

Results: A number of samples were found to have the rifampicin resistant genotype in the PCR assay. We will present data on all of these *M. leprae* strains genotyped for rifampicin resistance and tested at full (10mg/kg) and half (5mg/kg) doses in mouse footpad cultures.

Conclusions: While the rapidity of PCR based methods is a major advantage over MFP, the validation of genotype methods of detecting drug resistance in leprosy is critical for their wider use in monitoring this important problem.

OM&BM 30

VIABILITY OF *M. leprae* IN LEPROMATOUS PATIENTS AFTER COMPLETION OF 12 MONTHS OF MULTI-DRUG THERAPY.

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The Seventh WHO expert committee had recommended shortening the duration of multi-drug therapy (MDT) to 12 months from 24 months for multi-bacillary (MB) patients. We carried out a study to determine whether viable bacilli can persist in the body of treated MB patients after 12 months of MDT. 34 untreated lepromatous patients who had an

initial average bacterial index (BI) of 3+ or more were enrolled in the study. At the end of 12 months of MDT, skin biopsies were obtained from a site, which displayed the maximum number of bacilli on skin smear examination. An *M. leprae* concentrate was prepared from each of the biopsies and inoculated into the footpads of five thymectomized and irradiated (T900r) mice. The preparation of inoculum, method of inoculation, harvesting and counting of *M. leprae* from the footpad tissue was done using the method described by Rees. Harvesting was done at 6th, 9th and 12th month. Skin histopathological examination was also done on 32 patients on completion of 12 doses of MDT. In nine (26%) out the 34 biopsies *M. leprae* continue to exist in the footpads of T900r mice. These nine patients had an initial average BI of 4+ or more at the time of starting MDT. Histopathologically, resolving granulomatous lesions were found only in eleven (34%) of the 32 skin biopsies at 12 months. Skin smears at the completion of 12 months of MDT showed a fall of one log BI or more in only 18 (56%) patients. This study demonstrates that at the completion of 12 doses of MDT, a considerable proportion of MB patients with initially high average BI, harbor bacilli. It is possible that these are dead bacilli, not yet absorbed by the tissue. Long-term follow up of these patients will reveal whether these bacilli are alive or not. It may be necessary to maintain these mice for longer periods to study the behavior of persisting bacilli.

OPERATIONAL ASPECTS OF ELIMINATION

OOA 1

ACTIVITIES OF THE TASK FORCE IN THE ACCELERATION OF THE ELIMINATION OF LEPROSY IN BRAZIL

Vera Andrade – WHO

Tadiana Maria Alves Moreira – Secretary of Health of Rio de Janeiro State

Gerson Fernando Mendes Pereira – Ministry of Health

Marcos Virmond - Institute Lauro de Souza Lima

Gil Soares - PAHO

Artur Custódio de Souza – Movement for the reintegration of leprosy affected persons (MORHAN)

The strategy to encourage municipal health secretaries to be committed to the elimination of leprosy, by increasing coverage of MDT services, is a conjoint initiative of the National Council of Municipal Health Secretaries (CONASEMS) and WHO with support from the Technical Area of Sanitary Dermatology of

the Ministry of Health, MORAHN and PAHO. To establish such strategy CONASEMS has created in 1998 the Task Force for Accelerating the Elimination of Leprosy (GT/HANSEN/ CONASEMS), which aim is to identify practical solutions at the local level within the available structure and resources of the basic health system. At the methodological level it is stressed the need to strengthen the participation of various social and institutional partners, involving mainly the municipal managers and the community. At the political level, after including the issue of elimination in the agenda of local managers, it was created adequate condition to increase the coverage for diagnosis and treatment of leprosy with the additional outcome of a political profit to the local manager due to the success of eliminating leprosy from his municipality. In august 2001 the project has covered 52% of the municipalities through the country (2898 municipalities in 14 states), out of them 38% are priority municipalities for the MoH, mainly in the north and northeast region. In Tocantins, Piauí and Rio de Janeiro the process of decentralization is in its stage of consolidation. To support the decon-

centration of diagnose and treatment the following material has been distributed: 25,000 booklets, 25,000 posters on signs and symptoms, 2 million leaflets on signs and symptoms in simple language to the community, leaders of the Children's Pastoral from 3379 municipalities and their families and educational videos for 5600 dioceses. It was sent to all municipal managers (5559), through CONASEMS, technical information, a video with two vignettes and the film produced by the Global Alliance (WHO). Nowadays, it is difficult to identify in Brazil a municipal health secretary that is not aware of the strategy for elimination of leprosy. No doubt, this strategy, by its content and quality, represents an innovative and effective contribution towards elimination of leprosy and, in addition, citizenship.

Financial support was provided by the Brazilian Ministry of Health, CONASEMS, WHO and Novartis Foundation for Sustainable Development.

