



**REPORT OF A CONSULTATIVE MEETING ON
LEPROSY ELIMINATION CAMPAIGNS**
Geneva, 14 and 15 July 1999

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1. INTRODUCTION

1.1 Opening

The meeting was opened by Dr Maria Neira, Director, Department of Eradication and Elimination, Communicable Diseases. Professor W. C. S. Smith was selected as chairperson and Dr C. K. Rao as rapporteur. The agenda and list of participants are given in Annex 1 and 2.

1.2 Objectives

The objectives of the consultative meeting were as follows:

- a) To review the current guidelines and the operational difficulties encountered in carrying out leprosy elimination campaigns (LECs).
- b) To assess the impact of LECs.
- c) To revise the guidelines in order to make LECs more effective and adapted to operational realities in the field.

2. PRESENTATIONS

A summary of the presentations is given below.

2.1 Review of the outcome of LECs

Dr Myo Thet Htoon gave an overview of the outcome of LEC projects that were carried out in 24 countries between 1995 and 1999. Strengths and weaknesses observed in implementing the campaigns were presented along with the issues that need to be addressed in order to make future campaigns more effective. The LECs were able to train a large number of health workers and volunteers for elimination activities. The general health services were actively involved in all the campaigns completed so far. During the campaigns all available means were used to promote community awareness. Community involvement was found to be very high in all the campaigns and some local organizations supported the campaigns by helping in producing educational materials in local languages and in carrying out activities to raise community awareness.

As of March 1999, leprosy elimination campaigns have detected more than 500 000 new cases. Some campaigns were able to improve the multidrug therapy (MDT) coverage by being able to open new MDT clinics. These clinics were opened by involving the general health services.

It was observed that in some campaigns the detections were less than that expected and activities to raise awareness were poorly carried out. In others, case-holding was weak and defaulter rates were high along with low treatment completion rates. The problem of over-diagnosis and re-registration of old cases have contributed to an unexpected increase in the number of new cases detected in some of the campaigns.

The impact of campaigns on the annual detection rates after more than one year of follow-up varies from country to country. Campaigns that were properly carried out were successful in clearing the majority of the backlog cases and were able to demonstrate a decline in the detection rate in the years following the LEC.

2.2 Country experiences

2.2.1 Bangladesh

Dr Jalal Uddin Ahmed, of Bangladesh, presented the results of LECs carried out in 1997 (20 districts) and the nationwide LEC that was conducted during the first quarter of 1999. The overall detection in both the LECs (over 3000 cases) was much lower than that previously estimated. Over half of the new cases detected were multibacillary (MB) cases and the proportion of grade 2 disabilities was around 17%. Based on the outcome of these two LECs the leprosy problem appears to be less than that projected in the past. The estimated prevalence was revised to 15 000 from the 30 000 projected before the campaigns. Some of the districts would need special attention and the elimination activities would need to be strengthened in these areas.

2.2.2 Brazil

Dr Rita Christina Martins Borges, of Brazil, shared the results of the LEC in Cuiaba City, Mato Grosso State, carried out during 1997. The campaign was a success as it was able to open 29 new MDT clinics and it detected 185 new cases. The MB proportion among new cases was 35%. Community awareness was promoted using the local TV and radio station networks. In addition, posters were displayed in public places and pamphlets were distributed in the community. The detection rate has declined to 10.8 per 100 000 population in 1998 compared to 15.9 in 1996.

2.2.3 Chad

Dr Fatchou Gakaitangou, of Chad, explained about the LECs that were completed in Guera, Salamat and Logone Oriental Prefectures. Inadequate coverage of health services, limited health personnel and the difficult terrain contributed to the delays in starting the campaigns. The campaigns detected 59 new cases in Guera and 76 in Salamat and 328 in Logone Oriental. The MB proportion among the new cases was between 36% to 64% and the proportion of grade 2 disabilities was between 9% to 32%. The campaigns trained over 70 health workers and 230 community volunteers. It was successful in reactivating elimination activities in the above mentioned prefectures.

2.2.4 India

Dr N. S. Dharmshaktu, of India, presented the results of nationwide LECs undertaken during 1997-1998 in 22 states and union territories. More than 454 000 new cases were confirmed out of 2.87 million individuals suspected to be having signs of leprosy by the search teams. During the preparatory phase over 570 000 general health workers were trained along with 360 000 volunteers and their participation in the campaigns helped to make it successful.

The search teams were mostly made up of volunteers and they visited most of the households in the community. Various measures were used to promote community awareness including the use of regional and local television and radio stations. Various local organizations also supported the campaigns by providing materials and human resources and their participation greatly helped to reduce stigma and increase awareness about leprosy in the community.

