people) as a public health problem by the year 2000(2).

Since the implementation of MDT, the integration of leprosy control into the GHS has gained much wider acceptance. Integration means that leprosy control activities become the

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close to the community as possible (3). To a great extent this is based on the best utilization of

responsibility of the general health service i.e., a multipurpose, permanent, and decentralized health service, that is as _____
resources,because with the decreasing number of registered cases, vertical programs have become less effective. However, integration of leprosy services with the general medical services should be to the advantage of the patients (4).

Integration may involve the disappearance of specialized health care structures, but not the elimination of the program and/or the specialized staff at the most centralized levels of the health system. Integration involves administrative and operational changes at the level of multifunction health services, since there is no point in integration unless the multifunction health services have been given the means to deal adequately with the problem, taking account of the level of qualification and workload of their staff. Integration will necessitate in varying degrees supplementary training, appropriate instruction manuals, closer supervision, etc. This implies that the managers of the multifunction health services must have sufficient administrative authority and operational control (5).

In some countries where leprosy is endemic control programs are still vertical from national to operational level, with specialized staff and clinics, which are separated from other health services. This type of service has its own limitations leading to restricted achievement in leprosy control. The most frequently reported limitations are insufficient coverage, lack of comprehensive and continuous health care, inefficient use of resources, stigma, and dependency on donor's (3). In order to overcome these limitations, the general health services, which usually provide better coverage of the population than vertical programs must be involved.

At present, with the policy of decentralization in Ethiopia, leprosy and its control have become the responsibilities of the regional health bureau (6). In spite of the policy, the control program is still in its vertical implementation. There are several factors, which need investigation before handing over the program to the GHS in order to avoid the disadvantages on patient management. Based on these facts the aim of the present study was to get qualitative information on the involvement of GHS staff in leprosy control and to identify obstacles and future vision related to the management of leprosy patients in Southern Nations Nationalities and peoples Region (SNNPR), Ethiopia.

Methods

The involvement of the GHS staff in the management of leprosy control in SNNPR was assessed using a qualitative study during Jan– March 1997. The region has a population of 11.3 million within nine Zones and five Special woredas. A total of 28 leprosy field workers are running a vertical leprosy control program in the Region. At present in the SNNPR the integration of Leprosy Control Program into the GHS is in its initial stage. A total of 23 key informants (two from Ministry of Health, two Regional health Bureau, five Zonal Health Department, 12 Woreda Health office, and two Donors (ALERT and GLRA)) selected by purposeful sampling, participated in an in-depth interview. All the leprosy field workers and 18 health workers (six Doctors, six Nurses and six health assistants) participated in a total of seven Focus Group Discussions (FGD). Each FGD included 6-7 participants and took 1-2 hours duration. The in-depth interview was done with in 1hour duration. Two persons, one as facilitator/ interviewer and the other as recorder using questionnaire guides, held the FGD and in-depth interviews. In the guide, variables such as description of leprosy control programs, level of involvement, attitude of GHS staff, willingness for involvement, and the future vision were included. Qualitative data from FGD and in-depth interviews were analyzed using a matrix for the different items.

Results

As shown in Table 1, all levels of key informants described the vertical program implementation. At the zonal and woreda

Table 1: **key informant interview (summary), March 1997.**

NO.	GUIDE	MOH/RHB*	ZHD/WHO**	DONORS	REMARK
1	General description of leprosy control Program	Vertical program direction Limited integrated program (Tigray)	No information on the . burden of the disease .Vertical implementation .No direct relationship with ZHD/WHO	...Working as vertical Implementers .Combination with TBC in some areas. Association with charity	
2	Involvement of leprosy patients in management	.Involved in all components with specialized structure	Participation in diagnosis (suspect) of patients and referral .Occasional involvement in health education.No involvement in other activities because of specialized program	.Involvement in all activities as implementers (ALERT) .Support the implementation of activities (GLRA)	
3	Future vision in relation to the involvement of GHS	To integrate with other sease in the GHS	.Integrate with other diseases such as TB .All health institutions should render the service Fear. of resource shortage if integrated	.Combination with TBC .Integration with the GHS .Continue with the vertical approach in successful program areas	"Fear of job insecurity for leprosy field workers if integrated"
4	Ways to reach future vision	Policy for integration Training of health workers Support from donors in the direction of policy guidelines	.Training of health .Budget the workers .Support from program donors	.Clear policy on GHS involvement .Training of health .Incentive for health workers (workers top up, salaries, .Restructuring from allowances) vertical to integrated program	