OOA 2

ANALYSIS ON THE DETECTION OF NEW LEPROSY CASES BEFORE, DURING AND AFTER THE YEAR OF LEPROSY ELIMINATION CAMPAIGNS

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In order to analyze the impact on the situation of case finding after Leprosy Elimination Campaigns, the data of newly detected leprosy cases in the leprosy high endemic area have been collected before, during and after the year of carrying out Leprosy Elimination Campaigns. The result showed that the number of new leprosy cases detected during the year of leprosy elimination campaigns was significantly high. The number of newly detected cases after the year of Leprosy Elimination Campaigns was similar to that of detected before the year of carrying out Leprosy Elimination Campaigns in counties with persisting case finding activities. But the number of newly detected cases after the year of Leprosy Elimination Campaigns significantly decreased in counties without active case finding activities. The average distance from the house of leprosy cases detected during Leprosy Elimination Campaigns to the leprosy control unit at the count town is 62.8 kilometer which is farther more than that of other leprosy cases detected before and after the year of Leprosy Elimination Campaigns. The average disease delay-time of leprosy cases detected after the year of LEC shortened. The results also showed that carrying out Leprosy Elimination Campaigns will have no the significant impact on the trend of cases finding within a short time in local areas. But it may improve some indicators of leprosy patients and so promote the leprosy control in local areas.

OOA 3

AS AÇÕES DO PROGRAMA DE ELIMINAÇÃO DA HANSENÍASE NO MUNICÍPIO DE FERNANDÓPOLIS - ESTADO DE SÃO PAULO/ BR.

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O município de Fernandópolis situado a noroeste do estado de São Paulo, a 553 Km da capital do estado, constitui-se em um pólo regional com 60.521 habitantes. Configura-se como referência na área da saúde para uma micro-região de treze municípios. Adotou dentro do processo de municipalização da saúde a Gestão Plena de Atenção Básica Ampliada. Como problema de Saúde Pública destaca-se a endemia hanseníase, objeto de vários estudos. O objetivo desse estudo é descrever como ele está se organizando para cumprir as metas de eliminação dessa endemia que até 2001 estavam sob responsabilidade do estado. Mantém altos coeficientes de prevalência a mais de trinta anos, sendo considerado atualmente hiperendêmico com 10,25 casos/ 10 mil habitantes. Apesar de possuir onze unidades básicas de saúde concentra as ações de tratamento e seguimento dos doentes e contatos em uma unidade de saúde específica para o atendimento de doenças infecto-contagiosas e parasitárias, ficando sob responsabilidade das demais portas de entradas do SUS a suspeição diagnóstica. Assim, acreditamos que a centralização de algumas ações poderá melhorar alguns indicadores operacionais. No entanto, os grandes desafios permanecem: o diagnóstico precoce; a descentralização e ou desconcentração das ações para todas as Unidades de saúde e atingir a meta da eliminação até 2005

OOA 4

BRIDGING EFFECTS OF INTEGRATION: COULD INTEGRATION OF LEPROSY HAVE UNINTENDED IMPACTS?

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In many former colonial countries there still exists a sharp demarcation between preventive and curative sectors of healthcare. The bureaucracies in most health services are divided along these lines with little or no interaction between them. One of the reasons for the continuation of this division seems to be that the two sides have evolved to be relatively independent of each other in carrying out their routine

duties. However, with the introduction of new health policies such as the integration of leprosy services, new perspectives are unfolding which provide practical guidance to bring the curative and preventive sectors closer.

This paper discusses the influence of integration on the general health system of Sri Lanka based on empirical evidence. It could serve as an eye opener for individuals trying to bring together existing health services to facilitate the provision of better and more cost effective healthcare.

OOA 5

CHARACTERISTICS AND TREATMENT OUTCOME IN LEPROSY PATIENTS DIAGNOSED DURING ACTIVE AND PASSIVE CASE-FINDING ACTIVITIES

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Objective: To assess whether the case-finding method is a determinant for diagnostic characteristics and treatment outcome of newly diagnosed leprosy patients in northern Mozambique.

Methodology: A retrospective cohort study about the differences between entrance characteristics and treatment outcome in self-reporting patients and active case-finding during a Leprosy Elimination Campaign in 1999 in northern Mozambique.

Results: As a consequence of LEC activities three times more patients were found compared to a comparable period one year earlier. More young (<15 years) PB cases were diagnosed during LEC activities with – surprisingly – equal percentage of disability grades. No gender imbalance was found in diagnosed LEC patients contrary to self-reporting patient groups.

Comparing active case finding in 1999 with the passive group of 1998 and 1999 showed a slight but statistically significant better treatment result for the passive group. The classification of leprosy (in favour of PB) and age (in favour of older age groups) were also determinants for favourable treatment outcomes.

Finally, the type of health worker proved a major determinant of a favourable treatment outcome. Limited trained volunteers had a significant better result of treatment compared to trained nurses.

Conclusions: LEC proved to be a useful addition to the national Leprosy and Tuberculosis program in Northern Mozambique. As a result, many new cases were diagnosed and put on treatment, and their treatment results were comparable to those of self-reporting patients.

The type of health worker appeared to be a major determinant of a favourable treatment outcome. Lim-

ited trained volunteers have a significant better result of treatment compared to trained nurses, regardless of detection method.

