

ABSTRACTS OF ORAL PRESENTATIONS

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ON COMMUNITY BASED COMBINED LEP- ROSY AND TUBERCULOSIS CONTROL WORK IN NAVI MUMBAI

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This paper is an attempt to reflect on and derive lessons on work which combine two disease control programmes - Leprosy & TB.

The paper begins with a narration of ALERT-INDIA's community based leprosy and TB control work in the past 12 years.

It also brings out the crucial differences between two diseases in terms of socioeconomic and psychological characteristics. Keeping in view these differences, the paper proceeds to discuss the strategies and epidemiological features of the control programmes.

Finally, it highlights the major differences that emerge in the implementation of such programmes. Thus yielding valuable and critical aspects that need to be embodied in meaningful training programmes for both organisations and workers desirous of taking up such combined disease control programmes.

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LEPROSY CARE IN GENERAL HEALTH SERV- ICES - EXPERIENCES IN BIHAR, INDIA

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Intensive Leprosy Control activities has been sustained in Bihar State, India since 1996. Modified Leprosy Elimination Campaign (MLEC) was done twice from 1996 to 2000, involving general health services. During MLEC 1998, a system was devised so that leprosy care services are offered at all PHCs/Taluk & District hospitals at least one day a week (Tuesday). NLEC staff was also made available on this day at these centres. It was observed that this system offered following advantages.

- Leprosy care services were made available at general health services.
- There was active participation of different cadres of general health care personnel in leprosy programme.
- PHCs were recognised by the people as service provider for leprosy too.

Details on patients diagnosed and treated at PWCs will be presented.

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MYCOBACTERIAL DISEASE CONTROL IN A METROPOLIS OF SOUTH INDIA

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Gremaltes Referral Hospital & Leprosy Centre was started in 1971 for leprosy control work in the northern part of Chennai. It added tuberculosis control programme to its work in a phased manner from 1992.

49818 leprosy patients have been treated through the control programme working under the aegis of the National Leprosy Eradication Programme covering an area of 70 sq.kms over three decades. With the fall of leprosy prevalence to 6/10000 from 140/10000 in 1971, it was decided to integrate tuberculosis control work under the revised National Tuberculosis Control Programme. Initially we covered six corporation divisions and later on expanded RNTCP to the whole project area. Chennai district came under the RNTCP Dots Programme in 1999 in collaboration with the Corporation of Chennai. 195 sputum positive cases, 122 sputum negative cases and 13 E.P. cases have been treated from 1992 onwards. In other hospitals 166 sputum positive, 122 sputum negative and 22 E.P. cases belonging to our area are taking treatment.

The possibility of integrating TB-RNTCP Dots Programme into an already existing NLEP programme in an urban area is being presented.

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HARMONIOUS AMALGAMATION OF LEPROSY FUNCTIONS WITH GHC SYSTEM IN DISTRICT MANDLA

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Vertical NLEP Programme cannot run indefinitely being expensive especially when the prevalence rate has come down considerably. Vertical staff alone cannot generate awareness about Leprosy. Mandla is a tribal district with population of 9,50,000 with 1178 villages

in 9 blocks. Due to hills, rivers, nalas and dense forest, MLTU vehicles could not reach to deliver MDT drugs at many DDPs.

After consultation with the Chief Medical and Health Officer, a two day consensus building workshop was organized at District Training Center, Mandla in which one DLO, one BMO and 4 MPWs (2 Male and 2 Female) from Balaghat and one DLO, BMOs, BEEs and MPWs Male and Female (from Seoni District) were invited to discuss whether selected NLEP functions can be amalgamated with GHC system.

During the workshop, situation was analysed and the consensus was reached to amalgamate selected NLEP functions.

Accordingly, block wise task oriented training of GHC staff for capacity building was carried out on 2nd October '98.

It was observed that record keeping and reporting was not done as per expectations. As a result of this intervention in the district, number of voluntary reporting of cases has increased. The regularity of UT cases at health facility point has increased. MPWs have accepted NLEP function given as one of their responsibilities. The integration has been found feasible and result oriented.

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INTEGRATION STRATEGIES FOR LEPROSY CONTROL PROGRAMMES - A MODEL OF EVALUATION

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There are many kinds of leprosy projects operating across the globe. Now is the time for reflection and analysis, for each project to examine its systems, strategies and structure in the context of integration of leprosy into general health services.

An evaluation of an ongoing project with control programme and an IP ward is done to assess the strategies and structure it should adopt in the view of integration. This is important, as there are many other stakeholders with different roles in the field of leprosy. The plans of the Government and other funding agencies in terms of capacity building, IEC, POD, MDT reconstructive surgery are analyzed and it is decided that the strategies of the individual project should complement these efforts. Data was collected and analyzed from PHC / IEC, the district level and state level. This is in addition

to the internal analysis done within the project. Through this evaluation, a model has been evolved to formulate strategies for leprosy projects.

The authors propose to discuss the model adopted and its relevance in the process of integration.

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IMPLEMENTATION OF A JOINT LEPROSY/TB PROGRAMME IN AN ONGOING TRIBAL LEPROSY PROJECT - STRATEGY, RESULTS AND PROSPECTIVE ROLE OF NGOS IN IMPLEMENTATION OF RNTCP

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LEPRA India has established a leprosy project in two tribal districts in Orissa. The project covers a population of 1.5 million, predominantly tribal and distributed in 6096 villages located in difficult terrain. 8 tribal dialects are spoken by people, making communication a challenging task. The project has implemented leprosy programme by SET method. 14201 cases were treated with MDT. Based on an analysis of data collected from PHCs, it was realized that TB was a major problem that could also be tackled as a joint programme.

A joint Lep/TB programme was implemented from 1996 in a population of 2.5 lakhs within the project area. The staff has undergone training in implementing the programme. Necessary infrastructure to implement the programme was created. Initially, active case finding programme was taken up to identify TB symptoms. Subsequently, passive case finding methods were adopted. Only sputum positive cases are treated. DOTS was implemented as treatment strategy. Anganwadi workers are trained and utilized as DOTS providers. 1010 sputum cases were registered for treatment and 647 cases were cured during the last three years. The district in which this programme was implemented has now been recognized as RNTCP district. This has necessitated a revision in the strategy of participation of LEPRA India in the implementation of the TB programme.

In this paper, the implementation of TB programme as a joint programme, the results obtained, the role of local leaders and peripheral health workers as DOTS providers in difficult to reach areas and the specific areas in which a NGO working in leprosy could participate in RNTCP are presented.

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USE OF HEALTH CARE SERVICES AND UNMET HEALTH CARE NEEDS

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Green Pastures Hospital serves as a tertiary leprosy referral centre for the Western region of Nepal. Patient records of 142 leprosy patients from Kaski District registered for treatment between July 1991 and July 1995 were reviewed. This comprises 91% of patients registered in the district during that time. Their use of hospital services during the time from registration to RFT or up to three years (whichever came first) was reviewed.

Three patients were incorrectly diagnosed leaving the actual number of leprosy patients reviewed to 139. Of them, 65% were male and 35% female. Child proportion was 5.8%. Majority of cases (76%) were classified as multibacillary and the remainder (24%) paucibacillary. Highest skin smear was over 4+ in 22% of cases. At the time of diagnosis, 20% had WHO grade 2 impairments and 16% had grade 1 and 64% had no impairments.

The patient records were reviewed for number and length of hospital admission, number of patients treated for reaction, or having reconstructive surgery. In addition, it was assessed how often nerve function assessments were performed and how many patients received treatment for complicated ulcers, eye care, cataract surgery, protective glasses, protective footwear and late patient tracing. At the same time the indications for interventions were identified. The absence of interventions when indicated were referred as unmet health care needs.

