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Distribution: Limited

National Programme Managers for Leprosy Elimination

*Report of an Intercountry Meeting
Kathmandu, Nepal, 6-8 January 2005*

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1. INTRODUCTION

1.1 Background

The South-East Asia (SEA) Region continues to be the only WHO region that is yet to achieve the goal of leprosy elimination. However the Region is steadily nearing the goal. The leprosy prevalence rate as of December 2004 was 1.56/10000 population, down from 1.9/10000 population in March 2004. The Region as a whole, as well as the three countries yet to achieve the elimination goal, namely India, Nepal and Timor-Leste are making concerted efforts to achieve the goal by December 2005.

Bangladesh, Bhutan, DPR Korea, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand have achieved the elimination goal at the national level and maintained the prevalence levels below 1/10000 population and are aiming at sub-national-level elimination and further reducing the burden of leprosy.

Since the introduction of multi-drug therapy (MDT) in early 1980s, over 14 million persons have been cured of leprosy, nearly 12 million of them in the SEA Region.

The annual intercountry meeting of national programme officers has been useful in reviewing the progress, sharing experiences, identifying constraints and evolving measures to deal with the remaining challenges. With this background, an Intercountry Meeting of National Programme Managers for Leprosy Elimination was organized in Kathmandu, Nepal from 6-8 January 2005. Twenty-six participants from eight Member States, including national programme managers from seven countries attended. Representatives from The Leprosy Mission International, Damien Foundation-Belgium, Amici Raoul Follereuo, German TB and Leprosy Relief Association and staff from WHO headquarters, the Regional Office and WHO-India Office participated. The List of Participants and the Programme are at Annex 1 Annex 2 respectively.

1.2 Objectives

The main objective of the meeting was to take an overview of the progress of leprosy elimination in the Region and in countries, and plan for the future. The specific objectives were:

- (1) To follow up on the progress of implementation of Leprosy Elimination programme in countries during 2003-2004;
- (2) To discuss implementation of country plans of action for the biennium 2004-2005, and
- (3) To identify country-specific constraints and make appropriate recommendations for acceleration and intensification of activities for national/sub-national-level elimination.

2. OPENING SESSION

Dr Klaus Wagner, WHO Representative to Nepal, opened the meeting and read out the address of the Regional Director, WHO South-East Asia Region. In his message, Dr Samlee Pliangbangchang stated that, with a prevalence of 1.9 leprosy cases per 10 000 population, South-East Asia remained the only WHO region which was yet to achieve the leprosy elimination goal i.e. prevalence below one case per 10 000 population. However, the Regional Director mentioned that the Region had made noteworthy progress and highlighted the following achievements:

- Of the approximately 14 million leprosy cases detected and cured globally, 90% were from the SEA Region;
- The prevalence of leprosy had declined by 92% over a 17-year period from 1985, when multi-drug therapy (MDT) was introduced in phases, in all countries of the Region;
- Eight of the eleven Member States of the South-East Asia Region had achieved the elimination goal at the national level and had maintained the elimination levels;

- All countries had integrated leprosy services into the general health services, thereby increasing the accessibility to multi-drug treatment and improving the image of leprosy as a curable disease;
- The three remaining countries - India, Nepal and Timor-Leste had substantially reduced the burden of leprosy and were making concerted efforts to reach the goal by December 2005;
- Within the Region, India accounted for 88% of prevalence and 91% of new case detections in 2003. Therefore, WHO was giving the highest priority to India, followed by Nepal and Timor-Leste, the three countries which were yet to achieve the elimination goal, and
- While maximum efforts were directed to countries which were yet to achieve elimination, it was to be recognized that in countries which had achieved national-level elimination, there were still areas and pockets where leprosy was highly endemic; these countries would therefore continue to receive WHO support to reach sub-national elimination.

The Regional Director also highlighted the following concerns:

- The high level of annual new case detection reported in some countries, in spite of very effective MDT implementation. He drew the attention of participants to the systematic studies on case validation conducted in India in 2003 and 2004, providing evidence of a substantial "over-reporting" of cases in India, which may be true for some other Member States too. In addition, the leprosy elimination monitoring (LEM) exercise conducted in India, Bhutan and Nepal indicated that some operational factors like delayed treatment completion, delayed release from treatment and providing treatment beyond the duration prescribed by WHO were also influencing and inflating the prevalence figures in some countries. He requested programme managers to ensure that effective measures were taken to minimize and prevent such operational factors.

The Regional Director expressed happiness that besides national programme managers, participants included officials from states, divisions or provinces who were actually responsible for implementing leprosy elimination activities, and partners supporting leprosy elimination activities in Member States. "This combination of planners, implementers and partners will provide

an excellent forum for reviewing the progress of elimination at national and sub-national levels, identifying problems and constraints, and evolving solutions for the achievement of the elimination goal at national/sub-national levels", concluded Dr Samlee.