2.2.5 Madagascar

Dr Mamy Ralamboson, of Madagascar, shared the results of LECs carried out in 34 districts. The LEC has covered over 90% of the villages in the targeted districts and trained around 2200 health workers and 4300 community volunteers. A total of 11 061 new cases were detected with an MB proportion of 54% and grade 2 disabilities proportion of 18%. The number of new cases was much higher than anticipated and this created shortages in supplying MDT drugs in some districts. The importance of adequate planning for LECs was highlighted. Post-LEC evaluation showed that in some districts 30% to 40% of the cases registered for treatment had defaulted and measures have been taken to correct this by strengthening the general health services through training and proper supervision.

2.2.6 Myanmar

Dr Kyaw Nyunt Sein, of Myanmar, presented the impact of LECs undertaken in 55 townships during 1997 and 1998 and of the LECs carried out in 51 townships during 1998 and 1999. In the first round of LECs, 7457 new cases were detected with an MB proportion of 41% and grade 2 disabilities proportion of 18%. During the second round of LECs, 6412 new cases were detected with an MB proportion of 43% and grade 2 disabilities proportion of 21%. The key people involved in the campaigns were the midwives from the general health services. They are responsible for treating patients regularly and to make sure that these patients are cured within the specified time. Community awareness was created through information meetings held in the villages, display of posters in public places, distribution of pamphlets and slide shows in the cinema halls. A decline in annual new case detection rates was observed in the years following LEC compared to the previous years. LEC attracted the interest of the local health authorities and with their leadership and support a number of LECs were undertaken with marginal external support. LECs have shown that routine MDT services need strengthening and that the involvement of the local community is important for its success.

2.2.7 Nigeria

Dr T. O. Sofola, of Nigeria, presented the results of LECs carried out in Sokoto, Zamfara, Jigawa and Kano States. Under the LECs the general health workers were trained to provide MDT services and as a result of this initiative the number of MDT clinics increased from 311 to 1097 in the project areas. In the villages community members were informed about the disease and where to go for screening through messages sent out using the public address systems. In addition posters were displayed in prominent places and educational pamphlets were distributed. Educational messages were also broadcast by the local radio stations. A total of 1731 new cases were detected with an MB proportion of 79% and grade 2 disabilities proportion ranging between 6% and 27%. High cure rates (85% and 95%) were recorded in Enugu and Benue States where

LECs were carried out during 1996 and 1997. In these two areas the annual detection has also declined in the years following LEC. It is hoped that the low awareness of the disease and the poor geographical coverage of MDT services in some states will be corrected by carrying out LECs.

2.2.8 Philippines

Dr José Villarama, of Philippines, presented the results of 15 LECs that were carried out between 1996 and 1999. The LECs detected 1408 new cases with an MB proportion of 59% and the grade 2 disabilities proportion of 9%. As a result of the LECs annual new case detection increased by 22% between 1996 and 1997. A declining trend in the annual new case detection was observed in some areas after LEC. However, the MB proportion and the grade 2 disabilities among the new cases remain the same but the proportion amongst children (under 15 years) has decreased. Detection was low in some campaigns owing to poor support from the municipalities, lack of coordination and inappropriate timing.

2.3 Experiences of LECs in the Western Pacific Region

Dr P. S. Rao presented the results of LECs in the Western Pacific Region. A total of 44 projects (21 LECs, 8 Health Education Campaigns and 15 mini LECs) were implemented in the Region (29 in Philippines, 13 in Cambodia, 1 in Viet Nam and 1 in Papua New Guinea) covering a population of 23.6 million between 1996 and 1998. These campaigns detected 3265 new cases within a fairly short time. In general, case detection during LEC was higher than that of the routine annual detection except in Viet Nam. A decline in annual new case detection was noticed in some areas one year after LECs. LECs have played a crucial role in achieving elimination goal, notably in Cambodia and Philippines.

2.4 Future scope and expectations

Professor W.C.S. Smith gave a stimulating presentation on why LECs should continue, when to carry them out and how to improve them. It was pointed out that in addition to implementing the three core elements of capacity building, promoting community awareness, and diagnosing and treating patients the LECs provided additional benefits such as reducing stigma, improving accessibility and promoting community participation.

On the topic of *Why should LECs continue?* the presentation highlighted three aspects: economic appraisal, option appraisal and the epidemiological and control objectives. The economic appraisal involves value judgement about the cost and benefits of LEC. The potential within LECs to minimise costs and maximise benefits was pointed out. With respect to the option appraisal, it was pointed out that though the objectives of LEC can be achieved in other ways, this initiative has combined the core activities into one activity in a cost-effective way with important interactions. As for the epidemiological and control objectives, it was felt that the information provided by LEC when used with data from other sources could assist in the assessment and monitoring of the leprosy situation.