In this cohort 27.7% had at least one admission during the follow-up time. The total number of inpatient days in the cohort was 4293 days. At least one prednisolone course was given to 51 patients (39.8%) during the follow-up time. Total of 66 pairs of protective footwear was given to 27 patients. Complicated ulcers (n=23) were treated in 13 patients. Only 6 reconstructive surgery operations were done during the follow-up.

In summary, this study is a documentation of the use of health care services by leprosy patients in Kaski District as part of the catchment area of Green Pastures Hospital. At the same time it is believed that the design of this study leads to underestimation of the actual unmet health care needs.

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HEALTH REFORMS THROUGH HEALTH AND POPULATION SECTOR PROGRAMMES CODE (HPSP) IN BANGLADESH - SALIENT FEATURES AND EXPECTED IMPACT ON DISEASE CONTROL, ELIMINATION AND ERADICATION

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Bangladesh has introduced major health reforms since July 1998. The main thrust of the reforms has been the sector-wide approach and the implementation of an ESSENTIAL SERVICES PACKAGE (ESP). The priority areas of the ESP are :

- a) Child Health
- b) Reproductive Health
- c) Control of Communicable Diseases
- d) Limited Curative Care
- e) Behavior Change Communication (BCC)

In the new structure, leprosy elimination comes under Line Director (ESP) and a Programme Manager-Communicable Disease Control, with a Deputy Programme Manager (Leprosy) as the focal point. All activities like training, procurement & LEC are combined for all programmes under the overall supervision of the respective Line Directors.

The most peripheral unit of ESP will be the COMMUNITY CLINIC to be established at one clinic for every 6000-8000 population. It is planned to establish a total of 13,500 community clinics country-wide. All basic and essential health services will be provided through these fixed clinics to be run by two (2) health workers-one male and one female. The referral services will be provided at the Thana (sub-district) level through the Thana Health Complex which has provision of 31 beds and outpatient services.

The impact, advantages and disadvantages of the new system with particular reference to the National Leprosy Programme will be presented and discussed.

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Co 326**COMBINED TUBERCULOSIS AND LEPROSY CONTROL PROGRAMMES - THE BANGLADESH EXPERIENCE**

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Bangladesh was one of the first countries in the world to operate a combined Tuberculosis and Leprosy Control Programme, under a single Project Director. The combined programme commenced in 1985 and was accelerated in 1993 under a GOB/World Bank/WHO project.

Though TB and leprosy have certain commonalities like the cause (mycobacterium), mode of transmission (airborne), similar microscopy techniques and Rifampicin as the most potent drug for both diseases, there are major differences in operational objectives and strategies.

Though the two programmes were combined in Bangladesh, the expansion of TB and Leprosy Services and some of the activities connected with the country-wide expansion were separately implemented. The benefits, advantages and disadvantages of the combined TB and leprosy programmes within the Bangladesh context are presented and discussed.

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Co 335**CO-OPERATION BETWEEN NATIONAL AND INTERNATIONAL N.G.O.s IN THE FIGHT OF LEPROSY - YEMEN EXPERIENCE**

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Leprosy in Yemen is considered as a public problem more than a health problem. Before 1964, leprosy patients were subjected to an obligatory isolation in unsanitary houses outside the main cities. Between 1973 and 1982, some leprosy patients were given medical care by dapsone monotherapy. Though MDT was officially adopted in Yemen in 1983, there were no real leprosy control activities due to lack of support till an agreement between Ministry of Public Health (MOPH) - Republic of Yemen and German Leprosy Relief Association (GLRA) - Wurzburg - Germany was signed in 1989.

In 1992, a local non-government organization called Yemen Leprosy Elimination Society (YELEP) was formulated. This society together with GLRA further strengthened our fighting against leprosy in Yemen. With the support of GLRA, YELEP and other national and international non-government organizations, the prevalence of leprosy was brought down from 0.70 per 10,000 population in 1992 to 0.32 per 10,000 population in 1999.

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Co 383**EFFECTS OF MLEC ON MASS-AWARENESS**

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Modified Leprosy Elimination Campaign (MLEC) 98-2000 was a very successful drive in Bihar. It also produces a good effect on mass-awareness in the people of Bihar. The collection and analysis of data shows more voluntary reporting than previous reporting year.

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Co 17**REPEATED IMPLEMENTATION OF MLEC CAN BRING DOWN THE INCIDENCE OF LEPROSY IN THE COMMUNITY**

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The concept of the MLEC for the achievement of elimination of leprosy in our country and as well as in the State of Orissa has brought a revolutionary change in the incidence of the disease. During MLEC-I, which was implemented in the State of Orissa from 30th January to 5th February, 1998, 62844 leprosy cases were detected by examining 33857823 nos of persons whereas during MLEC-II which was implemented from 30th January to 4th February, 2000, only 27197 leprosy cases were detected by examining 27715988 nos. of persons. The detection rate during MLEC-I was 18.56 / 10,000 population and 9.81 / 10,000 during MLEC-II.

The 47.14% fall in detection rate just in 2 years interval indicates that repeated implementation of MLEC with more than 80% coverage of population can help in bringing down the incidence of the disease which will finally help in achievement of elimination of leprosy sooner than expected in the State of Orissa.

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LEPROSY ELIMINATION CAMPAIGN IN SELECTED DISTRICTS OF KARNATAKA AND KERALA

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There was a reduction of over 50% in registered PR in Shimoga district of Karnataka and Kottayam district of Kerala while NCDR has declined only in Shimoga district between 1995-2000. However, in Gulbarga district of Karnataka with Pre-MDT PR of over 80/10,000 brought under MDT in 1989 has shown a marked decrease in PR to 6 by 1995. No marked change could be observed in PR and NCDR in the district between 1995-2000, perhaps because of increased case detection during MLECs. MLEC-2 has resulted in detection of smaller number of cases in all the three districts compared to MLEC-1. VRC approach was followed in MLEC-2.

The consistently very high child PR in Gulbarga district during the last six years is a matter of concern. The results of the findings will be detailed. Constraints observed in the district/state as well as recommendations suggested to overcome them will be discussed.

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LEC IN LIMKHEDA TALUKA OF PANCHMAHALS DISTRICT

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The Panchmahals District is a high endemic tribal district of the Gujarat State. The Limkheda taluka in particular has very difficult to reach terrain and high migration rate of tribal people. The total 242 villages having a population of 3,29,644 will be covered with total 84 Leprosy Assistant/Leprosy Supervisors. The Primary Health Care staff, including M.O.-PHCs, MPHSs, MPHWS, AWWs are given one day orientation training. The case detection will be carried out during 10th July to 31st July, 2000. The preliminary report of the first four days

suggests high prevalence rate in the taluka. The details of the results will be discussed during the presentation.

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RESULTS OF LEPROSY SURVEYS AFTER MLEC

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Active survey for leprosy case detection with the help of paramedical staff of general health services was carried out after VRC programme in Mumbai as a part of MLEC-2000. Following this large scale campaign, the active survey was undertaken in three health post pockets by the PMWs of leprosy vertical programme where no or very few leprosy cases were detected by the general health staff.

The comparative results of MLEC and post-MLEC surveys in three urban pockets were as follow :

Pocket-1 Pocket-2 Pocket-3 Total

MLEC Post- MLEC Post- MLEC Post- MLEC Post-
MLEC MLEC MLEC MLEC

Population 27293 9533 69519 32211 101454 18180
198266 59924 Enumerated

Population 19008 5785 41097 18731 64604 11036
124709 35552 Examined (70%) (61%) (59%) (58%)
(64%) (61%) (63%) (59%)

New Cases 1 10 0 8 6 21 7 39

NCDR/ 0.52 17.3 0 4.3 0.9 19.0 0.6 11.0 10000

These findings call for look into the reasons for such difference in NCDR. In view of forthcoming integration of leprosy with general health services, these results also question abilities of general health staff in carrying out basic leprosy surveys.