The Regional Director thanked the Nippon Foundation for generously contributing to the Global Leprosy Elimination programme of WHO since 1975. Their contribution enabled WHO to provide free supply of MDT to all endemic countries from 1995-2000. Their example was followed by the Novartis Foundation for Sustainable Development, which pledged free supply of MDT from 2000-2005. Dr Samlee expressed his deep appreciation to the Novartis Fund which had indicated that they will extend the free supply up to 2010.

The Chief Guest, Mr Ashok Kumar Rai, Hon'ble Minister for Health, HMG, Nepal declared that the Government of Nepal was committed to the goal of leprosy elimination and thanked WHO and international donors for their support to the leprosy programme.

The Presiding Officer, Dr Banshidhar Mishra, Hon'ble State Minister for Health, HMG, Nepal assured his full support to LCD and specially thanked the WHO Representative, Nepal for the support received from WHO.

The Director-General of Health Services, Dr B.D.Chataut outlined the infrastructure, achievements, weaknesses, needs and future plans of the leprosy elimination programme of the Government of Nepal.

Dr V Pannikar, Leprosy Unit, WHO/HQ briefed participants about the global status of leprosy elimination, and constraints and challenges and future actions to be undertaken at the global level.

Dr Derek Lobo, Regional Adviser, Leprosy and other Priority Diseases, WHO/SEARO, introduced the participants, Temporary Advisers and Observers.

Dr Bimala Ojha, Director, Leprosy Control Activities, Nepal was appointed Chairperson of the meeting, and Dr G P S Dhillon, Deputy Director-General (Leprosy), India the Vice-Chairman. Dr A N Maqsuda was appointed Rapporteur.

3. TECHNICAL SESSION 1: GLOBAL AND REGIONAL SITUATION

3.1 Current Global Situation and Issues related to Sustainability and Integration

In his presentation, Dr Vijay Kumar Pannikar, Leprosy Unit, WHO/HQ highlighted the following points:

- Leprosy elimination was a success story: within a short span of <20 years, global cases had declined from 12 million in 1985 to around 0.5 million in 2004 and the registered prevalence had declined by 92%;
- At the beginning of 2004, the total number of leprosy cases globally was 453 497 (prevalence rate 0.77 per 10 000 population). All WHO regions had some leprosy burden except Europe. The SEA Region had presently the most number of cases, 302 860. Globally, nine countries were yet to reach the elimination target. This included India and Nepal from the SEA Region. The list did not include countries with <1 million population, hence Timor-Leste was excluded;
- The number of new cases detected was also showing a declining trend, from a peak of 763 262 in 2001 to 513 793 in 2003;
- Eighteen countries of the world contributed more than 97% of the cases of leprosy, with India and Brazil leading the pack.

Issues related to sustainability and integration:

- Though most countries had integrated leprosy services into the general health services (GHS), there was a need to strengthen the general services and build capacity to provide quality leprosy services. It also required phasing out of 'vertical' structures and staff which were not cost-effective any more;
- The tasks, management and organizational components related to the programme had to function in conjunction with the other components of the general health care delivery system. The process of integration should be in consonance with the core principles of primary health care and those of equity and social justice;

- There was need to develop a new strategy to ensure sustainability of leprosy services in low endemic situations. This required (i) competent health providers; (ii) informed participation of the community, and (iii) surveillance/monitoring;
- Resources had to be optimized without compromising on quality or community needs;
- There was need to further reduce the stigma and ensure that cured leprosy persons are fully integrated into the community;
- Partnerships needed to be strengthened and new partners co-opted, and
- Community involvement needed to be increased.

In the new scenario, the focus will be on timely diagnosis, prompt treatment, high treatment completion rates, and patient-friendly care and services. The main indicator needed to be shifted from prevalence to new case detection, with emphasis on quality of diagnosis and good recording and reporting practices. Active case-finding or campaign approaches were to be discontinued since they would not be cost-effective. The decision to set sub-national targets or time frames will be left to Member States.

It may be predicted that by the year 2010 the number of cases globally would drop from the present 360 000 to around 100 000. There would be sustainable leprosy services available, integrated with the GHS and supported by an efficient referral network. Adequate tools and resources for Prevention of Disabilities (POD) and rehabilitation would be available. There would still be new cases for some more time, but in reduced numbers, and hopefully without stigma or discrimination. Leprosy services would be based on the principles of equity and social justice.

