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Leprosy Elimination Campaigns (LEC)

and

Special Action Projects for the Elimination of Leprosy (SAPEL)

Questions and Answers

1997

Action Programme for the Elimination of Leprosy
World Health Organization

FOREWORD

The World Health Assembly resolution on the elimination of leprosy as a public health problem in 1991 has resulted in renewed efforts to solve the problem in leprosy endemic countries and has already led to impressive achievements. Under the Global Plan of Action for the Elimination of Leprosy, WHO has introduced and supported several initiatives with the aim of accelerating and strengthening leprosy elimination activities carried out by the national programmes. Special Action Projects for the Elimination of Leprosy (SAPEL) and Leprosy Elimination Campaigns (LEC) are two such initiatives.

LEC and SAPEL are aimed at addressing the needs of leprosy patients who do not yet have access to multidrug therapy (MDT), which was first introduced by WHO in 1981. Because these two approaches are new, certain aspects seem unclear for health personnel working in the field. It is hoped that this booklet, produced in a question-and-answer format, will explain clearly the objectives and activities of these two initiatives.

The WHO Action Programme for the Elimination of Leprosy would appreciate receiving comments and suggestions so that these two activities may be further improved.

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Leprosy Elimination Campaigns (LEC)

Q.1

What is LEC?

A: *LEC is an initiative which aims to detect leprosy cases, particularly the more serious ones referred to as "cases of consequence", that remain undetected in the community, and to treat them with MDT. It is not a new concept and similar activities have been carried out by others in the field. Under LEC, several activities are grouped as a new package, with the intention of obtaining maximum benefits from this initiative by carrying out these activities in a systematic way.*

Note: for more details please refer to the document on "Guidelines for carrying out leprosy elimination campaigns".

Q.2

What are the essential elements of LEC?

A: *LEC is a combination of three elements, namely: capacity building measures for local health workers to improve MDT services; increasing community participation to strengthen elimination activities at the peripheral levels; and diagnosing and curing patients, particularly "cases of consequence".*

Q.3

What do you mean by leprosy of consequence?

A: *Leprosy of consequence is a term used to denote cases with more than five skin lesions and skin-smear positive cases (where facilities are available and reliable). These cases are regarded to be of consequence because they are acting as a source of infection in the community and are likely to be suffering from disability/impairment or have a high potential to become disabled in the future.*

Q.4

Why is LEC needed in certain areas?

A: *In many areas where leprosy treatment services are currently available there is evidence that a number of patients remain undetected and therefore untreated. This is due to lack of awareness of the disease and its treatment on the one hand and the unattractiveness of the leprosy services on the other. These areas will need LEC to reduce the pool of undetected cases in the community, and thus reduce the disease burden significantly.*

Q.5

What are the activities to be carried out for LEC?

A: *Activities carried out under LEC will vary from country to country and even between regions within each country. They will depend on the specific needs of an area, its local situation and available resources. However, activities carried out under LEC should ultimately lead to detecting and treating leprosy cases including all cases of consequence. The proposed activities to be carried out under LEC are: orientation courses for local health workers and volunteers; community awareness creation activities using various forms of mass media and information sessions; case-finding through passive methods and treating every detected case immediately with MDT.*

Q.6

Will LEC be detecting and treating only leprosy cases of consequence?

A: *No, as part of the LEC activities all types of cases are expected to be detected and they should be promptly treated with MDT. However, LEC is not an exclusive active case-finding project. It is more likely that only those individuals with obvious skin lesions will be coming forward for diagnosis and that these will consist mostly of cases of consequence.*

Q.7

How will leprosy cases be detected in a community using passive means?

A: *By increasing community awareness including through health education, individuals with obvious skin lesions will become aware about the signs and symptoms of leprosy and self-report either to a health volunteer or to a local health worker for diagnosis. Volunteers can guide such individuals to the nearest health centre. Trained and motivated by LEC, the health worker will diagnose and treat with MDT all such cases. Ensuring that MDT services are available free of charge at every health facility will increase confidence of the community in the health services and promote self reporting.*

Q.8

Why not simply conduct house-to house surveys and detect all cases? Why wait for the patient to self-report?