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VOLUNTARY REPORTING OF LEPROSY CASES IN REFERENCE TO MLEC II AND V.R.C.CAMPAIGN

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In Madhya Pradesh, V.R.C. campaign was organised on 21 & 22 July, 2000 and Modified Leprosy Elimination Campaign was conducted in the month of February 2000.

A total of 53 cases in VRC and 275 cases in MLEC-II were registered.

New registered cases were interviewed for knowing the reasons for not being detected in MLEC-II. The data collection was done by either NLEP worker or supervisors.

Result of VRC campaign shows that 20% of cases were absent during MLEC-II, 60% of cases were ignorant about the signs & symptoms of leprosy, 8% of cases although had doubt in mind but kept hidden in their homes during campaign, 12% of cases could not get any answer to the questions asked.

The study indicates that ignorance in cases of leprosy is more than 60% of cases and the IEC should be incurred and strengthened.

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THE MLEC IS A VIAMEDIA FOR INTEGRATION OF NLEP WITH GENERAL HEALTH CARE SYSTEM

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As per WHO, one of the strategies for achieving elimination of leprosy is the broadening of the MDT service. The MDT services under NLEP in India as well as in Orissa is implemented through specialised vertical infrastructure. This system has been proved quite effective in tackling the enormous leprosy problem in the State of Orissa. But at certain point of time, the vertical system becomes incapable in controlling the transmission of the disease and also in bringing down the prevalence rate of leprosy further below as it has got limited potentiality to provide extensive coverage. So the MDT services cannot be made broadbased with vertical system unless the General Health Care System (GHCS) which has got enormous potentiality to give extensive coverage is completely involved and given full responsibility of NLEP.

Two successive rounds of Modified Leprosy Elimination Campaigns (MLEC) in Orissa has proved that the MLEC is the best via-media for activating involvement of the GHCS in leprosy elimination process. Now the NLEP in the State has been functionally integrated with GHCS in all the districts. With functional integration, the programme is made broadbased. The coverage has been remarkably improved and the cases

are now being detected at quite early stage and immediately put under MDT which reduces the potentiality of a patient to transmit the disease in the community. Treatment compliance has increased to almost 100%. Disability rate amongst new cases has reduced drastically below 1%. It has generated tremendous confidence in people to believe that leprosy is just like any other communicable disease and can be fully cured and services are available all the time within their reach. This has caused in high increase (80%) in voluntary reporting of new cases. These findings indicate that Orissa has got bright prospective for achieving elimination of leprosy sooner.

And these all could happen due to successful implementation of MLEC-I and II in the State by adopting the holistic approach of total involvement and ownership of General Health Care System in the programme.

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POST MLEC FOLLOW-UP CAMPAIGN FOR MOPPING UP LEPROSY CASE DETECTION

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Modified Leprosy Elimination Campaign (MLEC) was done twice in most of the leprosy endemic districts in India since 1998. Large number of new leprosy cases had been detected. There was inadequate follow-up of the impact of the intensive health education done during MLEC. Technical support team in Katihar district, Bihar tried another quick LEC. One block in the district (Balrampur) was randomly selected. A team consisting of one Medical Officer and two non medical leprosy workers visited 107 villages in one month. Quick propaganda was made in the village and workers examined people gathered at that spot. A total of 100 new leprosy cases were detected. During MLEC 89 new cases were detected in the same block with active search programme. Such programmes can be done by the existing leprosy programme personnel. This kind of follow-up action could improve the cases detection in leprosy endemic regions and hence elimination process.

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Co 173**LEPROSY ELIMINATION CAMPAIGN IN BIHAR : THE LESSONS TO LEARN**

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The second Modified Leprosy Elimination Campaign was carried out in Bihar in March 2000. It resulted in the detection of about 82000 new cases. A systematic evaluation of the campaign was done by the DFIT support teams placed in 20 districts in Bihar. The team selected one block in each district by random, screened all the suspects identified during the campaign.

Totally 7921 suspects were identified and from them 2238 cases were detected by the programme. Only 63% had been screened by the programme. Of those screened, 45% were new cases, 3.8% old cases and 51.2% not cases. 94.5% of cases seen by the team were found to be cases. About 3% of non-cases were found to be cases. About 11% of unscreened were cases. The teams detected 1200 new cases in the selected block during the exercise.

The consequences to the programme and to the strategy are discussed.

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Co 251**RESULTS OF IMPLEMENTATION OF LEPROSY ELIMINATION CAMPAIGNS IN THE HIGH ENDEMIC AREAS OF LEPROSY IN YUNNAN, GUIZHOU AND SICHUAN PROVINCES**

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The effectiveness of activities of leprosy case finding in the implementation of Leprosy Elimination Campaigns (LEC) integrated with routine leprosy program in the high epidemic areas of leprosy in Yunnan, Guizhou and Sichuan Provinces in 1999 were evaluated. Extensive leprosy health education in the community, leprosy training of primary health workers, implementation of clue survey, contact survey, diagnosis and treatment were carried out. A total of 122 new leprosy cases were detected in 6 high epidemic counties of leprosy through LEC in 1999 with a detected rate of 3.7/100000. In the last 3 years, the annual number of newly detected leprosy cases was only 67 cases

and the rate of case detection was 2/100000 on an average. Among the newly detected leprosy cases, about 47% of cases were leprosy household contacts. LEC combined with routine activities of case finding can promote the detection of the back-log leprosy cases in the communities. In the high epidemic areas of leprosy, especially in the remote and difficult-to-access areas, most leprosy cases can be detected by active and passive case finding methods through extensive health education, skin clinic, leprosy contact survey and clue survey.

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Co 327**NATIONAL LEPROSY ELIMINATION CAMPAIGN (N-LEC) IN BANGLADESH - ACHIEVEMENTS AND LESSONS**

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A six (6)-day National Leprosy Elimination Campaign (N-LEC) was implemented countrywide in Bangladesh in February, 1999. The salient features of N-LEC were :

- a) Implemented in all 64 districts, 460 thanas (sub-district), 103 municipalities and the 4 metropolitan cities of Bangladesh.
- b) A total of 45,400 health workers and community volunteers were directly involved in the 6-day campaign.
- c) Sixty three million of the population (52% of the country) was directly contacted through rapid photo survey conducted in about 61,000 villages (87% of the total villages) and 44,000 schools of the country.
- d) Prior to the campaign a total of 33,000 Imams (religious leaders) and 28,000 local community leaders were contacted through advocacy meetings.
- e) The campaign was supported by extensive country-wide media coverage.
- f) The campaign activists referred 60,878 suspects, of whom 2,435 new cases (PB-1198/MB-1237) were detected.

The impact, cost-effectiveness and the lessons learnt from this country-wide campaign are discussed.

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LEPROSY ELIMINATION - EVERYBODY'S RESPONSIBILITY

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Introduction

On reaching the goal of elimination, Urban Leprosy Eradication will remain to be a burning problem, if not addressed properly.

Context

- Peculiar nature of urban problem - Modified Leprosy Elimination Campaign (MLEC) as an intervention - MLEC I Feb. 1997 strategy, NLEP to people - Active

- MLEC II Jan 2000 strategy people to NLEP - Passive

Outcome of both almost same. (Details found in the presentation paper).

Information education communication very effective means to augment of case finding through voluntarily reporting.

MLEC Phase II found to be more rewarding for the following reasons:

- a. People suspect disease by themselves by identifying signs and symptoms.
- b. Awareness generated among a big mass which is the investment for future.
- c. Inter personal communication is more effective than the other methods which is more sustainable.
- d. Opportunity for people to take part in leprosy elimination.
- e. Expansion into many hands other than leprosy service providers.
- f. Involvement of various strata of the community i.e., broad based should be the ultimate goal.