3.2 Regional Review and Future Plan for Leprosy Elimination

Dr Derek Lobo highlighted the following points:

- There had been a dramatic decline in prevalence in the SEA Region during the decade: 1994-2004 and a steady decline in new case detections from 1998 onwards. The SEA Region was still the major

focus of the disease. It accounted for 69% of the prevalence and 81% of new case detections in 2003;

- Within the Region, India accounted for 91% of new cases detected in 2003. The states of Uttar Pradesh, Maharashtra , Bihar and West Bengal contributed the maximum number of cases;
- Eight countries of the Region had achieved the leprosy elimination goal at the national level, that is prevalence of less than one case per ten thousand population;
- India, Nepal and Timor-Leste were yet to achieve elimination but had reduced the prevalence rate substantially and were making concerted efforts to attain elimination by December 2005;
- Nearly 12 million cases had been cured, 10.5 million of them in India;
- All countries had integrated leprosy services into the general health care services;
- Extensive advocacy and IEC activities had resulted in greater awareness and reduced stigma;
- Deformity rates among new cases had declined dramatically;
- The regional leprosy prevalence rate (PR) had declined from 4.1/10000 population in 1998 to 1.9/10000 population as of December 2004. The regional new case detection rate (NCDR) had declined from 47.76/100000 population to 25.45/100000 population;
- The following problems were highlighted:
 - (i) A combination of detection targets, active search and repeated leprosy elimination campaigns without any control on the quality, accuracy and specificity of diagnosis had inflated the case load. This had also delayed the elimination of leprosy especially in India and Nepal as was obvious from the leprosy elimination monitoring exercise and case validation conducted in 2003-2004 in both countries;
 - (ii) The operational factors influencing prevalence and new case detection were – setting case-detection targets and basing

performance on target achievement; and over-diagnosis and re-registration of cases due to (i) non-adherence to WHO-recommended case definitions; (ii) active search and surveys; (iii) repeated leprosy elimination campaigns in the same area; (iv) lack of quality and accuracy of diagnosis; (v) delayed treatment completion and over-treatment, and (vi) job insecurity among staff involved in the vertical programme.

- The future challenges will be:
 - To achieve elimination in the Region, including in the three remaining countries, namely India, Nepal and Timor-Leste;
 - Sustaining political commitment and adequate resources, including free drug supply;
 - Detecting, treating and curing all new true cases;
 - Preventing operational factors like wrong diagnosis, wrong classification, re-registration of cases, over-treatment, delayed treatment completion and delayed release from treatment;
 - Extending multi-drug treatment (MDT) to underserved population groups like people living in difficult-to-reach areas, urban slums, migrant labour and those living in border areas, and
 - Integration of leprosy cured persons into the community.

4. TECHNICAL SESSION 2: COUNTRY PRESENTATIONS – INDIA

4.1 India

Dr G.P.S. Dhillon, Deputy Director-General (Leprosy), Government of India, highlighted the following:

- The strategies would be: to decentralize the services; integrate the services completely into the general health care services; intensify IEC; step up the training of general health care staff, and improve the POD services and reporting and surveillance systems;

- As of December 2004, the total number of leprosy cases was about 230 000 and the prevalence stood at 2.12 per 10 000 population;
- Fifteen of the 29 states and four of the six union territories (UT) had attained elimination. The most recent entrants being Gujarat State and the UT of Lakshadweep Islands. Another six states had a PR between 1-2;
- The high endemic states were: Bihar, Chattisgarh, Jharkhand, Maharashtra, Uttar Pradesh, and West Bengal;
- The NLEP was also focusing on the 170 high endemic districts and 834 blocks, and
- As per current trends and strong efforts to minimize the operational factors, India was confident of achieving the elimination target by 2005.

4.2 Bihar

Dr D.K. Raman, State Leprosy Officer, highlighted the following:

- The PR in the state was falling rapidly. The rate was 4.90 in March 2004 but by November it had fallen to 3.89/10000. The number of patients with grade 2 disability was 5 542 in 2000 and by November 2004 it was 232;
- As of November 2004, two districts had a PR between 1-2, 26 districts between 2-5 and 10 districts >5;
- Present status: New cases 32 887, MB cases 9 392, PB 23 495, Children 6 283; Proportion of MB cases was 29%; Child cases 19% and disability 0.7%;
- The stress at present was on case validation, (which showed 85% of cases to be correctly diagnosed) and register updating, and
- The action plan of the state was also mentioned. The plan sought to improve the quality of MDT services, minimize operational factors and improve community participation.

4.3 Orissa

Dr (Mrs) Anjali Chhotray, State Leprosy Officer (SLO), highlighted the following:

- The PR in March 2003 was 7.30/10000 which fell to 3.48/10000 by March 2004. By November it had further fallen to 3.32/10000;
- The state started MDT services in 1983 and it took thirteen years for the state to be covered fully;
- Presently two districts had reached elimination levels, five had a PR of less than 2, 14 districts had a PR between 2-5 and nine districts had a PR more than 5;
- The number of cases detected in various MLECs had shown a continuous declining trend;
- Presently, the activities in the state were focused on the high endemic pockets, bordering areas with other states, urban areas where the MDT services were weak and other priority areas. It was also proposed to organize SAPELs in the tribal and difficult areas.

