Letter to the Editor

INTEGRATION OF EYE CARE INTO A LEPROSY HOSPITAL SERVICE: EXPERIENCE IN MANGU, NIGERIA

Mangu Leprosy and Rehabilitation Centre was started in 1950 by Dutch missionaries. It had the aim of taking care of leprosy patients and rehabilitating those with disabilities. It is now owned by a church organization, with support from the Netherlands Leprosy Relief Association and other donors. It is run by medical officers interested in leprosy control. As a result of the previously wide spectrum of eye complications during monotherapy with dapsone for leprosy, it became necessary to train eye nurses to take care of these complications. The result was a significant reduction in the incidence of blindness from leprosy as most complications were recognized early and treated. Lid surgery was performed by trained nurses, while intraocular procedures were done by a visiting ophthalmologist from Jos.

Multi-drug therapy (MDT) has brought about a decline in the number of eye complications and inpatients admitted for care due to leprosy. There has therefore been a gradual integration of other specialist services, among which is eye care, in specialist hospitals such as that at Mangu.

There is now a well established primary eye care service with over 20 primary eye care clinics spread all over the state. These clinics have scheduled regular visits by the ophthalmic nurses from the centre. The base hospital has an outpatient eye clinic, eye ward, operating eye theatre and an optical workshop. These are staffed by four eye nurses, other support staff and a medical officer with a diploma in ophthalmology and occasional visits by a consultant ophthalmologist. The average attendance at the clinic is about 12,000 and about 1000 surgical procedures are performed every year. Figure 1 compares the general outpatient attendance with the eye clinic attendance of leprosy patients and eye surgery.

We have noticed the following advantages:

1. Accessible eye care. This hospital, like many of the other leprosy hospitals, is located in a rural area. This is where the majority of Africa’s population resides. Unfortunately, most eye care services are located in major cities. There are therefore a large number of blind persons living in rural areas who cannot afford transport to major cities. The location of this hospital and the 20 primary eye care clinics is able to meet the needs of a large number of the rural poor. The rural environment is also more familiar to these patients and less intimidating as is the case in most major cities.

2. Affordable eye care. The total cost of getting eye care to the patient includes direct costs such as those for transport, treatment, surgery, drugs, glasses and optical services, as well as the cost of utilities and staff salaries. This has affected the ability of many patients to access eye care. The integration programme has reduced the cost of eye care as the facilities are closer to a large proportion of the patients.

3. Available eye care manpower. The ophthalmic nurses who were employed to take care of the eye problems in leprosy patients have knowledge in general eye care and so are able to recognise other common eye problems. They therefore provide an already existing manpower for effective delivery of eye care.

4. Integration of leprosy patients. Presently, only about 30 leprosy patients with eye complications are seen out of a total of 5300 eye patients seen annually. The utilization of a leprosy service by non-leprosy patients will reduce the stigma of this disease. The process of ‘reverse integration’ supports the
integration of leprosy patients into their communities where people are already sharing the same facilities as leprosy patients. Persons attending this facility are no longer categorized as ‘leprosy patients’. Figure 1 shows the attendance of leprosy patients at the eye clinic and the pattern of eye surgery in the years 1996–2000.

5. **Effective utilization of personnel and facilities.** As the number of leprosy patients requiring inpatient treatment declines, the amount of work for the staff of such leprosy hospitals will also reduce. This will result in loss of work or under-utilization of personnel and the facility. Integration of eye care into a leprosy control programme will easily provide an avenue for effective utilization of these personnel who may only need re-training.

6. **Additional source of funds.** A purely leprosy control service is always supported by both non-governmental and governmental organizations as most leprosy patients cannot pay for health care. An eye care service being utilized by other patients could easily generate profit. This is especially so where optical services such as provision of reading glasses are being offered. Such profits will provide an additional source of funds and support for the leprosy control programme.

With regard to disadvantages, we did not make specific enquiries, but the proximity of this hospital to the people of this area and the reliability of the services at low cost may account for the absence of adverse criticism or complaints voiced by patients. We believe it is of interest that a hospital, started as a leprosy and rehabilitation centre with a rudimentary eye service, now deals mainly with non-leprosy patients. Stigma is by no means unknown in Nigeria, but in the integration process described above, no problems have arisen from medical, non-medical or political sources.

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**References**