Conclusion

It is strongly believed that leprosy elimination lies in people's hand which includes community, NGOs, Self Help Groups, women/men/youth groups along with Govt/NGOs meant for leprosy.

Data and other relevant information are provided in the presentation paper in the urban context.

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Co 10

EXPERIENCES OF SAPEL PROJECTS

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SAPEL is one of the initiative suggested by WHO for implementation of MDT in the under served area and under served population. Madhya Pradesh State is spread over an area of 4,42,466 sq. km. with population of 79968265 (1999). 23% population is tribal and 14% are scheduled caste. The physical features are characteristic of-undulating topography with low hills of Vidhyachal and Satpura range, narrow valleys, plateaus and plains. The state has nearly one eighth of total forest area of the country. Almost one third area of the state is covered by forest. MDT has been implemented in M.P. in phased manner, giving priority to high endemic districts from 1987-88. By the year 1992, all high endemic districts and by April 1995 remaining districts were covered under MDT. Prevalence rate of state had reduced from 43.4/10000 (1987) to 4.4/10000 (March 2000).

47 SAPEL projects were started in 21 districts during 1999 resulting in the following outcome - No. of village covered 2,004 Population covered 13,47,710 Population surveyed 9,53,594 (71%) Volunteers selected, covered and trained 2,612 Volunteers actually used 2,405

Female among volunteers 1,203(50%) No. of cases suspected for Leprosy 4,628

No. of cases confirmed, registered and put on treatment 981

(349 MB+555 PB & 77 SSL)

Most of the cases under treatment in SAPEL areas are receiving MDT through the volunteers. The services of volunteers were supported by NLEP/PHC workers in the form of drug-supply-monitoring, case confirmation, referral services for complicated cases, record keeping & reporting and monitoring the programme. The experiences gained & lessons learned are valuable for planning & execution of more such SAPEL projects in the state.

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Co 22

ALTERNATIVE METHODS OF NEW CASE DETECTION IN DISTRICT TIKAMGARH

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Case detection & MDT coverage is the first priority during present stage, i.e., leprosy elimination. Many

people do not come forward for examination during house to house survey due to stigma and ignorance. Therefore alternative methods of new case detection became a necessity.

Apart from MLEC & SAPEL, following methods were tried for new case detection: organizing skin disease diagnosis, therapeutic and educational camps (SD-DTEC) in short, called skin camp .

Own family survey by students of high school.

Screening of persons/patients attending out patient department of Government Hospital/ Dispensary.

Invited survey (Sarpanch invites NLEP team to examine villagers, collected on particular day).

District Tikamgarh adopted the first method that is organizing skin camp throughout the district, and throughout the year involving GHC system. The objectives of organizing these skin camps were - a. To educate the community about what leprosy is and what leprosy is not by demonstration methods.

b. To detect new (untreated) leprosy cases.

. To treat common skin diseases, free of cost.

d. To bring openness for diagnosis and treatment of Leprosy.

115 camps were organised during 1999. 676 new cases were detected, registered and put on MDT.

Continued on next page Key persons of the area (Village/Ward) were involved in planning and organizing skin camps. Community resources were mobilized, e.g. contributing drugs required by pharmaceutical companies & medical shops, volunteers for announcement & spreading awareness, furnished venue by school/panchayat/community halls and temples.

It was observed that these camps helped in zeroing distances between community and leprosy cases along with new case detection. This initiative has been adopted as a strategy throughout the state.

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EARLY LEPROSY CASE DETECTION BY VOLUNTEERS IN DIFFICULT AREAS IN THANE DISTRICT

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House to house leprosy case detection is very expensive and time consuming if we depend only on regular

trained Paramedical staff. Given the fact that sufficient number of trained paramedical personnel are not available, one may have to seek alternate human resources for the primary task of leprosy case detection. ALERT was required to survey for identifying new cases in far flung remote villages of Thane District that had become part of the Navi Mumbai Municipal Corporation limits in the recent years and is also part of ALERT's leprosy control project area (formally under Zilla Parishad leprosy control units). There was an urgent need to ascertain the leprosy situation in 40 villages newly added.

As qualified persons were not available, particularly because numbers were not adequate to complete the survey within a short period of 5 to 6 months, ALERT decided to engage volunteers and give them intensive training to identify cases of suspected leprosy. Thus, 13-H.S.C. qualified youth from the slum areas were selected. The volunteers were paid Rs.75/per day. As these villages were not connected by bus route, transport was also provided for staff to reach the villages and move from one to another.

In a short period of 133 working days (between November 99 to April 2000), these volunteers made house-to house visits and examined 1,29,383 persons in 40 villages. Volunteers suspected 332 leprosy cases . Of these, the doctors and trained paramedical workers of ALERT-INDIA confirmed as high as 54 per cent as leprosy cases. A further 10% were kept under observation. This study indicates that a significant number of new cases (NCDR - 14 / 10,000) has been detected with less expenditure and in a short duration by utilising the services of adequately trained volunteers in difficult areas too. Thus, the use of a voluntary force has yielded appreciable results, the use of such personnel is both economical and commendable in quality of work.

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COST EFFECTIVE METHOD OF NEW CASE DETECTION IN URBAN SEONI - WITH SCHOOL STUDENT INVOLVEMENT

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Seoni a small town in M.P. and a District H.Q. has a population of about 70,000. Leprosy survey work in city is difficult because of limited staff and problems inherent of any urban population. Hence a cost effective

tive method of survey by which all the citizens could be covered was planned taking the help of school students while carrying out school survey. All the students above 5th standard were given health education regarding leprosy, going to each & every class of school and then they were given a simple form to fill up at home as their homework after examining all family members.

In the format, students were asked to write about total number of family members and name of all persons in family suffering from any skin problem. Next day all the forms were collected and persons with skin problems were listed as suspected case and were called to attend free skin disease diagnostic camp in the school. In this method 720 skin disease suspected cases attended 8 camps over one year and 25 new cases of leprosy detected.

In this activity about 17,000 school students were directly surveyed by NLEP staff in 55 schools of Seoni in Jan, Feb 99 & then July to Nov 99 i.e. in 6 months time and more than 4000 families i.e. about 25,000 people surveyed by middle & high school students. Total 800 cases were suspected from a population of 40,000-45,000 and 25 new cases of leprosy could be searched from students and their families which were otherwise not taking advantage of Urban Leprosy Centre.

Thus this activity to search hidden cases which surveyed more than half the population of the town could be done with just two NLEP staff and one M.O. without any extra cost for detection of new case.

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THE STRATEGY OF 'SPECIAL LEPROSY CASE DETECTION CAMPAIGN' THROUGH VOLUNTARY REPORTING CENTRE (VRC) IS NOT GENDER SENSITIVE

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Recently, on 21st & 22nd July 2000, as per instructions of Govt. of India, a Special Leprosy Case Detection Campaign through Voluntary Reporting Centre (VRC) was launched in the State of Orissa At every health institutions of the State, including public and private sectors, the Voluntary Reporting Centers were established. Each VRC was managed by one Medical Officer, one Para-medical Worker (PMW) and one Health Worker (M/F). The VRCs were opened from morning 8 0 clock to evening 5 0 clock on 21st & 22nd July 2000. Atleast from 15 days prior to VRC dates, an intensive public awareness activities was launched through electronic media (AIR & Doordarshan). Special programmes which were developed by AIR and

Doordarshan with help from BBC WT were telecasted and broadcasted at prime time. With message to people regarding holding of Special Voluntary Reporting Centres at every health institutions of the State and regarding signs and symptoms of leprosy and such persons were requested to report at Voluntary Reporting Centre (VRC) and get himself or herself examined and get free MDT, if confirmed as suffering from leprosy.