4.4 Uttar Pradesh

Dr Rashmi Shukla, WHO State Coordinator made a presentation on behalf of the SLO and highlighted the following points:

- UP was akin to a country with a population of 18 crores (180 million), 70 districts, 3 194 PHCs and 162 district hospitals;
- As of November 2004, the number of cases under treatment was 34 372, with a PR of 2.6/10000;
- As of March 2004, the PR of two districts was >5/10000, 48 districts had a PR between 2-5/10000 and the remaining 20 districts with a PR between 1-2;
- Emphasis was given on assuring the quality of diagnosis by proper case validation and application of the correct case definition at all levels. Case holding was sought to be improved by more efficient defaulter retrieval, and improved and more extensive MDT services;

- Coordination with ILEP partners, SIS record updating and block-level IEC programmes were being implemented.

4.5 Chhattisgarh

Dr Ratre, State Leprosy Officer, highlighted the following:

- As on December 2004 the PR of the state was 5.88, the NCDR was 4.85, MB rate was 46.36%, the child rate was 8.65% and the deformity rate was 2.51%;
- Of all the leprosy cases in the country, 5% were from Chhattisgarh;
- Integration of leprosy services into general health services has been completed and MDT services were being offered in all government health institutes;
- Various types of local media being used for IEC were described in the presentation, as the state had a large tribal population and conventional methods were not adequate;
- The state planned to focus on local areas where the disease was still highly endemic by creating awareness through IPC, dialogue, SAPEL and LECs with the assistance of NGOs working in the area. The plan of action included POD camps, dermatology diagnostic treatment and education camps, staff training, and urban leprosy control activities with special emphasis on intensive tackling of endemic foci in future.

5. TECHNICAL SESSION 3: OTHER COUNTRIES

5.1 Bangladesh

Dr A.N.Maksuda, National Programme Manager, highlighted the following points:

- Bangladesh achieved the leprosy elimination goal at the national level in 1998, and in 2004 achieved elimination at the first sub-national level i.e. in all six divisions; since 1985, when MDT was introduced, a total of 165 503 persons had been cured;

- The PR at the end of the third quarter of 2004 was 0.51 /10000 population. Of the 64 districts, 56 had achieved elimination, leaving only eight districts and the metropolitan cities of Dhaka and Chittagong, to achieve the goal. The total cases under treatment at the end of September 2004 was 6 843 and the total number of new cases from January to September 2004 was 6 270;
- The deformity rate among new cases was high at 7.02%;
- By 2007, the country aimed to achieve elimination at the district level and to reduce deformity grade-2 below 5% among new cases. There was strong political commitment to achieve these goals;
- The major issues identified to be addressed to achieve sub-national elimination were: (a) relative lack of awareness in the community regarding leprosy; (b) high deformity rate among new cases suggesting delayed diagnosis or re-registration of old cases; (c) inadequate monitoring and supervision especially in hard-to-reach areas, and (d) reducing the prevalence in urban areas (Dhaka and Chittagong);
- Activities planned for 2005 included (a) sustaining the high level of MDT coverage and cure rate; (b) awareness creation (BCC), POD, vocational training and community-based rehabilitation, and (c) joint programmes with NGOs, various community groups and other professionals.

5.2 Indonesia

Dr Hernani, National Programme Manager, highlighted the following points:

- Indonesia achieved the leprosy elimination goal at the national level in 2000 and had sustained elimination levels with minor fluctuations. However, the annual new case detection had been static around 15 000 cases for the past four years;
- The country had set the target of provincial-level elimination by 2005 and at district level by 2008;
- The national strategy had been developed as below:

- In high endemic areas ($PR \geq 1/10000$), an accelerated approach - IEC, advocacy, intensified CF in endemic pockets, deployment of focal point personnel;
 - In low endemic areas ($PR < 1/10000$, $NCDR \geq$ than $0.5/10000$), all health centres to continue the current leprosy services;
 - In low endemic areas ($PR < 1/10000$, $NCDR < 0.5/10000$ for five consecutive years), leprosy services will be reduced to one-three health centres per district, while others would be termed as "suspect and refer";
- The main problems were: (a) consistently high PR and CDR in endemic areas; (b) geographically difficult areas; (c) difficulty in sustaining political commitment and resource allocation; (d) MDT drug management; (e) quality of patient management; (f) urban leprosy problem; (g) support to low endemic areas, and (h) rehabilitation and referral;
 - Activities implemented in 2004 – (a) Advocacy and planning meeting in high endemic area; (b) Leprosy Day; (c) Working Group meeting; (d) LEM and LCV; (e) Focused LEC; (f) RVS; (g) intensified contact examination; (h) development of simplified RR and MDT management; (i) workshop on leprosy elimination guidelines; (j) field trial of leprosy elimination guidelines and integration; (k) development of TV spot and other IEC material;
 - A total population of 88 663 was covered under LEC in 180 villages of 19 districts and 287 new cases were detected;
 - LEM and case validation conducted in a sample of patients indicated 16% wrong diagnosis and wrong classification in 40% cases;
 - Planned Activities Proposed for 2005 - LEC, RVS, intensive contact-examination in high endemic areas, IEC (TV and radio spot) and other printing material, LEM and LCV (leprosy case validation), advocacy in difficult-to-reach districts, capacity building (province, district and health centre levels), intensive supervision and review meetings at all levels, and procurement of MDT, prednisolone and clofazimine. In addition, sustainability of leprosy services will be ensured through total integration within PHC, general hospitals, medical-paramedical schools, disease surveillance, partnership with

other programmes, public-private mix, involvement of dermatologists and community-based rehabilitation.