OOA 6

COMMUNITY INVOLVEMENT FOR LEPROSY ELIMINATION

P.R. Manglani; B.L. Sharma; S. Postma

Delay in achieving elimination in an area enables the programme managers to analyse the factors responsible. The reasons elicited were enlisted. They are; lack of Community involvement and support, stigma attached to the disease and passive role of service recipients.

The process of community involvement was given higher priority through service based action programs like; Care & concern Camps, Skin Disease Diagnosis Treatment & Education Camps, Dastak i.e. knocking the doors to knockout leprosy, introduction of festivity in Leprosy Elimination etc. This has led to creation of concern, demystification and destigmatisation of disease and openness for early diagnosis and treatment. This has also helped for Zeroing distances between the patients, people around and providers.

OOA 7

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 na-

tional and international non-government organizations the prevalence of leprosy was brought down from 0.70 per 10,000 populations in 1992 to 0.32 per 10,000 population in 1999

OOA 8

DEVELOP PARTNERSHIP, STRENGTHEN INTEGRATION, TRANSFER SKILLS AND OWNERSHIP TO HASTEN ELIMINATION

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The presentation evolves around Tamilnadu's success story. The PR was 118 / 10000 in 1983 when MDT was introduced, which was drastically reduced to just 31 / 10000 in 1991 when total coverage was reached. In October 2001 the PR was 3.7, indicating elimination a definite possibility.

Since maintaining a vertical structure with declining PR was not cost effective the programme was integrated with the Primary Health Care system in 1997.

Massive capacity building measures were undertaken to ensure that the PHC system provides better MDT services. This means, to suspect and refer cases for confirmation, treat, manage complications and refer, maintain simple information and reporting system and counseling to patient, family and community.

Integration has not reduced detection of new cases by routine methods. Instead, voluntary reporting has increased due to easy accessibility. The availability of the Female Health Worker has helped women in terms of coverage and accessibility to services.

In essence, integration ensures full participation of the PHC services in Leprosy Elimination. The deficiencies are addressed by regular capacity building measures to upgrade skills and equip the PHC system to accept responsibility and ownership of the programme to hasten Elimination.

The presentation records with appreciation the sacrifices made by all those involved in the Programme beginning with the Missionaries, various Partners and the Community. It is their contribution that has helped in greatly reducing the disease burden and the stigma attached with it.

We shall move forward in building a World without Leprosy with all our Partners

OOA 9

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

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House to house leprosy case detection is very expensive and time consuming if we depend only on regular trained Para Medical staff. Given the fact that sufficient number of trained paramedical personnel 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. 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.

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 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 (14/10,000) has been detected with less expenditure and in a short duration by utilizing the services of adequately trained volunteers in difficult areas too.

OOA 10

FIRST STEP TOWARDS INTEGRATION: DEVELOPING A BLUEPRINT

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Planning and implementing the structural changes to integrate leprosy in the general health services is a challenging task as established procedures, responsibilities and relationships, both institutional and personal have to be altered. A blueprint which clearly articulates the vision of how the integrated system should function is critical to guide the implementation process. In Sri Lanka the blueprint was drawn up in a highly participative manner involving intensive discussions with various categories of health care staff both at peripheral and central levels over a three month period.

The blue print clearly outlines the new procedures, roles and responsibilities as well as monitoring mechanisms based on a careful understanding of the func-

tioning of the general health services, likely problem areas and pragmatic ways to deal with them. Various technical details had to be worked out including, a distribution system for MDT, simplifying records and the reporting system, monitoring procedures at the local level, and role definitions for the most important partners involved. This process culminated in a goal oriented project planning workshop at which the detailed plan for the integration process was developed, which was then presented to the National Steering Committee and WHO for approval.

This paper describes the process adopted, the components of the blueprint, proposals for action and how it was used as a springboard for action. The blueprint also serves as a source of institutional memory and a shared reference document for the different players to be involved in the process

OOA 11

FOCAL SURVEY FOR INTENSIFIED CASE DETECTION – A COMPARATIVE STUDY CONDUCTED AT ENDEMIC AND NON ENDEMIC STATES IN INDIA

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This is an intensive case detection activity implemented in selected pockets of certain endemic and non-endemic states in India, where the case detection is low due to various reasons. The survey team consist of 20 Paramedical workers (PMW's), 2 Non Medical Supervisors (NMS) and a Medical Doctor. 10 PMW's, 1 NMS and the Doctor are from out side the state. The duration of survey is one week, covering a population of 7000 – 10000. In most of the places the focal survey team could detect 2-3 fold more new cases than the normal case finding activity. It was also observed that, whether it is an endemic or non-endemic state the case detection was almost same. The results of this survey helped the management to decide the future strategy of leprosy work in the area. It was also reported that after the focal survey there was an increase in new case detection in the respective places