Apart from programme through AIR & Doordarshans, mike announcements, hand bills distribution, banner display at strategic points regarding holding of VRCs were done by the District Leprosy Societies for publicity of VRC.

Preliminary reports from few districts shows that out of total 6257 persons reported at the VRCs only 2227, i.e. 35.6% were female and out of total 351 cases were confirmed, only 125 cases (35.6%) were female. Whereas during MLEC-II more numbers of female population was examined and equal numbers of male and female leprosy cases were detected in the State just 6 months back. So this outcome of Special Leprosy Case Detection Campaign indicates that the VRC strategy is not a gender sensitive strategy.

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SPECIAL ACTIVE PROJECT OF ELIMINATION OF LEPROSY (SAPEL) IN BHANDARA DISTRICT, MAHARASHTRA

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Project was undertaken to strengthen the MDT activities to eliminate leprosy in problematic/ remote areas with the help of community awareness and case holding programmes.

There are 14 blocks in Bhandara District - 4 are tribal out of these. The total population of the district is 21,03,276 and total number of villages is 1643 plus 5 towns. Tribal population is 3,76,349 and the number of tribal village is 432.

MDT Project started from 8th December 1988 and the whole district is covered under the MDT. PR before starting MDT was 70.6 /10,000 and PR by the end of December 1999 was 6.4/10,000.

Selected Problem Areas

1. Tribal areas
2. Remote areas
3. Vacant post of PMW since long
4. Poor transportation/communication facilities

5. Dense long-distance forests
6. Temporary immigrated population

Villages selected from tribal and remote areas and non-tribal areas of SET units and LCU. These villages are having poor transportation and communication facilities, posts lying vacant since long, long distance forest areas where it is not possible to do routine activities for individual leprosy workers. Case detection activity during the last three years is very poor as compared to the rest of the areas in the district.

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ALTERNATE ACTIVE CASE DETECTION ACTIVITIES - AN EXPERIENCE IN GAYA DISTRICT, BIHAR

Dr. Bishwanath Prasad, Peter Paul & A. Jesuraj, Damien Foundation India Trust, Chennai

MLEC II was conducted in Bihar state during March 2000. About 81000 new cases were detected during 6 days door to door active search by the General Health Staff. DFIT which has established District Support Teams in 24 districts of Bihar conducted an evaluation of MLEC during May and June 2000. This was done by random selection of one block in each district and examining all the suspects identified by the search team. In Gaya district of Bihar, Manipur block was selected for this purpose. There were 247 suspects identified by search teams of which 126 reported to the PHC for screening. 62 were confirmed as leprosy cases; (21 MB, 40 PB and 1 SSL) the remaining 121 suspects did not turn up for examination.

A. The support technical team during its evaluation examined all the 247 suspects and registered 37 new cases (14 MB, 22 PB & 1 SSL). During the screening of suspects, additional 69 cases were detected in the community (12 MB, 57 PB).

B. The team also conducted skin camps in 10 selected places in the block. The camps were done after intense propaganda by audio system fitted to the team's jeep, involving local general health staff. During the camps, 244 more suspects were identified of which 59 (17MB, 39 PB & 3 SSL) turned out to be leprosy cases.

The total additional cases detected were 165 of which 106 cases were detected during examination of suspects and 59 by skin camps. The outcome of evaluation recalled that more than 250% of cases were not detected during MLEC. The total expenditure was Rs.3605/- about Rs.22 per case.

The future strategy for active case detection is to involve local General Health Staff and do block wise mini MLEC.

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CASE FINDING (LEPROSY) USING VILLAGE CHILDREN - BIHAR EXPERIENCE

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Intensive MDT programme with active survey changed to Leprosy Campaigns, etc. Innovative methods are being explored in leprosy control programme. Bihar State in India has been known for leprosy endemicity. Three LEC were done from 1996 to 2000. Post LEC quick campaign done in this region has yielded a large number of new cases of leprosy. The technical support team (Leprosy) in Purnea district, Bihar tried another innovative method.

Any new corner to a village is first greeted by the group of children. They are curious and anxious to participate. These children were educated on signs of leprosy using diagnostic cards. They went to their houses and examined their household members. Any one with suspected leprosy lesions were brought to the team for examinations. The support team could cover about 50 villages in 13 days and detected 135 new leprosy cases including 8 patients with lepra reaction. In addition to this, 94 absentees for treatment were also contacted. This seems to be another useful method for case detection in rural areas. Further details will be presented.

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UNAPPROACHABLE AREA MADE APPROACHABLE THROUGH SAPEL IN BILASPUR DISTRICT

Dr. Vijay Kumar Verma & Dr.K.P.Rathore, Bilaspur

District Bilaspur is having 25 blocks out of which 8 blocks area is having dense forest and are unapproachable practically for 7 months in the year. The Health functionaries though posted to cover the area are either not residing in the HQS or they cannot move in their area due to hills and forest, so the services are poor. To come up from this situation and to render Leprosy Services SAPEL was proposed for Sectors in

3 Blocks. 136 new cases surfaced and got treatment during SAPEL period (from January 1999 to September 1999) using volunteers who were trained for one full day to suspect Leprosy Cases. Extensive I.E.C. activity resulted in voluntary reporting which is still continuing.

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SHORT-TERM IMPACT OF THE NATIONAL LEPROSY ELIMINATION CAMPAIGN (N-LEC) IN BANGLADESH

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A six-day National Leprosy Elimination Campaign (NLEC) was implemented country-wide in Bangladesh in February, 1999. The main objectives of NLEC were :

- a) Capacity building at all levels
- b) Creating nation-wide awareness on leprosy
- c) Detection of remaining hidden and backlog cases and provide them MDT

An immediate post NLEC survey was undertaken one month after NLEC implementation, to assess the short-term impact of the country-wide campaign. This was done through a sample survey conducted by six(6) teams of investigators, who collected data from 34 thanas (subdistricts) of eighteen (18) districts. The teams validated NLEC findings, investigated results and documented information with the aid of a prepared questionnaire. A total of 8 MDT centres, 56 leprosy patients, 195 health workers, 32 community volunteers and 2,200 members of the community were covered by the survey.

The salient features and findings of the survey and the short-term impact of NLEC are presented and discussed.

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Co 29

PROBLEMS OF LEPROSY AMONG PEOPLE WHO MIGRATE TO OTHER STATES

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The Leprosy Mission, Champa in M.P. has been given an area of 1785 sq. kms. spread over two blocks in Bilaspur and one block in Raigarh District. Case detection, provision of MDT, care of deformity and other anti-leprosy activities are done by The Leprosy Mission in these three blocks.

About 5% of the population of the two blocks in Bilaspur District migrate during non-farming season every year to other states, especially to Punjab, U.P. and J.K. This migrant population mainly belongs to people below the poverty line.

The persons who develop leprosy among this group are always detected late and are prone to develop deformities.

This paper presents the practical problems faced to detect cases among this particular group of people and discuss ways to overcome late detection, deformities and irregularity in treatment.

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LEPROSY AMONG NOMADS AND ITINERANT GROUPS

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Nomads and Itinerant groups are sections of population who are normally not accounted for in any census. Leprosy surveys are likely to miss them. New leprosy cases occurring among them are generally brought to light by voluntary reporting. We submit two reports.

The first is a case of a nomadic group of about 800 individuals who were cloth sellers, who settled for a short time in the vicinity of our institution. A survey done using leprosy paramedical worker trainees resulted in the finding of 8 new cases, which is a fairly high figure for that population. With three of them being highly bacilliferous, we consider it significant in terms of potential transmission.