5.3 Myanmar

Dr Tin Shwe made the presentation in the absence of the National Programme Manager and highlighted the following:

- Myanmar achieved national-level elimination in January 2003 and by June 2004, had achieved elimination at the first sub-national level i.e. in all 14 states/divisions;
 - The PR as of September 2004 was 0.54/10000 population;
 - Of the 324 townships, 301 had achieved the elimination target, leaving only 23 townships to achieve the goal. Myanmar was aiming at township level elimination by December 2005;
 - The main challenges included elimination in townships, to sustain the elimination at national and sub-national levels, timely detection of the new and backlog cases if any, to provide services in under-served areas, to sustain community awareness and participation, and to expand the Prevention of Disability programme and initiate rehabilitation activities;
 - The Plan of Action for 2005 had been divided into three groups of activities:
 - Activities for achieving leprosy elimination;
 - Activities for sustaining leprosy elimination, and
 - Activities for POD and Rehabilitation.
- (1) **Activities for achieving leprosy elimination** included (i) workshop on area identification following action programme to intensify elimination activities; (ii) special activities (focus LEC) in 60 health centres; (iii) expansion of leprosy services in uncovered areas; (iv) special action projects (SAPEL) for migratory and self-isolation groups; (e) workshop on management of urban and peri-urban leprosy control and implementation of health care package of leprosy control in urban and peri-urban areas.

- (2) **Activities for sustaining leprosy elimination** included (i) workshop on management of leprosy control for health supervisors in low-endemic areas; (ii) central, state and divisional level coordination meetings; (iii) township review meetings; (iv) strengthening monitoring and supervision; (v) development of LEM procedure and implementation, and (vi) improving community participation and awareness.
- (3) **Activities for POD and Rehabilitation included** (i) preparation workshop on POD and rehabilitation, and (ii) capacity building of junior leprosy workers on POD.

5.4 Nepal (National)

Dr Bimala Ojha, Director, Leprosy Control Activities, His Majesty's Government of Nepal highlighted the following points:

- The population was about 25.2 million. The country had 19 000 health units and 90% of health workers were trained in leprosy. Various international NGOs were also providing health care.
- The total number of registered leprosy cases was 5 635 and the number of new cases detected in the last four months was 1 927. Of the registered cases, 9% were children, 27% were women, the disability rate was 2% and the percentage of MB cases was 46%. Four districts had a PR greater than 5, 13 districts had a PR between 3 and 5, 30 districts between 1 and 3 and 28 districts had a PR of less than 1.
- The PR had declined from 4.41 in 2002 to 3.04 in 2003 and to 2.41 in 2004. The new case detection rate similarly had shown a downfall from 5.73 in 2002 to 3.04 in 2003 and to 2.84 in 2004. The Prevalence-Detection (PD) ratio was 0.85.
- The future strategy was to carry on the present activities like strengthening integration, training more general health care staff in leprosy, greater regional involvement, IEC impact assessment, LEM and register updating.

5.5 Nepal – Mid-Western Region

Dr Shravan Kumar Choudhary, Regional Director, Health Services, highlighted the following points:

- The population of the region was 3 190 136. It was divided into 16 districts. The current PR of leprosy was 1.8/10000 population and NCDR was 0.47/10000;
- Human resources were a problem as a large number of posts were lying vacant. More than 90% of medical and paramedical staff were trained in leprosy;
- Three districts had a PR of less than 1, eight districts had a PR of 1-2, and four districts had a PR >2;
- Recently, there had been a substantial fall in the NCDR, especially in the disability rate which had come down from above 18% to below 3%. The impediments in the path of reaching elimination were restricted mobility of staff, inadequate and untrained manpower and lack of motivation for leprosy work.