A: *The ideal situation would be for the community to be so well-informed about leprosy that when any member becomes diseased he/she will come forward for diagnosis and treatment before impairment and disabilities set in. By contrast, conducting house-to-house surveys is a very time-consuming activity requiring a lot of resources. The cost-effectiveness of such surveys is questionable. In addition, such surveys are known to over-diagnose cases with minimal or doubtful lesions who refuse to accept the diagnosis and treatment, while at the same time missing cases of consequence.*

Q.9

What is the risk of re-registering cured individuals as new cases?

A: *There is some risk of re-registering cured individuals as new cases. However, this is expected to be very small and is acceptable in the overall context of LEC.*

Q.10

How will the national programme select an area for LEC?

A: *The national programme will be responsible for identifying certain areas where the support of LEC is needed by reviewing the past trends in prevalence, case detection and the overall performance of the elimination programme in all areas under its jurisdiction. Such areas should be selected carefully so that the additional inputs coming from LEC can be used effectively for reaching the goal of elimination. An overall plan for LEC should then be developed and incorporated into the national plan of action.*

Q.11

Will LEC be replacing routine leprosy elimination activities?

A: *LEC is not intended to replace routine leprosy elimination activities. It is aimed at strengthening and supplementing the present activities carried out in a selected area. This is done by diagnosing all the back-log (hidden) cases in a short time by involving all health facilities and the community in the process.*

Q.12

What is the expected duration of LEC?

A: *Each campaign is expected to be conducted for a short period in most of the endemic countries. On the average it is expected to be finished in the space of 3-4 months. This period may be extended in certain situations, for instance, if the area to be covered is large and LEC is being used to extend MDT services to areas with relatively weak health infrastructure. Since LEC is an intensive activity involving all health care facilities and personnel in the area, conducting it for a longer period is likely to disturb the routine activities in the area and risks a loss of momentum.*

Q.13

How flexible is LEC methodology?

A: *The LEC methodology is not a rigid requirement. Depending upon the local situation, the methodology can be flexible as long as additional cases are detected in a predefined time period with full participation of the community and the general health services.*

Q.14

What is the expected long-term impact of LEC? Will there be a re-accumulation of undetected cases once LEC is over in an area?

A: *By conducting LEC in an area it is expected that the pool of undetected cases will decline significantly. The improvement in MDT services because of the additional inputs received from LEC will improve self-reporting, which will lead to a further reduction in the number of prevalent cases. The two elements of the campaign, capacity building of local health workers to provide MDT services and improving community awareness about the disease, are expected to reduce delays in diagnosing and managing cases in the area. This will to a large extent prevent the accumulation of undetected cases, provided that all LEC activities are carried out properly.*

Q.15

Could LEC be repeated in the same area?

A: *Yes but, LEC's impact is likely to last for a considerable time, even after the actual campaign is over. Normally some elements of LEC will become part of routine activities and should be continued at the local level. If necessary another LEC may be implemented in the same area after 1-2 years.*

Q.16

What indicators will be used to evaluate the immediate outcome of LEC in an area?

A: *The immediate outcome of LEC is to be evaluated using the following indicators:*

(i) *Number of new cases (paucibacillary and multibacillary) detected during the campaign period.*

(ii) *Number of new cases with more than 5 skin lesions.*

(iii) *Proportion of disabled (Grade 2) among new cases.*

Q.17

Can you give an example of LEC?

A: *Kandal Province of Cambodia, with a population of 980 000, was selected for LEC by the national authorities. It had 155 registered cases at the end of 1995 and 108 new cases were detected during that year. The new case grade 2 disability proportion was 27%. The campaign was carried out during April and June 1996. Orientation courses for about 300 commune health workers and 2000 village volunteers were conducted. Campaign teams visited the communes and ran several information sessions for the community members. Posters and educational pamphlets were used to create awareness about leprosy in the villages. As a result of LEC activities, 167 new cases were detected within 3 months and were promptly started on treatment with MDT. The MB proportion among the new cases was 55% and the grade-2 disability proportion was 33%.*

Special Action Projects for the Elimination of Leprosy (SAPEL)

Q 18

What is SAPEL?