*ministry of Health/Reginal Health Bureau **Zonal Health Department/World Health Organization

levels, information on the burden of the disease was not known by health officials. In relation to the involvement of the GHS staff in leprosy management at zonal and woreda levels the study showed that health workers are involved in suspecting and referring cases to leprosy clinics and occasional health education programs. As shown in Table 2, a similar result was found during the FGD among the GHS staff. The availability of the service in all health institutions and the decrease in disability were the major advantages raised by the GHS staff in relation to managing leprosy in the GHS (Table 2). Among the disadvantages, a decreased emphasis on specialized services such as prevention of disability and the occurrence of isolation of patients were the major ones (Table 2). In the same discussion, all health workers felt that leprosy as a health problem is their professional responsibility and expressed their willingness to be involved in its management. The FGD, with leprosy field workers (Table 3) revealed a better relationship with the GHS in areas where leprosy is combined with a tuberculosis program. The leprosy field workers felt that most GHS staff are not willing to participate in leprosy management because of fear of the disease. Early treatment in the nearby facilities as an advantage to the patient, and more assistance to the leprosy work for the field staff, were the major points raised by involving the GHS staff. In the same discussion, little attention given to leprosy patients, and fear of losing status for the leprosy field worker, were raised as issues

Table 2: **FGD with general health service staff, March 1997**

No	FGD GUIDE	DOCTORS	NURSES	HEALTH ASSISTANTS
1	Experience related to leprosy	.Referring suspects and patients to leprosy clinics	.Appointment of patients for treatment day .Referral of patients and suspects to leprosy clinics .Never worked in leprosy	.Referral of suspects and patients .Helping in treatment of patients
2	Is it possible to manage leprosy in the GHS	**Advantages** .Availability of the service in all health institutions .Decreases disability	**Advantages** .Availability of treatment in all institutions .Availability of treatment at any time Decreases disability	Decreases labeling of patients .Changes the attitude of the **Advantage** community and health workers .Availability of treatment in all institutions .Early diagnosis without .Decreases disease transmission complication **Advantage** Decreases labeling of patients .Changes the attitude of the
		Disadvantage No time for POD* activities Follow up may not be done by the same person Isolation of patients	**Disadvantages** .Physiotherapy and other activities may not be performed .Care may not be given as needed .Isolation of patients .Irregular follow up	**Disadvantage** .Increases psychological problem of the patients .Isolation can occur .Care may not be given as the vertical program

3	Willingness to be Involved in leprosy management	.Is a professional responsibility	.A professional responsibility	.Is a professional responsibility .Increases the knowledge of health workers
4	What should be done in the future	Convince health staff to participate in managing leprosy patients Integrate the program slowly Continue with vertical program	.Continue as vertical program .If integrated it will lose ownership .Training of GHS staff on referral of patients	Training of health workers .Use more sites by integrating the service .Give more public education .Patients should not be neglected for the sake of integration

*POD = prevention of disability

related to involving the GHS staff. The leprosy field workers, in increasing their relationship to the GHS staff, considered the involvement, in work other than leprosy, advantageous.

Except the nurses in the GHS who stressed the loss of ownership, integrating the vertical program into the GHS was perceived as a future vision in all levels of the key informant interview and FGD. The fear of resource shortage was raised by zonal and woreda levels. In order to reach the future vision all felt the need for a clear policy, training of health workers, and adequate budget allocation for the program in the GHS.

Discussion

From this study it is evident that the leprosy control program in most places is still a vertical program. Even though the policy of the MOH stresses that any health activity including Leprosy control, should be the responsibility of the Regional Health Bureau and institutions under them, in practice it is not yet fully exercised (6). The lack of information related to disease burdens at Zonal and Woreda offices is mainly due to the recording and reporting system using a vertical structure. This is one of the disadvantages in a vertical program where a single purpose structure, parallel to the GHS, will have its own information system (7).

Table 3: **FGD With Leprosy field workers, March 1997**

NO	FGD GUIDE	RESPONSES	QUOTATIONS
1	Relationship with the GHS	.Little relationship because of single disease activity .Referring suspected cases .Using rooms in the GHS .Better relations in areas with combined TB/Lep program	as health worker rather as leprosy "Leprosy field worker is not considered patient" "Leprosy is not an emergency disease, therefore priority is not given"
2	Attitude of GHS to participate in leprosy	.Does not want to treat patients not paying (free) .Lack of communication with leprosy field workers such as leprosy .Some feel that leprosy field workers arebecause of fear of disease transmission getting special incentives and doing less job	"Most of the time we do not tell our profession to friends because of fear of stigma"

3	Advantage and Disadvantage of Involving the GHS	**Advantage** .Can be treated in their locality **To the patient** .Increases contact tracing .Can be treated before developing disability .Patients can save money .No stigma (isolation)	**Disadvantage** .Low attitude of GHS leads to no treatment .Little attention for thorough physical examination .Stigma (isolation) .More disability because of difficulty No time for POD activities In managing reactions
		For leprosy field workers .Can get promotion opportunities like GHS staff .More assistance to the work .Increases relationship with GHS staff .Decrease workload on leprosy	.Lack of experience in managing other diseases .Fear of decrease in status .Decrease in financial resource .Increase overall work load
4	Willingness to be involved in other works	.Can help more patients with other diseases .Get more knowledge on different diseases .Decrease status	
5	Prospects for better eprosy anagement	.Practical integration with GHS .Training of health workers .Convince health officials on integration .Continue with vertical programs especially for POD .Form strong TB/LEP units in health institutions like MCH, EPI .In areas with patient load open special program	