OOA 12

IMPLEMENTATION OF MODIFIED LECS WITH INTEGRATED APPROACH IN THE STATE OF ORISSA- INDIA HELPED IN REDUCTION OF NCDR

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Orissa is one of the constituent states situated along the east coast of India with a population of 36.7 million. Leprosy was highly endemic in the State with PR 121/ 10000 in 1983. In 1998 though PR had come down to 9.6/10000 but NCDR with 21.7/10000 was posing main hindrance in leprosy elimination within targeted period. Successive 3 rounds of Modified LECS in the State with regular intervals have helped in bringing down NCDR to 7.8 and now goal of elimination looks real possibility in next 3 years. MLECs are well planned, short time, intensive, integrated community approach for detection of all undetected cases of leprosy in a community where disease is highly prevalent and dealt by vertical infrastructure. MLEC-I was implemented in Orissa in 1998 resulted in detection of 62844 cases in 28961085 populations with NCDR 21.7. MLEC-II was implemented in 2000, resulted in detection of 27197 cases in 27715988 popl. With NCDR 9.8. MLEC-III was implemented in 2001 with detection of 12326 cases in 15802564 popl. with NCDR 7.8/ 10000. Fall in detection rate in 3 and 1/2 years was 64%. This fall would have not been achieved even in another 10 years of MDT implementation with routine manner through vertical infrastructure. 3 rounds of MLEC in Orissa not only helped in detection of large number of undetected cases within shortest possible time but also helped integration of leprosy control activity with General Health care System and at village level with integrated child and women development scheme, in reduction of average duration of case presentation from more than 2 years to only 6 months, improvement in drug compliance from 78% to 99.6% and voluntary reporting of cases from 50% to 79.6% and have created new hope for elimination of leprosy in a highly endemic State of Orissa.

OOA 13

INTEGRATING LEPROSY CONTROL INTO GENERAL HEALTH SERVICE IN A WAR SITUATION: THE LEVEL AFTER FIVE YEARS IN EASTERN CONGO

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Although plagued by insecurity and inaccessibility due to two consecutive wars, South Kivu Provincial Leprosy Control Programme, DR Congo since 1995 started a process to integrate leprosy into general health facilities. General health workers (GHW) were trained, and a network of district TB/Leprosy supervisors provided, as regularly as possible, drugs, logistics and supervision to general facilities having patients. A questionnaire survey of 9 of the 14 dis-

districts in the province assessed the level of integration after 5 years. Structural integration was assessed by the proportion of health facilities with MDT and functional integration, by the proportion of health facilities where general health workers (GHW) are involved in leprosy activities. 37.5% of facilities had MDT and 73% had a trained nurse. GHW were involved in screening in 59% of facilities but diagnosed in only 36%. For drug dispensing and POD, they were involved in 78% and 26% respectively. Their degree of involvement put health facilities into four grades of functional integration: 1. Fully functional, fully integrated: tasks performed entirely by GHW, 2. Semi-functional: jointly performed with supervisors, 3. Semi-integrated (structured but not functional): leprosy supervisors did these activities alone, and 4. Non-integrated: nobody performed these activities. 80% of facilities had some degree of integration. 70% of the facilities were fully integrated in dispensing MDT and keeping records; 31% were semi-functional and 49% semi-integrated in diagnosis of leprosy.

The leprosy prevalence at the districts directly correlated with the levels of structural integration, dispensing MDT and case finding. The presence of a trained nurse significantly related to performance of case finding and records keeping, but it was irrelevant to suspecting leprosy, dispensing MDT or doing POD. Structural integration is thus low in South Kivu and the gap between % of facilities with MDT and % with a trained nurse suggests a delay in actually integrating leprosy after training. This could be a direct result of movements of trained nurses because of the war. Functional integration is higher in MDT activities and low in case finding and POD, where obviously more skills are required.

OOA 14

INTEGRATION OF LEPROSY SERVICES AND THE CONCERNS ABOUT QUALITY OF CARE. THE EXPERIENCE OF JIGAWA STATE OF NIGERIA.

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Since the inception of the Nigerian National Tuberculosis and Leprosy Control Programme (NTBLCP), integration into the Primary Health Care system (PHC) has been a major objective. Jigawa State, located in northern Nigeria, is currently one of the most leprosy endemic states in the country and in the fore front of the integration initiative. During a Leprosy Elimination Campaign (LEC) organised by Jigawa in 1999, 304 PHC workers from various health units, and 368 volunteers were trained in basic leprosy, all of whom participated in case finding and initiating MDT treatment. Consequently there was rapid expansion of MDT services from 75 clinics

prior to the LEC to 264 in 2000. Since then, leprosy patients are managed by the PHC workers, while specialised staff provides technical advice.

In order to assess the impact of the integration on the quality of leprosy services in Jigawa State, treatment records of 159 selected leprosy patients in Jigawa State were studied. 76 of these patients were detected and treated by the vertical staff between 1997 to 1998 (pre-integration), while 83 were detected and managed within the period 1999 onwards (post-integration).

The study found that quality of care for leprosy patients including assessment at diagnosis, monthly follow up, disability prevention and management and treatment results were not significantly affected by the integration of the MDT services. It is therefore concluded leprosy care is not necessarily jeopardised by integrating into the GHS, instead could improve the accessibility of MDT services.