A: *SAPEL is an initiative aimed at providing MDT services to patients living in special difficult-to-access areas or situations or to those belonging to neglected population groups. These underserved groups have been neglected so far mainly because of the limited resources available and the difficulties foreseen in reaching them in a cost-effective manner. Now that the accessible areas have been reached, some resources can be made available to address this problem or, where this is not the case, additional assistance sought. The most important thing is for the elimination programme to reach everyone who needs MDT services.*

Note: for more details please refer to the document on "Special Action Projects for the Elimination of Leprosy".

Q.19

What are the essential elements of SAPEL?

A: *The essential elements of SAPEL are, firstly, to find cases living in difficult situations who are in need of treatment and, secondly, to cure them. Innovative and practical strategies involving mainly operational solutions will be used in order to provide MDT to these patients. Since the project operates in situations where the health infrastructure is weak or does not exist, the strategies used should promote self-reliance and self-help, and must involve the community so that the activities began under SAPEL can be sustained.*

Q.20

What are the special situations and population groups to be addressed by SAPEL?

A: *Special situations and populations facing difficulties because of inaccessibility to MDT will differ from place to place and from time to time in terms of the nature and size of the problem. Examples of such situations are:*

(i) areas where there is no health infrastructure;
(ii) areas where the existing health services are unable to deliver MDT;
(iii) geographically difficult-to-access areas;
(iv) a temporary breakdown of services due to hostilities or natural disasters;
(v) urban and peri-urban slums;
(vi) patient groups living in isolated communities due to social stigma;
(vii) nomads and other migrants; and
(viii) refugee and other displaced populations.

Q 21

Isn't it the duty of governments to reach these underserved areas/populations?

A: *Yes, it is the duty of everyone involved in the elimination activities to reach these underserved areas/populations, and in many countries the health services are trying their utmost to reach them. Innovative strategies are needed to reach leprosy patients living in these areas and populations. The SAPEL initiative can be a trend-setter in implementing new approaches, especially where flexibility in terms of giving utmost consideration to the human and cultural background of affected populations is required.*

Q 22

Why were these groups neglected so far?

A: *The routine health services are not reaching them because of the remoteness of the areas, security problems, lack of financial resources and the unique living conditions of certain population groups.*

Q 23

Since SAPEL is not likely to cover large populations or a large number of cases, will it be cost-effective?

A: *SAPEL will be relatively more expensive compared to the costs per patient in routine programmes since it is an initiative addressing the issue of equity in health care and it is not expected to cover large populations and large numbers of cases. However, certain extra costs to reach such patients are justifiable if leprosy elimination is to be attained in all areas and the possible benefits of improving health care access in these areas are factored in.*

Q 24

How flexible is SAPEL methodology?

A: *Flexibility is built into SAPEL. Depending upon the need, the methodology employed for SAPEL can be quite flexible, as long as the central purpose of reaching hitherto unreached patients is attained in the identified difficult areas.*

Q.25

How will SAPEL supplement routine leprosy elimination activities?

A: *SAPEL projects are confined to exceptional situations where routine activities are non-existent or are not practical. As such, SAPEL will be filling the gaps that exist in national programmes for MDT services. It will accelerate the implementation of MDT in difficult areas and hopefully will stimulate other activities related to health and socio-economic development.*

Q.26

What is the expected duration of SAPEL?

A: *As a project, SAPEL is expected to be of limited duration, with a maximum period of 12 months. It is hoped that the innovative approach can be tried out and evaluated within this period. Further extension of the activity and expansion to other areas facing similar problems will be incorporated within the national plan of action.*

Q.27

How will the immediate outcome of SAPEL be evaluated?

A: *The immediate outcome of SAPEL is to be evaluated using the following indicators:*

(i) *Number of villages or communities reached by the project.*

(ii) *Number of cases (paucibacillary and multibacillary) diagnosed and cured.*

(iii) *Feasibility of replicating the approach in other areas in the country.*

Q.28

Can you give an example of SAPEL?