5.6 Sri Lanka

Dr Sunil Settinayake, National Programme Manager, highlighted the following points:

- Sri Lanka achieved the leprosy elimination goal at the national level in 1995 and had sustained elimination levels, with minor fluctuations. Seven of the nine provinces and five of the 25 districts had attained elimination;
- The country aimed at provincial-level elimination by December 2005 and district-level elimination by 2007;
- Leprosy services were totally integrated into the general health services. All health care providers (medical officers and assistant medical practitioners) of the government curative health units (from central dispensaries to teaching hospitals) had gained skills in diagnosis and management of leprosy. The leprosy situation was monitored by the Regional Epidemiologist (RE) at district level and by the MoH/DDHS at divisional level, and all health units had adequate stocks of drugs, registers, forms and other printed materials related to

leprosy. The general public was aware of the early signs of leprosy and availability of treatment, and the stigma was reduced. Cured persons with deformities were rehabilitated physically and socially;

- The main problems were: (i) dependence of some provinces on ALC; (ii) absence of RE (District Team Leader) in some districts; (iii) over-diagnosis, especially in children; (iv) re-registration and recycling in few areas; (v) unnecessary referrals of uncomplicated cases by some MOs to specialized units, and (vi) difficulty in compilation of cure rate;
- The main challenges were: (i) to achieve elimination target in remaining five endemic districts; (ii) to intensify leprosy elimination activities in the war-torn north-east provinces; (iii) to hand over full ownership to the General Health Service; (iv) to improve the quality of life of deformity patients and patients with reactions, and (v) investigation of child cases to identify risk areas;
- Plans and activities proposed for the future included: (i) regular review meetings with members of the district leprosy team; (ii) ongoing refresher training for medical officers; (iii) leprosy elimination activities in high-risk areas selected on the basis of epidemiological parameters; (iv) leprosy elimination monitoring (LEM) by WHO experts, and (iv) repealing of obsolete leprosy ordinances.

5.7 Thailand

Dr Krisada Mahatorn, National Programme Manager (Leprosy), highlighted the following:

- Thailand was the first country in the Region to achieve elimination, in 1994. By October 2004, 75 of the 76 provinces had achieved elimination. The remaining one province was expected to attain elimination in 2005;
- The country had a population of 63 million and was administratively divided into 76 provinces and 926 districts. The national PR was 0.29/10000 as of October 2004, the lowest in the Region. Of the 926 districts, 390 were free of leprosy; in 392 districts the prevalence was <0.5/10000; in 109 districts it was 0.5-0.99/10000, and in 35 districts it was 1-2/10000. These 35 districts were in 16 provinces;

- The low-prevalence situation had resulted in inadequate political commitment, low priority of leprosy as compared to other health problems, high turnover rate of officers in charge, lack of awareness and skills of medical officers/health staff and reduced awareness of leprosy among the general population;
- The above problems resulted in delayed presentation, low MDT completion rate, inefficient POD services, inadequate rehabilitation activities and persistence of stigma attached to leprosy-affected persons;
- The special activities in 2004 included rapid village surveys and workshops on "The Interpretation of Leprosy Epidemiological Indicators" and "Leprosy Sustainability under Low Endemic Situation";
- The ongoing activities included a project on "Accreditation of Leprosy Elimination at Provincial Level" and a research study on "Effectiveness of Single Dose 600 mg Rifampicin in Leprosy Prevention among Leprosy Contacts Living in High Risk Community";
- The Plan of Action 2005 includes implementation of the Fourth Leprosy Elimination Campaign (LEC) during the commemoration of the 60th anniversary of His Majesty the King's accession to the throne. The focus will be on 55 districts in 27 provinces and the main strategy will be passive case finding. It also includes "Training on Health Systems Research" for doctors, technical officers and staff of the Regional Office of Disease Prevention and Control, Zone 1-12.

6. SPECIAL PRESENTATION

Dr Rajan Babu represented the International Federation of Anti-leprosy Agencies (ILEP) and highlighted the following points during his presentation on "The Role of Partners in Leprosy Services":

- (1) The ILEP aimed at a 'World Without Leprosy' and believed in partnerships in trying to achieve the ultimate aim;
- (2) Partnerships should be based on shared vision and goal, and mutual respect and should benefit leprosy patients and communities;

- (3) The ILEP priorities and spotlight were on: (i) timely identification of cases; (ii) appropriate MDT; (iii) timely management of reactions; (iv) prevention of disability, and (v) rehabilitation for those who needed it. The objective was to detect, treat and cure patients without residual deformity;
- (4) The support provided by ILEP agencies to countries included: (i) technical support such as District Technical Support Teams (DTST) in India; (ii) monitoring and supervision teams in Nepal; (iii) participation in national-level exercises; (iv) production of learning materials for health staff; (v) providing reconstructive surgery, physiotherapy and rehabilitation services, and (vi) research;
- (5) The ILEP will support sustainability of leprosy services through (i) technical guidance; (ii) ensuring quality diagnosis of leprosy in an integrated set-up; (iii) improving access; (iv) surveillance of leprosy situation; (v) promoting simplified information system; (vi) strengthening referral system; (vii) MDT drug distribution if requested (as in Nepal); (viii) support services for management of disabilities, and (ix) advocacy, rehabilitation and operations research. The ILEP will continue to work with the community and the government through an holistic approach and commitment to a world without leprosy.