The second report is the case of an itinerant group of a large family hailing from Rajasthan, numbering about 35, two of whom reported with signs of leprosy. Upon examination of the whole family, it was discovered that 8 of them had leprosy, three of them with a high

BI. The importance of targeting such groups for surveys and health education campaigns cannot be overstated. The details of our findings will be presented and discussed.

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Co 192

LEPROSY IN TAMIL NADU (INDIA) - A SPECIAL REFERENCE TO MDT REGIME

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Leprosy is caused by mycobacterium leprae. It is one of the chronic disease which causes much concern and remains as a challenging public health problem in India. Tamil Nadu is one of the states to witness a high prevalence rate of leprosy. MDT programme was introduced as a revised strategy replacing the dapsone monotherapy treatment to achieve quicker results in discharge of patients as cured and with the ultimate aim of eradication of leprosy. The study has identified the dimensions that have played a vital role in the health status of the leprosy affected population. It also shows the significance of MDT programme and its impact on the prevalence rate of leprosy in Tamil Nadu. Both primary and secondary data were collected from all districts in Tamil Nadu. The primary data was collected from 600 leprosy patients based on stratified random sampling procedure. Keeping in view the importance of MDT the present study analysed and identified the major dimensions of MDT with reference to Paucibacillary (PB) and Multibacillary leprosy (MB) on the basis of selected variables.

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MASSACRE OF M LEPRAE IN JAHANABAD, BIHAR

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Bihar state in India has mostly difficult areas for any field based health programme. Jehanabad is known for the problem of law & order situation. It is difficult to implement out-reach welfare programmes under such circumstances. National Leprosy Elimination Programme is no exception. There have been other problems like inadequate communication, etc. The support technical team coordinated the leprosy programme ac-

tivities. There has been active participation and support from programme managers.

Several training programmes on leprosy were done for various categories of general health services personnel and NLEP staff. The NLEP staff and general health care personnel with assistance from technical support team could bring about a positive change in leprosy scenario of the district. The two key elements of leprosy elimination programme, namely case detection and treatment delivery have been maintained at a satisfactory level. Details will be presented.

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LEPROSY SCENARIO IN MADHUBANI DISTRICT - THE POISE AND THE PERSPECTIVE

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Madhubani District, situated in north Bihar, India is moderately endemic to leprosy. The Damien Foundation India Trust has placed a support technical team in the district from February 1996. The team assists the local National Leprosy Eradication Programme staff in case detection, treatment delivery. The data available reflects significant improvement in the performance of the programme in the District. The new case detection rate has increased 3 fold in 97-98, 8 fold in 98-99 and over 3 fold in 99-2000. There is striking improvement in treatment compliance. Deformity rate among new cases has declined from 6.2% in 96-97 to 2% in 99-2000. 5000 absentees were traced through General Health Staff and community leaders and treated by the team in 97-98 though records were not available. However, the performance needs further improvement. Covering a population of 3.15 million with just 2 Non Medical Supervisors (NMS) and 29 Non Medical Assistants (NMA) is a pipe dream indeed. Three major rivers flowing through a major part of the district expose it to the fury of floods and inundation resulting in major operational constraints for four to five months in a year. Therefore, an alternate strategy is being planned. Making MDT services available through all PHCs, empowering general health staff to play an effective role in the program through capacity building and transfer of technology to extra medical personnel are the main contours of this approach. Special case detection drives through IEC and community participation is yet another priority area. A deviation from the conventional method is inescapable to hasten the process of elimination in this deprived district.

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PARTICIPATION OF A VEHICLE DRIVER IN LEPROSY ELIMINATION PROGRAMME

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Our organisation works in the 'A' ward of the Municipal Corporation of Greater Mumbai (MCGM) where there are head offices of several private and government undertakings but the residential area is low. We started our work in 1982 with a novel idea of leprosy exhibition on wheels. Our vehicle, with its exhibits on leprosy, gets parked at vantage points where passersby have a cursory look at our exhibits and at times, use the facility of spot examination by our trained workers inside the van. Since I am a person who has taken the complete course of PBMDT successfully, I take an active part in explaining the various posters to lay people in a simple language, usually Hindi, which is understood by a majority of people coming to Bombay.

During the period from 1984 to 2000, approximately 28 leprosy patients were detected by me during such exhibitions of which 18 were from our project area and 10 were from outside our project area. Ten were MB +ve, eight were MB +ve and ten were PB. These were all from LIC. I built up a rapport with them and 23 completed the course of MDT, two patients left the area before completion of the course; they took only 6 pulses. Three are still completing their course of MDT.

I think every component of the leprosy elimination machinery such as a driver can take part in the elimination by giving health education, therapy, detecting leprosy and curing patients with regularity of Rx and preventing deformities.

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Co 242

THE FACTORS AFFECTING 'LEPROSY THREE EARLYNESSES' AND ITS COUNTER MEASURES

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In the situation of the market economy and facing the basic elimination of leprosy, the implementation of early case - finding, early diagnosis and early treatment was affected by the factors of the misunderstanding the campaign of leprosy elimination, the imbalance between the social and economical benefit in the leprosy control, the lack of leprosy knowledge in the public and the deviations of the knowledge and ideology of leprosy workers. The authors suggested intensifying governments commitment and participation widely popularizing the leprosy health education, tightening up the organizations management and the construction of leprosy control contingents, and launching leprosy science research as well as implementing the strategy of science and education prosper leprosy work. It is appropriate measures to ensure the prosperity of leprosy control work in the future.

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PROCESS OF LEPROSY ELIMINATION IN AN ENDEMIC COUNTY

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Mengla situated in the southern tip of Yunnan Province, protruding into Laos, is a highly mountainous county, covering 7,093 sq. km with 195,000 population (1999). Mengla consists of 13 townships with 23 different ethnic groups, the majority being of Dai ethnic origin, leprosy control began in 1980, one year following the selection of the 3 leprosy settlements for therapeutic study of FDMDT. During the period from 1980 till 1999 the case detection rate decreased from 52.5/10,000 to 1.0/10,000 and prevalence from

5.3/10,000 to 0.2/10,000. During the last 5 years, there is a continued decrease in detection and prevalence rates, P/D ratio = 2.0, 0% child rate and 100% voluntary reporting, but due to the few number of patients detected annually (mean 5.5, range 1-2), the MB and deformity rates fluctuate between 0 to 100%. During LEC campaigns, carried out in the two most endemic townships with 98.3% school children, 92% contact and

5.5% endemic village surveys did not detect any leprosy, inclusive 42 suspected single lesion leprosy. Although the above data meets the elimination criteria of WHO, further strenuous case detection activities inclusive continued health education to the public and training of primary health workers are required for the next 5 to 10 years.

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ANALYSIS OF NEWLY DETECTED LEPROSY CASES IN CHINA (1990-1998)

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The results of case-finding and the clinical characteristics of newly detected leprosy cases in China 1990-1998 are analyzed. All of the data came from the database of National System of Leprosy Surveillance, National Center for STD and Leprosy Control. The data were collected by local leprosy doctors and then sent to the Center for analysis. A total of 19453 new leprosy cases were detected during 1990-1998 with an average detection rate of 0.17/100000 (0.16-0.29/100000). In recent 5 years, the detection rate has been fluctuating within 0.14-0.16/100000.

However, there were 271 counties that had a detection rate of 0.5-2.2/100000 in China in 1998. The number of newly detected leprosy cases in Yunnan, Guizhou and Sichuan Provinces accounted for 53% of the total number of new cases in China. In this study, about

70.8% of all new cases had a definite history of contact with active leprosy cases. About 95% of all cases were detected by the skin clinics, self-report, clue survey and contacts surveillance. The number of cases with skin smear positive and BI>4.0 accounted for 62.9% and 11.4% in all new cases, respectively and about 11.1% of cases has only got a single skin lesion and 24% of cases has got disability of Grade II. Although the detection rate of leprosy in China has declined during 1990-1998, the leprosy problems in some areas should not be neglected. It is advisable to do case-finding actively combined with passive methods, so that leprosy cases can be early detected and treated and the disabilities can be reduced.