Details of findings to be discussed.

OOA 15

INTEGRATION OF LEPROSY WORK – AN EXPERIMENTATION

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It was expected that the leprosy services would be integrated with the general health services in the area with reduced prevalence rate. The introduction of MDT has resulted in a sharp decline in prevalence rate by over 90% with a drastic reduction of visible deformities among new cases. Districts where MDT has been implemented for 15 years have the NCDR of 20/10,000 on an average. In a 5000-population area, the estimated active caseload will be 10 and this load is expected to be managed by a general health worker. Accordingly a 10-years retrospective study was conducted in an experimental zone of the Balarampur control unit of Gandhi Memorial Leprosy foundation in Purulia district of west Bengal. Total 41 General Health workers were involved in the programme from 1988 to 1997. It was observed that the contribution of the general health workers was substantial in relation to case-detection, patient persuasion, and inclusion of leprosy in health-talks and handling adverse situations. Total 440 persons were referred, 373 diagnosed as leprosy cases, 1029 patients were persuaded for regular drug intake and leprosy was discussed in 1204 health talks. Six social problems were handled. It was observed to be cost effective with better utilization of logistics and human resources. The integration processes should be supported with adequate training and supervision and monitoring system at least for next five years till the GHWs develop their own expertise. They should also gradually be exposed to and entrusted with the

processes of rehabilitation and POD activities, which is utmost necessity in leprosy field

OOA 16

IS LEPROSY ERADICATION PROGRAM FEASIBLE IN VIETNAM?

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Since leprosy is no longer a serious national health problem in Vietnam, the decreasing workload in terms of leprosy disease prevalence has pushed the stakeholders to find the ways to sustain leprosy works. The target set for eradicating leprosy is to cut the transmission of leprosy, and the provincial managers have to focus on areas where leprosy is endemic, or leprosy pools.

LEC is continued where leprosy prevalence is still high or previously known to have had many leprosy cases. Recruitment of ex-leprosy patients as volunteers among community members can be a good idea: Health education materials should be distributed to the community to create people's awareness on leprosy, break down the silence and stigma surrounding leprosy and promote early reporting of leprosy patients. The use of community volunteers and ex-leprosy patients as health educators is considered. Education for school children is seen as the most effective approach to broadcast messages on leprosy to the people. A kind of quizgame called democratic picking flowers has been initiated and proved that it is very promising.

Besides the traditional training, the problem-based teaching and learning as well as field training are adopted. A new module of training called active education has been realized, setting a new style of training in Vietnam.

According to the WHO proposal, Vietnam begins to implement for a post-elimination surveillance system. A part of leprosy program is shifted to rehabilitation aspect, which is the rising concern of the people and local government for leprosyaffected-people. These efforts for improving the (ex-) leprosy patients lives should be mobilized nation-wide, to respond to the noble mission: working together for a world without leprosy.

OOA 17

LEPROSY ELIMINATION MONITORING (LEM) 2001, BANGLADESH

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Leprosy Elimination Monitoring Exercise was carried out in Bangladesh between 21 January 15 February 2001. To validate data on prevalence, detection, integration and quality of MDT Services. The sample covered 1202 cases, records collected from 60 MDT centers (10%) of 20 randomly selected districts. Data collection was done by qualified Medical officers, especially trained for this activity using WHO recommended schedules.

Exercise was guided supervised and lead by WHO nominated Monitor along with one independent national Monitor nominated by the national Govt.

The actual data collection in the field was carried out between 30 January - 08 February 2001. The data consolidation and report preparation was done between 09-14 February 2001.

Over 5 years reduction in prevalence is observed. However this fall is not associated with expected change in clinical profile of new cases. As majority of the cases were detected by voluntary Reporting (40%) with long duration of delay (average 20 months) and grade 2 disability (10%). This pattern confirms further the need for intensive BCC in population and reorientation of staff on identification/detection of early Leprosy.

The summary of the main findings and observations of LEM will be presented

OOA 18

NEPALESE LESSONS ON COMMUNITY AWARENESS AND CAPACITY BUILDING OF HEALTH SERVICE DELIVERY SYSTEM TOWARDS LEPROSY ELIMINATION

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Nepal, a tropical country in South Asia has a history of high prevalence of Leprosy since last 150 years. Nepal has adopted the WHO resolution to eliminate leprosy by 2005 from the world and by the end of 2003 from the country.

Leprosy elimination activities were escalated from 1996 onwards with intensive Leprosy Elimination Campaign (LEC) during 1999 and 2001. Nepal is actively engaged in Information Education and Communication methods and mediums. The country is building up the capacity of health service delivery system / basic level health care workers to provide

diagnostic and treatment services up to the Village Development Committee level, which is lowest. It is found that strong political commitment followed by an efficient programme support on intensive IEC component helps achieve this time bound vision.

This paper discusses the objectives, strategies, activities and major outcomes of elimination efforts. Paper includes secondary information (data) gathered from LCD/ DHS/MOH and presented with the help of simple statistical tools.