The availability of services in all health facilities and decrease in disability, raised as major advantages of involving the GHS, are related to the early detection and treatment of cases. Stigma or isolation of patients was mentioned as a frequent disadvantage during the FGD. This is mainly associated with lack of exposure to the program, or fear of management by inexperienced staff. The problem of stigma can be decreased by increasing exposure of staff, which can be mainly done by integrating the program into the GHS. In addition, involving the community and public education can solve the problem (8).

The better relationship between the GHS and leprosy field workers in areas where the program is combined with tuberculosis control is mainly related to frequent communications at facility level and the use of the leprosy infrastructure for case holding of tuberculosis patients. This is especially useful in supporting the basic health service with an insufficient referral system. In addition to this, both diseases have similarity in epidemiology, organization, and management of control programs (9,10,11).

Integration is felt as a threat to leprosy technical staff. This can only be solved through continuous discussion with the involved personnel by clearly starting their role during integration (12). The fear of incompetence of GHS personnel is mainly related to the lack of training and exposure to the program. This can be solved by giving refresher courses for GHS staff, introduction of leprosy in the curriculum of basic health training, and continuous training of GHS staff (13,14).

Most participants of the discussion perceived the need for integration of the program into the GHS. In order to achieve the perceived need some prerequisites, such as political commitment to PHC, adequate training, adequate supply of drugs and equipment, regular supervision, and a well functioning basic health care system in which to integrate should be fulfilled. Unfulfilled prerequisites may end up in program failure (15).

One of the principal advantages of in-depth interviews and FGD is the ability to elicit a large amount of information in an efficient manner. In terms of the human and physical resources required, the cost of these methods is considerably less than that of a survey or analytic research

design. Limiting factors are the qualitative nature of the information and concerns about the generalizability of the finding (16).

In general, the overall result showed a positive attitude from most participants of the discussion toward integrating leprosy into the GHS. Therefore, there is a need to create a forum for discussion among all stakeholders in leprosy control activities on methods of integration. Based on the results of the discussion, a clear policy on the process of integration is required.

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References

1. WHO, A Guide to Eliminating Leprosy as a Public Health Problem. Document for Action Program for the Elimination of Leprosy, WHO, 1995;95:1.
2. WHO, Weekly Epidemiological Record. WHO, 1993.
3. Peter Feenstra. Leprosy Control Through General Health Services and/or Combined Programs. Leprosy review. 1993;64:89-96.
4. Becx-Bleumik M. New Developments in ALERT Leprosy Control Program and the Issue of Integration. Ethiopian Journal of Health Development. 1994;1:49-55.
5. Bart Criel, Vincent De Brouwere, Sylvie Dugas. Integration of Vertical Programs in Multifunction Health Services. Studies in Health Services Organization and Policy 1997;3.
6. MOH, Health Policy of the Transitional Government of Ethiopia. MOH, Sept. 1993.
7. WHO, Integration of Health Care Delivery, Report of a WHO Study Group. WHO Technical Report Series, 1996;861.
8. Anita NH. Leprosy and Primary Health Care: The Mandwa Project, India. Leprosy Review 1982;53:205-209.
9. Becx-Bleuming M. Priorities for the Future and Prospects for Leprosy Control. International Journal of Leprosy. 1993;61:82-101.
10. Fine PEM, Leprosy and Tuberculosis, an Epidemiological Comparison. Tubercle. 1984;65:137153.
11. Ad de Rijk Combining Tuberculosis and Leprosy Services in one Program. Ethiopian Journal of Health Development. 1984;1(2):37-43.
12. Bainson KA, Integrating Leprosy Control into Primary Health Care: The Experience of Ghana. Leprosy Review. 1994;65:376-384.
13. Wandroff DK and Wandroff J A, Leprosy Control in Zimbabwe: from a Vertical to a Horizontal

Program. Leprosy Review 1990;61:183-187.
14. Myint T and Htoon MT, Leprosy in Myanmar: Epidemiological and Operational Changes, 1985-
92. Leprosy review. 1996;67:18-27.
15. Roos BR, Van Brakel WH and Chaurasia AK. Integration of Leprosy Control into Basic
Health Services, an Example from Nepal. International Journal of Leprosy. 1995;63:422-429.
16. Corlien M. Varkevisser, Indra Pathmanathan, Ann Brownlee, Designing and Conducting health System Research Projects. Health System Research Training Series, 1991;Vol.2:Part-1, IDRC.