

# Editorial

## INTEGRATION

There are fashions in words, and in ideas. Some words emerge from the study, the laboratory or perhaps even the gutter, achieve a more or less transient popularity, and then disappear. Other vogue-words and phrases really fulfil a long-felt need and pass into the language, perhaps undergoing more than a little sea-change on the way. The “protagonists” seeking “parameters” of “psychosomatic disease” await the “psychological moment”.

“Integration” is one of these vogue-words—a watchword that is in danger of becoming a mere catchword, a battle-cry that gets muted into a parrot-cry. We hear it in relation to leprosy and to leprosy control. We shall hear more of it in the future, because it does stand for something desirable and necessary. Integration must come, sooner or later. Leprosy cannot remain in isolation, “splendid” or not-so-splendid. And the leprosy services, the leprosy control programmes, must sooner or later become an integral part of any plan to deliver some kind of comprehensive medical care to the mass of citizens.

Sometimes, for various reasons—most of them non-medical—a leprosy programme has been the first impact of Western medicine on a non-Western rural population. It has tackled a considerable and obvious and neglected problem, a problem made worse by prejudice and ignorance. Historically, the compassionate care of the early days was at length supplemented by scientific therapeutics, and then by reconstructive surgery and rehabilitation. For various reasons, some good, some less than convincing, a separate leprosy service has developed, with its separatist outlook and traditions, its own staff structure, and its vested interests. An over-emphasis on one disease has undoubted drawbacks: while focusing attention on a grossly neglected human problem, it may have contributed in some measure to the perpetuation of the stigma, the aura of uniqueness, of leprosy; while ensuring that leprosy sufferers were at least offered treatment, it may have turned them into over-privileged citizens enjoying a degree of medical attention denied their neighbours who were suffering from pulmonary tuberculosis, or trachoma, or from some physical impairment resulting from an accident or disease other than leprosy.

In all too few countries integration proceeded quietly and unspectacularly, even naturally. A rural health service was in existence, and when the new anti-leprosy drugs became available, mass treatment was offered through the dispensaries and health centres to all leprosy sufferers. Social discrimination and medical “apartheid”, fortunately, did not disturb this process. Integration became a *fait accompli*, because the possibility of any alternative was not entertained.

The present position is thus diverse and confused. Government planners and economists, costing their programmes and cheese-paring their estimates, are understandably chary of piecemeal schemes for separate diseases. Special campaigns may from time to time be necessary—for malaria or yaws, for trachoma

or trypanosomiasis; but health and nutrition and population control are but different facets of one indivisible problem—man in community.

Any new programme for disease control should take advantage of the new knowledge and the changing climate of opinion. Any new scheme for reconstructive surgery and rehabilitation, any plans for long-term care of the hopelessly disabled and handicapped, and any proposals for vocational therapy and sheltered workshops, should be broadly conceived so as to include those whose disabilities are due to leprosy. Similarly, in many instances those pioneering activities designed exclusively for leprosy sufferers might well cease to “discriminate” against those suffering from other conditions, such as congenital deformities, poliomyelitis, trauma (industrial or traffic accidents, or warfare), etc. The sheer size of the aftermath of leprosy may sometimes justify a special institution, but only in the context of approximately equivalent facilities being made available to the victims of conditions other than leprosy.

Admittedly, specialist advice and expertise must be readily available to governments that are faced with a sizeable leprosy problem. And there will always be a need for the devoted individual, be he research scientist or field worker, with restricted interests but deeper knowledge. Furthermore, as leprosy touches on (and oft-times illuminates) neighbouring branches of medicine and of science, the sheer fascination of the study of our specialty should captivate more and more the enquiring mind and the dedicated hand. But . . . the “one-track mind” is an anachronism today. There are other tracks, maybe parallel, often converging, and all of them important to the study and practice of leprosy and leprosy control in the community.

Governments and voluntary agencies have their parts to play in this inevitable integration of leprosy into the general health services. There are difficulties in the way, of course. Adaptation of buildings, in-service training of auxiliary workers so that by supplementary courses they become polycompetent; widespread education of the medical and nursing professions, political leaders, and the public at large in order to break down prejudice and undermine vested interests; the transformation of leprosy clinics into polyvalent dispensaries and health centres—in short, the “rehabilitation” of leprosy into the thinking and practice of all those concerned with the health of the community.

The voluntary agencies historically concerned with leprosy, and still in the forefront of the worldwide campaign against the disease, have a unique rôle in this process of integration. With their resources and attributes—of initiative, flexibility, and speed of operation—they might well pioneer in this, as they have in other directions. Any possible risk of loss of identity will be more than offset by the certainty of bringing more hope and better health to more people, including those suffering from leprosy. For the present, and for as long as the victims of this scourge suffer discrimination of many kinds and remain without treatment, there must be a continuing campaign to ensure that they receive a fair deal in the commendable efforts to plan integrated medical services.