The study revealed the fact that prevalence rate has gone up significantly after planned LEC; such sustained campaign has been contributing to reach the un-reached population (hidden/undetected/cases of consequence) in the areas where the prevalence rate is more than 3/10, 000. The current trend shows that the MB proportion, child proportion and GII disability is declining considerably providing hopes of elimination within the stipulated time

OOA 19

PROBLEMS ASSOCIATED WITH INTEGRATION OF LEPROSY IN BIHAR STATE IN INDIA AND POSSIBLE SOLUTIONS

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Bihar is the second largest populated state in the country comprising 11% of the population of India. It is highly endemic for leprosy. It has the highest number of cases of leprosy in India and it accounts for 28% of caseload of the country. Since introduction of MDT in 1996 more than 800,000 cases have been treated and at present (Jan 2002) total of 105000 cases are registered for treatment with MDT. The phase II of NLEP has identified integration with General Health Care Services as one of the key strategies for easy accessibility of leprosy services for early detection and treatment. Integration in Bihar has been undertaken from July 2001. These are however a few problems being faced in applying integration in practice and therefore the emphasis is presently being given on functional integration down to Health Sub Center level. Integration of following aspects is being implemented viz. Provision of diagnosis facilities on all days at PHC, Addl. PHC and Government hospitals and drug delivery to patients. Some of the factors which contribute to the problem are deficiency of GH staff.(44%) and NLEP staff (56%) with a wastage of 3% every year, poverty, low literacy and low awareness level among the medial fraternity and community. The Government has taken various measures to tackle these problems. The details will be discussed.

OOA 20

PROJETO PRIORITÁRIO "TOLERÂNCIA ZERO: MATO GROSSO SEM HANSENÍASE"

Secretaria de Estado de Saúde de Mato Grosso

Mato Grosso é campeão brasileiro de prevalência em hanseníase com 20 casos por 10 mil habitantes. Por esta razão o Governo em parceria com a SES-MT, lançou o projeto "Tolerância Zero" que tem por objetivo a eliminação da doença como problema de saúde pública até o ano 2005. Atualmente são 2.913 casos notificados e 3.900 casos estimados. Como incentivo a detecção precoce a SES-MT proporciona um "bônus" para equipes e saúde da família e agentes comunitários. Para cada caso detectado, o agente irá receber R\$ 20 (vinte reais) e os integrantes da unidade de saúde R\$ 100 (cem reais) por paciente com alta por cura. Na primeira etapa que compreende 2001 a 2002, o projeto foi implantado em todos municípios do Estado, que foram divididos por ordem de prioridade em 4 categorias, tendo por parâmetro a prevalência e o número de habitantes. Cada município deve elaborar um plano de intervenção para implementar atividades em sua área de abrangência, considerando o perfil epidemiológico e operacional da região, identificando as áreas de maior risco da endemia para definição de ações a serem desencadeadas, compor equipe técnica com profissionais qualificados, desenvolver parcerias com demais entidades, ONGs e órgãos, além de criar agenda de treinamentos e acompanhamento da equipe. Os municípios que atingirem as metas estabelecidas receberão um incentivo de acordo com os níveis de prioridade que vão de R\$ 30 mil a R\$ 2 mil reais, visando a detecção de 95% dos casos estimados nos municípios e redução da prevalência de 30% ao ano. Este recurso deverá ser investido, pelos municípios, na implementação das atividades de promoção, prevenção e atenção básica de saúde.

OOA 21

REACHING NLEP SERVICES TO THE DISTANT POOR TRIBAL POPULATION IN CHHATTISGARH

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DANIDA assistance in the programme of NLEP helped in the satisfactory coverage of under-privileged poor people living in the distant inaccessible tribal areas. The indicators also reflect that prevalence of leprosy have been reduced considerably in these areas since DANLEP extended services to cover wider areas in all the districts including tribal districts. As women population who in general gets

neglected and deprived of many health facilities, in NLEP particularly coverage of women in the programme has been seen to be satisfactory. The trend of reduction is an indication of probability of elimination of leprosy by 2003.

OOA 22

REGIONALIZAÇÃO DAS AÇÕES DE ELIMINAÇÃO DE HANSENÍASE INTEGRADAS NA ATENÇÃO BÁSICA – BAHIA, PERNAMBUCO E PIAUÍ

2001 – 2002

Lúcia Possídio (8ª DIRES – Petrolina Pe.); Geania Rocha (15ª DIRES – Juazeiro Ba.); Tâmara Stélvia (Secretaria de Saúde Pi.); Vera Andrade (GT/HANSEN/CONASEMS)