7. GROUP WORK

The participants were divided into four groups and the topics for discussion were as below:

- | | |
|----------|--|
| Group 1: | Measures needed to achieve leprosy elimination in India, Nepal and Timor-Leste by December 2005; |
| Group 2: | Minimization of operational factors influencing prevalence and new case detection; |
| Group 3: | Sustainable leprosy services for the South-East Asia Region, and |
| Group 4: | Operations Research. |

The group discussions were interactive, participatory and resulted in useful recommendations which have been incorporated in the meeting resolution.

8. CONCLUSION AND RECOMMENDATIONS

8.1 For India and Nepal (countries yet to achieve elimination)

- (1) The most critical and priority activities for 2005 should be: (i) routine case confirmation prior to registration; (ii) monthly updating of registers, and (iii) capacity building of health staff in order to minimize the 'operational factors' influencing prevalence and new case detections. These activities can be done through focal teams like District Nuclei/District Technical Support Teams/NGO Support Teams and WHO consultants.
- (2) Sentinel staff (staff trained and experienced in leprosy) should be placed in priority and problem pockets. The priority and problem pockets should be identified through careful analysis of data and available information and, if necessary, after field visits to ensure that the area is truly high endemic.
- (3) In order to ensure quality of new case detection, programmes should ensure:
 - (a) Case finding is mainly focused on promoting self-reporting and that active case finding activities are not employed at any level; instructions should be issued to discontinue active case detection activities which seem to accentuate the problems of wrong diagnosis and re-registration of cases;
 - (b) Strict adherence to case definitions as per WHO and national guidelines;
 - (c) Confirmation of new cases by competent health staff/MO prior to registration and initiation of MDT, and
 - (d) Considering the history of previous treatment and ensuring that previously treated cases are not registered as new cases, even if they require MDT.

- (4) The policy of “Accompanied MDT” should be adopted for certain groups like patients from hard-to-reach and distant areas, migrant labour, floating urban population and nomads, etc.
- (5) Services in urban areas should be integrated and medical colleges and private practitioners for leprosy diagnosis and treatment should be actively involved.

8.2 For Timor-Leste (yet to achieve elimination but in early stage of MDT implementation)

- (1) The rapid survey and situation analysis of leprosy in all districts should be completed.
- (2) MDT services should be established in all health facilities, especially in high endemic districts.
- (3) Appropriate advocacy and IEC materials should be developed to promote self-reporting and awareness.

8.3 For Countries which have Achieved National-Level Elimination and are Aiming at Sub-National-Level Elimination

The recommendations for such countries are:

- (1) It is noted that most of these countries are pursuing strategies to attain sub-national-level elimination as a national goal/policy, with sub-national levels and timeframe varying with countries. It is recommended that these countries continue to pursue such strategies based on the geographic level and timeframes nationally determined, and simultaneously take action to ensure that leprosy services are sustained even after sub-national elimination.
- (2) It is noted that some of the large countries have decided to continue with ‘prevalence’ as the indicator for sub-national elimination. Such countries should consider a shift to ‘new case detection’ as the primary indicator, after attaining the targeted sub-national elimination.

- (3) The required organizational set-up should be developed to ensure strengthening and sustaining of quality leprosy services including diagnosis, medical/surgical management, counselling, referral, IEC, POD and monitoring/supervision within selected facilities in an integrated set-up, in close coordination with all partners. This would also ensure convenient and satisfactory services.
- (4) Mechanisms for counselling of patients and family members should be developed in all aspects of the disease and its treatment including POD. Welfare schemes available for other disabled and under-privileged persons should also be available to those affected with leprosy.
- (5) Appropriate indicators should be developed and used to measure the quality of leprosy services.
- (6) Priority should be accorded to "Training of Trainers" and training of untrained general health staff in order to sustain the skills for leprosy diagnosis and treatment.
- (7) "Good Registration and Case Holding Practices" should be ensured, such as strict adherence to WHO-recommended case definitions in all cases, especially children, regular updating of treatment register at PHC level, timely completion of treatment, i.e. 6/6 for PB and 12/12 for MB, timely RFT on the date on which the last MDT blister pack is issued.
- (8) Special attention should be given to under-served population groups, including urban, through involvement of medical colleges, other health institutions, NGOs, and private sector and private practitioners, for leprosy diagnosis and treatment.
- (9) In very low endemic situations or areas with zero leprosy over a period of time, it may not be cost-effective to stock MDT drugs in all peripheral health facilities. In such areas, the leprosy diagnostic services may have to be based at a higher administrative level, e.g. at the district level. Minimum MDT facilities should be available at the district level and at a number of health facilities depending upon the endemicity.

8.4 Operations Research (for all countries)

The following were the recommendations:

- (1) In order to further consolidate on the achievements and provide solutions to specific problems, the meeting identified the following topics for operations research:
 - Measurement of deformity burden at national/regional level;
 - Validating under-diagnosis through examination of identified suspects;
 - Monitoring trends of new case detection and validation of registered prevalence;
 - Study of trends in attack rates among household contacts;
 - Impact of IEC on case detection and awareness;
 - Extent of hidden cases through indirect methods, such as measurement of delay in diagnosis and occurrence of deformity among new cases;
 - Measuring the magnitude of urban leprosy and multiple registrations;
 - Gender factors influencing detection of leprosy and utilization of services, and
 - Value of accompanied MDT.