On the topic of *When should LECs be undertaken?* it was stressed that LECs should be carried out when significant numbers of undetected cases were expected (gap between registered and estimated cases). A LEC which results in few new cases could be due either to a poorly conducted LEC or that the initial estimate of undetected cases was wrong. There is a case for conducting LECs more than once after careful review of the methods of implementing the LEC.

On the topic of *How should LECs be conducted in the future?* it was pointed out that there is room for improvement in all aspects of the LEC from planning through evaluation. Experience gained from implementing LECs should help in improving the planning process. The LECs must involve the general health services at all levels and this is crucial for sustainability and ensuring treatment completion. The quality of diagnosis must be kept high though a certain level of over-diagnosis and under-diagnosis is inevitable. Treatment completion rates should be at an acceptable level and monitored closely. Core elements of a leprosy control programme are being strengthened by LECs and it is important that these elements are maintained in future LECs.

2.5 Evaluation of the impact of LECs

Dr C. K. Rao presented the impact of LECs conducted in Bangladesh, India (Maharashtra and Orissa States) and Myanmar. In summary it was observed that LECs had achieved the desired results and a favourable impact on the leprosy profile was observed in most areas. The political, administrative and professional leadership at the national level were all actively involved in implementing LECs and they provided sustainable support to leprosy programmes. In some areas, LECs were not successful in bringing out the remaining undetected cases as expected because of various operational problems. In such areas, after carefully reviewing the situation, a LEC may have to be repeated. It was also observed that some LECs were successfully implemented with marginal additional funds from external sources. This was possible because the local health authorities took ownership of the LEC and included it as part of their routine health care activities. Even though it was not the intention of LEC in the first place, it has provided additional information to help assess the magnitude of the leprosy problem especially in areas where it was properly carried out. The health services should give high priority towards providing MDT regularly to all patients and should ensure that all cases are cured within the specified time.

3. SUMMARY OF GROUP DISCUSSIONS

During the group discussions, Group A discussed *ways to improve capacity building and promoting community awareness* and Group B discussed *ways to improve case-finding, treatment, monitoring and evaluation*. The recommendations are as follows:-

3.1 How to improve capacity building and the promotion of community awareness ?

Recommendations on capacity building for local health workers:

- Policy makers should be convinced of the aims and objectives of the LEC and ensure the involvement of general health workers not only during but even after carrying out the LEC. The general health services should be strengthened so that they can properly carry out elimination activities and be made to regard them as part of their routine responsibilities.

- Every health facility in a high endemic area must have an “MDT package”. This package should include a simple “Guide” printed in the local language, a booklet with clinical pictures, posters and an adequate supply MDT drugs.
- Training should be combined with other training programmes, if possible during the LEC period. The training should be task oriented and the period should depend on the number of tasks the health workers are expected to perform. The trainers conducting the training should be well qualified in order for such training to be effective.
- To cope with the increased workload after LEC, the specialized staff are expected to help the general health workers by guiding them in diagnosis and treatment, making sure they have sufficient stocks of MDT drugs with them and assisting in filling reports.
- To sustain the capacity of the health worker to deal with leprosy, “on-the-job” training, meetings and refresher courses should be provided from time to time.

Recommendations on promoting community awareness:

- Community awareness should be improved by developing key messages, whenever possible with the support of communication experts. Key messages to be included are:
 - Leprosy is curable.
 - Treatment with MDT is available free of charge at your health centre.
 - Deformities are preventable.
- Increasing community awareness could be achieved in a cost-effective way by collaborating with various local organizations such as the scout and guide movement, parent and teachers associations and religious associations, etc. Whenever possible, local donors should be approached and they should be encouraged to provide support by printing information materials (posters, flyers, etc.) in the local language.
- The assessment of community knowledge, attitudes and practices (KAP) may not be necessary before undertaking a LEC, but there is a need for some periodic feedback from the community after the intervention.
- Community awareness should be sustained after the LEC by ensuring that leprosy is included in the health education component of primary health care activities and by celebrating annual leprosy day/week.

3.2 *How to improve case-finding and treatment, and monitoring and evaluation ?*

Recommendations on case-finding and treatment:

- The magnitude of the problem of undetected cases in the area targeted for LEC should be properly assessed. Plans should be discussed with local health administrators, various agencies other than health and local organizations to ensure their support and participation. The benefits to be gained and the cost of carrying out the LEC should be carefully assessed.