A: *The national programme of Chad developed a SAPEL project to provide MDT services for the nomadic population in Eastern Chad. The projects covered Kyabe and Am Timan districts close to the Sudanese border. A team from the national programme visited these nomads at their resting place, diagnosed cases and started treatment on the spot. It was able to treat 52 nomadic patients, out of which 38 were new cases. Leaders from the nomadic communities were provided with blister packs and made responsible for the treatment of patients living in their community. The team will be visiting these nomads at their next resting place to replenish the MDT supply, monitor treatment completion and screen individuals presenting with dermatological complaints.*

Q 29

What sort of treatment regimen is to be provided to leprosy patients in LEC and SAPEL areas?

A: *Patients registered for treatment in LEC and SAPEL areas will be treated with WHO-MDT fixed-duration treatment regimens using blister packs. However, there may be a need to treat a small number of cases with alternative regimens, especially those living in inaccessible areas. Such regimens are currently being tested, not yet ready for widespread use, and their implementation will be limited to only special patients. Since almost all patients can be managed with WHO-MDT, implementation of LEC and/or SAPEL should not await the availability of new regimens.*

Q.30

Who will be responsible for implementing LEC or SAPEL at the country level?

A: *The national programme will be responsible for developing and implementing LEC or SAPEL. It is important that relevant national and international non-governmental organizations collaborate with the national programme in developing and/or carrying out LEC or SAPEL.*

Q.31

What is WHO's role in LEC and SAPEL?

A: *WHO's role is to stimulate and where necessary assist the national programmes in identifying areas for LEC or SAPEL, and to provide technical and limited financial support to enable national programmes to implement them. WHO, together with the national programme and its partners, will monitor and evaluate these initiatives and where indicated, their extension to other areas with similar needs.*

Q.32

Why do we need to involve the general health workers and the community in LEC and SAPEL?

A: *General health workers and members of the community should be involved in LEC and SAPEL so that all available human resources that exist at the community level can be used for elimination activities. This will improve accessibility and also help in sustaining MDT services in the area.*

Q.33

Why do we want to increase community awareness about leprosy in LEC and SAPEL?

A: *Community awareness about leprosy needs to be increased to promote case detection, to reduce the stigma of leprosy and to involve members of the community in supporting patients to get regular treatment. Both LEC and SAPEL initiatives are community-based and should respond to the demands of the affected community.*

Q.34

Between 1996 and 2000 how many cases will benefit from these initiatives?

A: *Between now and the year 2000, it is estimated that about 650 000 cases will be diagnosed and treated through LEC and about 100 000 cases through SAPEL.*

Q.35

What mechanism will be set up to sustain these activities in the future?

A: *These activities should become part of the national plan of action supplementing routine activities. International and local non-governmental organizations will be partners with WHO in mobilizing additional resources to support the national programmes for these initiatives and there is increasing evidence that it is possible to mobilize additional resources to expand these activities. Non-governmental organizations working at the grass-root levels are in a much better position to carry out similar activities in areas where either LEC or SAPEL is needed.*

SUMMARY
Essential differences between LEC and SAPEL

Aims: LEC aims to detect "hidden" (back-log) cases present in an area and to strengthen on-going activities. SAPEL is aimed atproviding MDT services to patients who for various reasons are not yet reached by routine services.

Area: LEC is to be conducted in high endemic areas where a large pool of undetected cases exists in spite of the availability of a reasonably adequate health infrastructure. SAPEL is focused on reaching patients living in difficult areas or under "special" situations where MDT services and even general health services are non-existent.

Activities: LEC activities are basically routine programme activities which are being intensified for a short period. On the other hand, SAPEL activities are innovative because routine activities are not feasible or practical.

Duration: LEC is for a limited period, on average 3 months, whereas SAPEL could last for up to 12 months.

Local resources: LEC will make use of all existing health personnel, either specialized or integrated, who are available in the area. SAPEL will identify community-resource persons to support and maintain MDT services in a given area.

Additional resources: Additional financial support for LEC will be minimal, due to the short duration and the presence of an existing health infrastructure. External resources needed for SAPEL could be larger in relation to the number of patients reached, due to lack of health infrastructure and difficult logistics. Additional trained personnel from outside the area will be needed to support and supervise SAPEL activities.