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A NOVEL APPROACH TO ABSENTEE RECALL IN CENTRAL REGION OF NEPAL

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Leprosy services are provided in an integrated manner in Nepal. Health workers receive minimal training and supervision. Often they encounter difficulty with the diagnosis of leprosy, and in convincing patients to complete a course of Multi-drug Therapy (MDT). The public's lack of confidence in local staff, may contribute to this absenteeism.

In three districts, in Nepal, with high prevalence rate and high defaulter rate, leprosy orientation was given to Village Health Workers and Community Health Volunteers, with emphasis on the importance of MDT completion. Immediately after the orientation course, these trainees visited absentees requesting them to re-attend their local clinic where they were re-examined by specialist leprosy staff, who could confirm the diagnosis of leprosy, offer any needed disability care, and counsel the patients. Supporting the local staff in this way resulted in a high number of absentees resuming treatment, and deduction from the register of misdiagnosed cases.

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EARLY EVIDENCE FOR FALL IN DISEASE TRANSMISSION IN LEPROSY

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Though it is difficult to imagine that the treatment of all cases of leprosy should reduce disease transmission, it is conceivable that good leprosy treatment programme along with extensive BCG coverage and improvement in socio-economic status may bring down disease transmission.

We examined data on new case detection for the past 15 years from an area where the leprosy control work has been consistently good. Sustained antileprosy work is expected to have an effect on annual new case detection rate, mean age at onset and proportion of MB among newly detected cases. Similarly, BCG vaccination and true reduction in disease transmission are expected to produce certain time trends in the above parameter. We examined the observed time trends in the context of the above theoretical constructs. There appears to be early evidence of true reduction in the rate of disease transmission in the study area.

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Co 25**WHAT DO FIELD WORKERS FEEL ABOUT LEPROSY PROGRAMMES?**

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Since the introduction of MDT in NLEP, Government guidelines have been issued time to time with the specific approach of reaching the national goal of Elimination of Leprosy within stipulated time period. Though the experts at higher level formulate policies for this, the success of programme is always in the hands of those who implement it, i.e. Field Workers.

In view of this, an attempt has been made to collect the views of Field Workers about the strategies presently used and their impact on reaching the elimination goal. A simple questionnaire consisting of five questions was distributed to 116 Field Workers who participated in the Regional Conferences of field workers, organized by H.K.N.S., Mah. Branch at Miraj and Panvel in March 2000.

Of 116 participants, 91(78%) responded voluntarily. The analysis of responses revealed that over 95% field workers were well aware about the statistical information about their district.

Majority of the Field Workers expressed that - i) it is possible to Eliminate Leprosy in their district (66%),

ii) single dose ROM is adequate for SSL patients (78%) and

iii) MDT for 12 months is enough even for Smear +ve MB cases (71%).

Further analysis of the responses and the views about their utility during post-elimination period will be presented and discussed.

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Co 119**ROLE OF MEDICAL COLLEGE, GWALIOR IN LEPROSY ELIMINATION**

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Gwalior

MDT programme in Gwalior district was started in a phased manner. It was implemented in one block from July 1992 and gradually by September 1993 the whole district was covered. Medical College Gwalior contributed in the following forms - Adopting area for MDT services - 19 wards and about 3 lacs population of urban area has been adopted for MDT services. One

NMS has been posted for case detection and drug distribution at 5 DDPs. Since last seven years, 377 new cases were registered, all cases were put on MDT and 185 cases were released from treatment.

Referral services - Leprosy patients are referred for confirmation of diagnosis and management of complications. These cases are seen in the department of skin VD.

Deputation of medical college staff to attend training in leprosy at SLTRI Karigiri. One Assistant Professor of PSM was deputed to attend training. Special studies (Health System Research) are conducted by department of Community Medicine (PSM) to analyze and solve the priority problems in leprosy elimination. Two studies have been completed and third one is being planned. Participation in National Campaigns - G.R. Medical College Gwalior participated in planning and conducting MLEC-1, MLEC- 2 and Polio Campaign (PPI).

Medical College provides trainers, lecture halls and AV aids for training the Medical Officers, Health Workers and Community Volunteers as and when required. Participation in planning, implementation and monitoring of MDT programme mainly urban area - The Dean/HOD - PSM are often invited by District Collector to participate in discussion regarding planning new, activities and progress.

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Co 130**LEPROSY CONTROL AND ELIMINATION IN DELHI, INDIA**

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Delhi is the capital city of India. Migration of population into the city for job opportunities is known to be a problem. Majority of them are from leprosy endemic states of Bihar and Uttar Pradesh. There are numerous settlements of people belonging to lower socio-economic group. Infrastructure for National Leprosy Eradication Programme (NLEP) has been inadequate. Southwest district of Delhi with a population of 1.8 million is covered by the Damien Foundation & Lepa combined urban leprosy project. This project has a manpower of Medical Officer (1), Non Medical Supervisor (2), Non Medical Assistants (6) and a driver with vehicle. Different strategies are employed for case detection. During the past one year, 800 new leprosy patients are registered for treatment. Treatment regularity is more than 95%. Details of procedures for case de-

tection, treatment delivery and follow up will be presented.

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IMPACT OF INDUSTRIALISATION ON PROSPECTS OF LEPROSY ELIMINATION IN RURURBAN SECTORS

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District Raigad situated on western coast of Maharashtra (INDIA), is first among highly prevalent districts in the state for leprosy. It has observed 82% fall in Prevalence Rate (PR) in post MDT of 10 years. PRs in its Northern Blocks are much higher (8.71-12.6/10,000) than that of the District (7.71/10,000). These blocks, besides being adjacent to the Metrocity-Mumbai, are also identified as fast growing Industrial Zones. Hence, the retrospective study was undertaken to assess the effect of industrialization on Leprosy Elimination Programme in this region.

In this contest, the paper presents the data of Jaskhar SET Centre, of Uran Block which harbors major international business port JNPT and other major industries. The SET has noticed very slow fall in PR (63%) against a steep rise in New Case Detection Rate (NCDR) (106%), in last ten years. It is observed that the proportion of migrants among new cases is over one third in last five years, highest being 41% in 1999-2000. 56% of the cases detected in MLEC 1999-2000 in Voluntary Reporting Centers are migrants. MB patients constitute 35% among migrants (all being male & 89% adult) against 23% in denizens of the centre. 79% of migrant leprosy patients are labourers while 69% are staying temporarily. Regularity for treatment in this group is unexpectedly satisfactory. Other relative analysis is presented in the paper.

The authors discuss the prospects of leprosy elimination in rural areas, highly prone to industrialization and urbanization. However, authors, prima facie, conclude that the progress of leprosy elimination in the SET centre is brought to standstill because of industrialization of the region. They also caution that unless appropriate measures are not worked out, prospects of leprosy elimination in rururban sectors will be always under great threat.

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A DISCUSSION ON ADMINISTRATIVE INTERVENTION FOR 'LEPROSY 3 EARLYNESS ON CASE FINDING, DIAGNOSIS AND TREATMENT'

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In Jiangsu Province, the goal of basic elimination on leprosy has been realized and it is also passed the assessment by China Ministry of Health. However, from then on, some new problems have been emerging. For the new situation, the governments and communities at each levels should pay more attention to the new challenge. It is most important that professional organizations need to set up a new goal for leprosy control to consolidate the achievements achieved in the past. At present, leprosy control should be focused on three measures, which are early detection, early diagnosis & early treatment, to maximumly detect the new cases hidden by Campaign of Leprosy Elimination. So, we need to give more efforts to shorten 4 durations for leprosy control in future, namely the duration from patients having sense of suffering leprosy by themselves to them seeing doctor, the time from patients seeing doctor to doctor giving initial diagnosis, the duration from the patients being doubted for leprosy to them being diagnosed or removed as well as the time from patients being diagnosed to being given MDT.