- The population coverage should be high and should include specific population group(s) where it is estimated that a large number of cases remain undetected. LEC activities should cover all existing health infrastructure. MDT services should be made available to patients as close as possible to where they live.
- The approach to case-finding should generally be through passive means. This should be supported by proper training of local health workers and by carrying out activities that will increase community awareness and ultimately lead to self reporting of cases. LEC should use all available means including various electronic and print media to promote community awareness.
- Case detection and community awareness promotion activities should be undertaken only after first ensuring that MDT services are available in the area.
- The quality of diagnosis should be assessed. Over-diagnosis should not be more than what it was under routine conditions.
- Patients should be able to obtain their MDT drugs easily and at the nearest health centre after the implementation of LEC.
- The health services should ensure that all patients are able to complete their treatment within the specified time. The cure (treatment completion) rates should preferably be 100%. However, as this may not be possible always the cure rate should be maintained at around 90% to 95%.

Recommendations on monitoring and evaluation:

- The present criteria for selecting an area for LEC remains valid. However, there is an additional requirement: a high level of political and administrative support for the LEC must be obtained.
- Priority should be given to carrying out subnational LECs in areas where large numbers of undetected cases are expected.
- LECs should only be repeated in an area after carefully assessing the situation and reviewing the cure rates among patients detected during the previous LEC.
- The short-term evaluation should be inbuilt in the LEC. The long-term evaluation should be part of the routine annual review process of the programme.
- In assessing the performance of LECs, looking at case detection alone is not sufficient and one should also review the cure rates and other parameters such as improvement in MDT coverage, capacity building of local health workers and increasing community awareness.

4. CONCLUSIONS

LECs were able to strengthen routine activities in the field and initiate integration of MDT services in some areas. They were also successful in mobilizing the general health services and the community for leprosy elimination. For LECs to be effective, careful selection of the area and planning are needed. All available means should be used to promote community awareness. The involvement of local authorities and voluntary organizations is important. LEC should not replace routine activities and should be repeated in an area only after reviewing the situation carefully, looking at other options and analysing its cost-effectiveness.

ANNEX 1

**CONSULTATIVE MEETING ON
LEPROSY ELIMINATION CAMPAIGNS (LECs)**

Geneva, 14 and 15 July 1999

AGENDA

Wednesday, 14 July 1999

- | | | |
|-------------|--|--|
| 09:00-09:15 | Opening of the meeting. | <i>Dr Maria Neira</i> |
| 09:15-10:15 | Review of the outcome of LECs in selected countries.
Discussion. | <i>Dr Myo Thet Htoon</i> |
| 10:15-10:45 | <i>Coffee break</i> | |
| 10:45-12:30 | How LECs were carried out and their short-term and long-term impact: country experiences.
<i>(15-20 minutes for each presentation and discussion)</i> | <i>Dr Jallaludin Ahmed
Dr Rita Christina Borges</i> |
| 12:30-14:00 | <i>Lunch break</i> | |
| 14:00-16:00 | How LECs were carried out and their short-term and long-term impact: country experiences
<i>(15-20 minutes for each presentation and discussion)</i> | <i>Dr Fatchou Gakaitangou
Dr N. S. Dharmshaktu
Dr Mamy Ralamboson
Dr Kyaw Nyunt Sein</i> |
| 16:00-16:30 | <i>Coffee break</i> | |
| 16:30-17:30 | How LECs were carried out and their short-term and long-term impact: country experiences. | <i>Dr T. O. Sofola
Dr J. Villarama</i> |
| | Experience of LECs in the Western Pacific Region
<i>(15-20 minutes for each presentation and discussion)</i> | <i>Dr P. S. Rao</i> |

Thursday, 15 July 1999

- | | | |
|-------------|--|--------------------------------|
| 09:00-10:30 | Future scope and expectations: why, when and how LECs should continue. | <i>Professor W.C. S. Smith</i> |
| | Evaluation of the impact of LECs. | <i>Dr C. K. Rao</i> |
| | Discussion. | |

10:30-11:00 *Coffee break*

11:00-12:30 Working groups to revise the guidelines and strategy on the main elements of LECs:

Group A: Capacity building.
Promoting community awareness.

Group B: Case-finding and treatment.
Monitoring and evaluation.

Expected outcome of working groups: recommendations on how to improve LECs.

12:30-14:00 *Lunch break*

14:00-15:00 Continuation of working groups.

15:00-16:30 Presentation of main conclusions

(Coffee break at convenient moment around 15:30)

16:30 Closing of the meeting.

ANNEX 2

**CONSULTATIVE MEETING ON
LEPROSY ELIMINATION CAMPAIGNS (LECs)***Geneva, 14 and 15 July 1999*

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