Através da articulação com GT/HANSEN/CONASEMS e principalmente a partir da vontade e adesão dos gestores estaduais e municipais da Bahia, Pernambuco e Piauí foi elaborado um plano na perspectiva da estratégia de aceleração proposta pelo referido grupo técnico, que prevê o aumento da oferta do diagnóstico e tratamento da hanseníase com a descentralização e desconcentração das ações, integrando-as nas atividades da atenção básica, passando pela implementação de uma rotina de atualização sustentável dos profissionais de saúde da rede, pela ampla divulgação sobre a universalização da cura da doença e pelo estabelecimento de parcerias com instituições e áreas afins, sociedade organizada e comunidade. A 8ª Regional de Saúde /Pe. expandiu o PCEH para 100% dos seus municípios, a cobertura anterior ao plano era 43%. Em relação aos serviços a cobertura passou de 11,4% para 82,3%. No Piauí as ações de eliminação foram descentralizadas para mais 50 municípios e o número de unidades em 53 municípios aumentou de 50 para 136. Na 15ª Regional de Saúde/ Ba. o PCEH estava implantado em 100% dos municípios. A cobertura dos serviços no período anterior ao plano, era de 15,7% que passou para 64,5%. O trabalho que vem sendo desenvolvido busca atingir o objetivo proposto de facilitar o acesso da população ao diagnóstico e ao tratamento integrando as ações de eliminação nos serviços da atenção básica, detectando precocemente os casos reduzindo a morbidade e o aparecimento de casos com incapacidade física. Nessa perspectiva pode-se afirmar que o controle e eliminação da hanseníase como problema de saúde pública pode ser efetivado

OOA 23

RESISTANCE TO CHANGE: HIGH POINTS IN THE SRI LANKAN INTEGRATION PROCESS

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The sheer scale of the process of converting a vertically structured leprosy service into a horizontally structured system, during decentralization inevitably involved a number of formidable challenges. The Anti-Leprosy Campaign had for decades been accustomed to working directly only with the 24 leprosy workers - with the general health services playing only a supportive role. Now it had to collaborate on a broader basis with provincial health directors, epidemiologists, dermatologists, pharmacists, and directors of numerous local hospitals, motivating them to provide the necessary services without the necessary "authority" to ensure that the services are provided. It became clear that considerable skills in the areas of team building and teamwork, conducting negotiations, and monitoring were needed.

Integrating leprosy services into the local health-care system has also involved a sometimes delicate exercise in sharing responsibility and adjusting to new roles. Natural resistance to these changes was observed both within and outside of the ALC.

This paper shows how the different levels of players perceived integration and how they reacted. The paper also proposes what should be done to sensitize stakeholders and what they ought to consider before launching integration.

OOA 24

ROLE OF COMBINED MONITORING AND UPDATING REGISTERS IN ELIMINATING LEPROSY IN AFRICA, GUINEA AND CAMEROON EXPERIENCES

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Leprosy Elimination Monitoring (LEM) is a process to collect data and build three groups of 22 indicators enabling to identify leprosy programme weaknesses and to propose measures for improving activities towards the elimination of leprosy. Updating Leprosy Registers (ULR) is an exercise to review leprosy information forms and examine leprosy patients under Multiple Drug Therapy (MDT) in view of obtaining the real prevalence according to the definition of a case of leprosy. These two activities can be combined and implemented by external monitors, leprosy programme national managers and district health teams. Combined LEM and ULR exercise is a strong tool for the reduction of leprosy prevalence and improvement of leprosy programme activities. The Regional Office of WHO for Africa initiated 2 combined LEM/ULR in Guinea and Cameroon, respectively in November-December 2000 and Au-

gust 2001. These combined exercises permitted to reduce the prevalence of leprosy of 50% in Guinea and 38% in Cameroon. Re-cycling old cases of leprosy, late or false diagnosis, over-treatment of MB patients, mismanagement of MDT blister packs were main problems identified with LEM indicators. Recommendations were proposed to solve those problems. They consisted mainly the integration of MDT services into general health services and routine ULR during supervisory visits to peripheral health facilities.

[Key words] Updating, Monitoring, and Elimination

OOA 25

SURVEY OF LEPROSY IN UNAPPROACHABLE AND UNCOVERED AREA

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There is no doubt that due to the implementation of multidrug therapy the prevalence rate (PR) of leprosy has declined drastically. New case detection rate, however, has reduced only marginally or has remained static in certain areas, this may be due to the foci of infections in the society lurking in unapproachable areas or due to mobility of the community members and spreading the disease.

The survey report of such population is reported

- a) The examination 3030 labourers of five different construction work places revealed six leprosy cases giving a PR of 20/10000.
- b) The group of male fishermen (304 persons at Panvel) who remained 8 months on sea were examined in rainy season revealed four new cases (PR 131/1000) of which one was smear positive MB case.
- c) The examination of 3457 tribal population on hilly area of Pen yielded 11 leprosy cases (PR 32/10000) of which five were MB. Such pilot studies suggest that special surveys of selected population groups may have to be undertaken systematically, if the leprosy elimination target by the year 2005 AD is to be reached.

