

CONCLUSION AND LEARNINGS

A special action project, as its name indicates, is designed to meet special needs. Through SAPEL, state health departments and DANLEP have initiated a massive effort to do just that: to reach out to disadvantaged and neglected populations in remote areas within the overall effort to eliminate leprosy from every part of the country. Levels of success in the various aspects of SAPEL vary from project area to project area. There have been lapses in training, or commitment, or community mobilisation. But in every project area, the access problem has been overcome, the majority of people have been surveyed, most if not all cases have been detected and treated, knowledge has been communicated in a move towards banishing centuries-old fears and misconceptions.

How far have the stated objectives of SAPEL been achieved in these project areas?

ACCESSING ISOLATED COMMUNITIES

This has largely been achieved because of the extra resources made available and the intensity of the detection process. Where there have been shortfalls in coverage, the main reason has been scheduling of the search immediately after the monsoon when rivers are in flood or during seasons of labour migration.

COMMUNITY PARTICIPATION

Lanji, where full community participation was achieved, is the exception. In other project areas, IEC was effective to the extent that people generally cooperated with the search teams. In some areas a considerable number of local residents participated in the search as volunteers. For the population in general, passive cooperation rather than participation has been the rule. There are indications that health personnel prefer this situation as they are able to carry through the operation efficiently in ways to which they are accustomed.

REMOVAL OF MISCONCEPTIONS AND STIGMA

IEC aimed at this objective has been successful in generally

removing misconceptions about the causes of leprosy. Isolation and neglect of leprosy patients is also becoming rare and the SAPEL process has contributed to this. But marriage with someone who has been affected or even with a relation of such a person is avoided. This remaining stigma is offered as the reason why most people shy away from identifying the disease as leprosy. Short of obvious disability, the disease is identified by other names and there is withdrawal and hostility when the word leprosy is mentioned. Health personnel tend to avoid the hostility by using the locally preferred vocabulary so that the aim of detection and cure is achieved.

KNOWLEDGE AND AWARENESS OF LEPROSY AMONG GENERAL HEALTH WORKERS

The participation of multi-purpose workers (particularly the women) in SAPEL has been a major feature in all project areas. Those who played a part in identifying cases and/or were in charge of administering treatment show a high level of knowledge and awareness. Others who underwent training but did not come in contact with confirmed cases ask for refresher courses. Where MOs and NMSs have made discussion of leprosy a part of weekly review meetings, knowledge and awareness levels are high.

OTHER LEARNINGS

Treatment providers have found direct administration of drugs at the beginning of every month impractical, especially during the rains. Where there is no responsible local volunteer to maintain contact with the patient, means of checking whether the medication is being taken regularly are inadequate. There is no set procedure for RFT.

Specific target groups for community participation, such as women's groups and teachers, have not been effectively drawn into the process, possibly because IEC has been general. In particular teachers, who form an important resource pool, have been the least interested everywhere.

The post-SAPEL sustainability of leprosy elimination in the project areas is open to question. Seen as an intensive, time-bound activity, the SAPEL focus has narrowed down to the sequence of

IEC, training, detection survey, confirmation and initiation of treatment. The end product of SAPEL is seen as the number of cases detected. It was suggested in Orissa that a second round of SAPELs, covering the same project areas about two years after the first, would make elimination more feasible. Ways could also be explored to strengthen the immediate follow-up to SAPEL.

WHAT FACTORS HAVE CONTRIBUTED TO THE VARIOUS SUCCESSES AND FAILURES OF SAPEL?

Concentration of resources, the intensity of a short-term project and the commitment of MPWs have been major ingredients of success. An exceptional case like Lanji shows how community participation can ensure success.

Short-term intensity, while contributing to success in detection, has also had the negative effect of making long-term sustainability difficult. Other negative factors have been blinkered attitudes and poor commitment of some health staff, IEC activity of limited scope not achieving community participation, under-utilisation of resources.