The above topics will be discussed and prioritized at the next meeting of the Regional Technical Advisory Group (RTAG), scheduled in April-May 2005. The RTAG will advise WHO on further action.

- (2) It was pointed out that in certain border areas (intercountry and intra-country), patients may not be registered. There was need to exchange information and formulate guidelines to resolve this problem, if necessary, through intercountry and intra-country border meetings.
- (3) In view of the strong evidence that 12-dose regimen is adequate for MB leprosy, the national programme authorities in countries which still follow the 24-dose regimen for MB leprosy, should consider adopting the 12-dose regimen. In collaboration with WHO, such countries should consider organizing an orientation for

dermatologists and other professional bodies advocating WHO-recommended treatment duration. WHO should take the initiative to include the fixed-duration MDT therapy for leprosy in the new edition of Medicine and Dermatology textbook. It should also give wide publicity to the efficacy of MDT and low rate of relapse after MDT.

- (4) The strategy for “sustainable leprosy services” as discussed/ developed at the bi-regional consultation at Manila, Philippines (December 2004), which is under process of being finalized, should be adapted to country-specific needs. For example:
- In very low endemic situations or areas, it may not be cost-effective to set up MDT services in all peripheral health facilities. In such situations, one or more MDT service delivery points may have to be strategically located at a higher administrative level like the district;
 - In addition to the existing IEC tools, in the above situation, emphasis should be given on information regarding location of MDT availability, since services are likely to be available only at selected facilities.
 - Patients and family members should be counselled on all aspects of the disease and its treatment including POD. Welfare schemes available for other disabled and underprivileged individuals should also be made available for leprosy-affected persons.

[Note: Though recommendations 8.1 – 8.3 are grouped under three categories of countries, some of them will apply to all countries.]

Annex 1

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Annex 2

PROGRAMME

Thursday, 06 January 2005

- | | |
|-------------|--|
| 0830 – 0900 | Registration |
| 0930 – 1015 | Inaugural Session <ul style="list-style-type: none">• Opening by Master of Ceremonies• Welcome Address and RD's Message – WR Nepal• Address by DG-Health Services, HMG, Nepal• Inaugural Address by Chief Guest – Hon'ble Minister of Health, HMG• Introduction of Participants – RA-Leprosy, WHO/SEARO• Nomination of Chair, Co-Chair and Rapporteur – WR Nepal• Vote of Thanks – Director-LCD, HMG |
| 1045 – 1145 | Technical Session-1 – Global and Regional Review <ul style="list-style-type: none">• Global Review and Future Plan for Leprosy Elimination – Dr.Vijay Pannikar, WHO-HQ• Regional Review and Future Plan for Leprosy Elimination – Dr Derek Lobo, Regional Adviser-Leprosy & Other Priority Diseases, WHO-SEARO |
| 1145 – 1300 | Technical Session-2 – Country Presentations <ul style="list-style-type: none">• India – National (15 minutes)• India – 3 States (7 minutes each)• Nepal – National (15 minutes)• Nepal – 2 Regions (7 minutes each) |

1400 – 1530 Technical Session-3 – Country Presentations
(15 minutes each)

- Bangladesh
- Indonesia
- Myanmar
- Sri Lanka
- Thailand

1600 – 1630 Technical Session-4 – Country Presentations
(10 minutes each)

- Bhutan
- Maldives
- Timor-Leste

1630 – 1700 Discussion

Friday, 07 January 2005

0900 – 1000 Technical Session-5 – Special Presentations (10 minutes each)

- Role of Partners in Leprosy Elimination – Dr Cornelius Walter, ILEP Coordinator for India
- Post Elimination Strategy for Sustainable Leprosy Services– Dr Derek Lobo

1030 – 1230 10.30-12.30: Group Work

Group 1: Achieving Elimination in India, Nepal and Timor Leste and Sub-national Elimination in other countries

Group 2: Minimizing Operational Factors affecting prevalence and new case detections

Group 3: Sustainable Leprosy Services for South-East Asia Region

- 1400 – 1530 Group Work Continued
Parallel Session – Technical Briefing to the Media
- Resource Persons – Dr Bimala Ojha, Director-LCD, Nepal, Dr Derek Lobo, RA-Leprosy, SEARO
- 1600 – 1700 hrs Preparation of Group Reports and Recommendations

Saturday, 08 January 2005

- 0900 – 1030 Presentation of Group Reports and Recommendations/Discussion
- 1100 – 1130 Preparation of Final Report and Recommendations
- 1130 – 1200 Presentation of Final Report and Adoption of Recommendations
- 1200 – 1230 Closing Session