OOA 26

TECHNICAL SUPPORT TEAM (TST) FOR THE PROMOTION OF LEPROSY AND TUBERCULOSIS WORK IN THE DISTRICT – A CONCEPT PAPER

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The National Leprosy Elimination Programme (NLEP) and the National Tuberculosis Control Programme (NTP) are the two effective programmes taking care of the leprosy and tuberculosis problems in India respectively. The involvement of Non Governmental Organisations (NGO) in the National Leprosy and Tuberculosis programmes are well recognized. German Leprosy Relief Association (GLRA) and Swiss Emmaus Leprosy Relief work (ALES) are two international organisations engaged in leprosy and tuberculosis work in India. These two organisations already launched Technical Support Teams (TST) in 5 districts of Andhra Pradesh for providing support to the ongoing National Leprosy Elimination Programme (NLEP). This district based Technical Support Team consist of a well-experienced Medical Officer, trained both in leprosy and tuberculosis, a trained supervisor and a driver. The same team will be used for the support of the Revised National Tuberculosis Control Programme (RNTCP), by augmenting the system.

The concept of TST for leprosy and tuberculosis conveys the following:

Intensified leprosy elimination process and effective integration with General Health System.

Improved cure rate of sputum positive tuberculosis to more than 85%.

Through a well drawn out work plan with the government this concept will prove to be an effective strategy.

OOA 27

URBAN LEPROSY CONTROL IN ENDEMIC COUNTRIES — AN UNDER - RECOGNIZED PROBLEM

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Since the recommendations of the International Leprosy Congress held in Bergen, Norway in 1973 focused world attention on the need for research in urban leprosy, several national and international meetings have stressed the exclusive importance of this aspect of leprosy management. It is however debatable whether the reduction in mean prevalence rate (PR) through MDT is due to an exclusive strategy adopted consciously in urban areas by the planners of leprosy control.

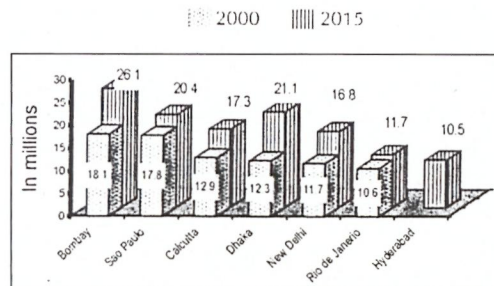
Perhaps we are driven to the necessity of bestowing attention on this subject as the incidence rate of lep-

rosy is not coming down due to urban pockets, especially those in the slums, with hidden leprosy. Due to rapid industrialization and migration of population into the slums, especially of metropolitan cities of the endemic world, special challenges are posed to reach the target set for elimination of leprosy. The population in major cities in the Indian sub-continent is expected to increase by nearly 40% by 2015.

The slum population (about 6 million) in Bombay itself reaches the dimension of the entire population of some countries in the developed world.

Though the lesser cities also face the problem in varying degrees, the exact magnitude is not known. The anomaly of using P.R to judge the effectiveness of leprosy elimination is classically exemplified by the unrealistic statistics relating to the megalopolis of Bombay, where the P.R is reported to be just 2 per

10,000 in the face of about 5000 new cases (10% skin smear +ve) being detected every year.



It is strongly urged that the recommendations already made by a series of Seminars, Workshops, Congresses etc., especially in the Indian subcontinent be implemented meticulously

POD & REHABILITATION

OPOD 1

A GRASS ROOT PERSPECTIVE ON REHABILITATION EFFORTS

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In 1975, the International Nepal Fellowship (INF), a Christian medical mission, was assigned the responsibility for the National Leprosy Control Programme in the western part of the Kingdom of Nepal. In the same year, INF founded the Socio Economic Services Programme (SES). The aims were to assess the needs of patients and where called for, to undo adverse social and economic consequences of leprosy. In 1997, SES became the Partnership for Rehabilitation Programme (PFR).

The decision to carry out an impact evaluation was taken in 1998. The objective was to investigate the outcome of the socio-economic rehabilitation interventions with emphasis upon how the clients and their communities viewed the assistance given. Starting in mid-1999, for a year and an half, two thirds of the clients from the cohort of new clients of 1995 were followed up in the field.

The study was essentially a retrospective observational, before and after, evaluation which sought to determine if the interventions were relevant and appropriate for the client needs, if they were properly carried out, and their short and long term effects on the target population.

In all instances clear cases of need were demonstrated, in the great majority of cases the interven-

tions were implemented in a way acceptable to the clients and their communities, and in almost every instance, the immediate results were positive. However, for most of the clients the input of SES/PFR only changed their life for the better for a time, but did not drastically change their situation long term. Perceived reasons as to why will be presented.

The project based within the Statistics and Research Department of RELEASE, ran over a year and an half.

OPOD 2

A HARD LOOK AT THE PROBLEM OF REHABILITATION IN LEPROSY

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At present, rehabilitation activities are carried out by different organisations as *ad hoc* provision of some help to some of those who demand it. Such programmes do not inform us about the non-users of the services and the reasons for their not using them. By and large, the approach to rehabilitation, especially in the context of leprosy, has been governed more by emotion than reason and this has led to some distortions in our perceptions, attitudes and activities. First, any help provided to leprosy-affected persons (even providing MDT!) is equated with rehabilitation. Second, rehabilitation is still considered as charity towards the affected. Third, all persons with leprosy-related deformities are considered as needing rehabilitation. Fourth, correction of deformities is considered essential for rehabilitation. Fifth, voca-