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HOW TO LAUNCH LEPROSY CONTROL WORK IN THE HILLY AREAS

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Our county is located in the hilly area and leprosy is in a low endemic status. The local economy is not good to be compared with other counties located in plain areas. With the establishment of market economy in China, our institute insists on investing profit of 5-10% which from the income of skin disease and venereal clinics in leprosy work, allocating key members of health workers to carry out once or twice clue survey in the key townships annually, working out a policy of material reward for case report and training personnel in leprosy knowledge. In addition, we also utilize economic and non-economic means to divide the control tasks at county, town and village three levels and the tasks were incharged of by themselves. Through these comprehensive measures, the leprosy endemicity was effectively controlled and leprosy work has been stepped into a normal operation

track. All these efforts result in no new case to be detected in the past 10 years.

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THE ISSUE OF EARLY DISCOVERY OF LEPROSY IN SHANGHAI - ANALYSIS OF 47 PATIENTS DIAGNOSED IN THE 1990s

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By 1990, Shanghai had basically eliminated leprosy. However, 47 outpatients, 8 of whom were Shanghai natives and 39 of whom came from other parts of China, were found suffering from this disease from 1990 to 1999.

Among the 47 new cases, 29 (61.7%) were classes as multibacillary (MB), and 18 (38.3%) as paucibacillary (PB); the ratio of the two types was 1.6 to 1. The patients went to doctor 14 months after getting ill. Unfortunately, they received an accurate diagnosis 24 months later. These was an average delay of two years.

87.2% of them had had consultation with doctors at various hospitals before being diagnosed as having leprosy; some even did so several times. This showed that with the raising of cultural level, the improving of living conditions and the implementing of health education, people got used to seeking medical advice when they had a disease, and that the complete survey conducted at epidemic-stricken spots and due investigation were no longer critical methods of discovering patients.

The misdiagnosis rate of 85% indicated that it was important for doctors at all levels to remain vigilant against leprosy and to improve their diagnostic skills. In fact, it was not difficult to diagnose most of the cases, as 34 patients (72.3%) were found bacterium-positive. The diagnosis of MB leprosy, viewed as the source of infection, can usually be determined through looking for the bacterium. So, keeping alert to possible leprosy cases was even more crucial than the diagnostic level itself.

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FACTORS THAT CONTRIBUTED TO THE ACHIEVEMENT OF THE LEPROSY ELIMINATION GOAL IN BANGLADESH

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BANGLADESH has achieved the leprosy elimination goal as of December 1998, well ahead of the target date of December 2000. Thus, it does not figure in the list of Top Endemic countries published by World Health Organisation(WHO).

The success of Bangladesh in attaining the leprosy elimination goal can be ascribed to five (5) factors :

1. Integration of Leprosy Services into the General Health Services.
2. Model partnership with leprosy NGOs.
3. Collaboration with key groups like media, religious leaders, scouts and local community leaders.
4. Effective implementation of some focussed activities, such as Leprosy Elimination Campaigns (LECs).
5. Prevention of the factors of over-diagnosis & re-cycling of cases.

The paper will provide details pertaining to each of the five factors and their impact/contribution towards attaining the leprosy elimination goal.

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LEPROSY STATUS AND TRENDS IN THE WHO WESTERN PACIFIC REGION, 1999 AND A FRAMEWORK FOR COST EFFECTIVE POST ELIMINATION SURVEILLANCE SYSTEM

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As at the end of 1999, leprosy has been eliminated as a public health problem in 31 of 37 countries/ areas of the region, representing 99.7% of the population of WHO, Western Pacific Region.

There were 14,243 registered cases at the end of 1999 compared to 19,800 at the end of 1998. The prevalence rate decreased from 0.12 per 10,000 in 1998 to 0.09 in 1999, a decrease of 25%.

There were 9,495 new cases reported in 1999, with a new case detection rate of 0.57 per 100,000 population compared to 10,648 reported in 1998, with a detection rate of 0.64, a reduction of 11%.

The prevalence rate has declined continuously and

consistently since 1988 by 94% whereas the new case detection rate has remained stable with small variation between years. However, in 1998 there was a marked reduction of 23% compared to 1997 and a further decline of 11% was observed in 1999.

Efforts will be intensified in the few countries and areas that did not reach the elimination while targeting elimination at sub national level in large countries that already reached the elimination.

However, major challenge will be the design and implementation of a cost effective post elimination surveillance system, which may be based on the followings:

1. Establishing leprosy services in selected and designated referral centres, preferably dermatology services, to maintain expertise in diagnosis and case management;
2. Making leprosy a notifiable disease, integrated into the general disease surveillance and health information system;
3. Sustaining awareness on leprosy through yearly national campaigns to ensure community and general health workers participation in case finding and management;
4. Periodic evaluation.

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WHAT STRATEGY AGAINST LEPROSY?

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The tremendous impact of the elimination strategy (i.e. 10 million patients having been cured in one decade) fully justifies the existing strategy. Since we still lack a primary prevention tool however, it is fully justified to extend the elimination plan up to 2005.

In implementing the elimination strategy, technical problems are few and relatively easy to solve. But operational difficulties are many and tend to be more and more serious when elimination activities move to areas not yet covered, which is now generally the case. Of special importance are the problems related to adequate MDT coverage, integration of services, information and motivation of all groups concerned. WHO has developed various activities to help in solving these operational problems and is undertaking operational research projects that address other specific difficulties. Problems can be expected in relation to the decrease of political will of national authorities when the number of remaining patients has decreased sharply, or even in relation to humanitarian disasters. It could also be that, at global level, cooperation requires

strengthening between the various partners of the recently launched Global Alliance for Elimination of Leprosy.

On the whole, the impact of the elimination programme has been impressive so far, but the ongoing problems are tremendous. Even if the elimination target could be reached at national level in all endemic countries by 2005, there is serious doubt about the possibility of reaching elimination at sub-national level in several countries.

For these reasons there is an urgent need to stimulate vigorously both basic and applied research on leprosy. Subjects of prime importance are M.leprae infection and disease transmission, and the development of reliable test(s) for subclinical infection and incubation period. The sequencing of the M.leprae genome, now complete, opens promising avenues in many disciplines. The scientific community appears to be ready for this new beginning of leprosy research, but coordination of efforts requires streamlining to achieve maximum results without further delay.

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ANALYSIS OF PERSONAL HYGIENIC HABITS OF MULTIBACILLARY HANSEN'S CASES WITH RELATION TO DEVELOPMENT OF NEW CASES IN COMMUNITY

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The disease is known since time immemorial to mankind. The disease and its consequences of visible deformity contributes for social stigma, which further leads to discrimination, disintegration of patients and families from society. The disease also affects directly or indirectly the productivity and economic growth.

The early detection, and case holding for prompt treatment is of paramount importance to uphold the Leprosy Elimination strategy. It is also observed that the operational researches and technical with academic researches on socio-cultural and habitat of community vis a vis suffering patients, so that the necessary precautionary measures can be taken and modalities can evolve for effective health education.

In the state of Maharashtra, the District Chandrapur was having high prevalence 139/10000 (1987) and now also 8.1/10000 (1999) compared to other Districts. The NCDR is also highest (10.6/10000) in state: which attracts the attention to analyse: the disease activity, its transmission and spread in community and its attributable factors.