LEPROSY CONTROL AND THE BURDEN OF LEPROSY IN THE PHILIPPINES

2006-2010
ACKNOWLEDGEMENTS:

Special thanks are due to all the people whose collaborative efforts went to this final documentation of the review entitled:

_Leprosy Control And The Burden Of Leprosy in The Philippines: 2006-2010_

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<tr>
<td>ALM</td>
<td>American Leprosy Mission</td>
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<td>ARMM</td>
<td>Autonomous Region of Muslim Mindanao</td>
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<tr>
<td>BHS</td>
<td>Barangay Health Station</td>
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<tr>
<td>BHW</td>
<td>Barangay Health Worker</td>
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<tr>
<td>CHD</td>
<td>Center for Health Development</td>
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<tr>
<td>CFI</td>
<td>Culion Foundation Incorporated</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>FAHAN</td>
<td>Foundation for the Assistance to Hansenites</td>
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<td>F1</td>
<td>FOURmula One</td>
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<tr>
<td>GLP</td>
<td>Global Leprosy Program</td>
</tr>
<tr>
<td>GOP</td>
<td>Government of the Philippines</td>
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<tr>
<td>HEC</td>
<td>Health education campaign</td>
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<tr>
<td>HSRA</td>
<td>Health Sector Reform Agenda</td>
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<tr>
<td>IEC</td>
<td>Information, education, communication</td>
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<tr>
<td>ILEP</td>
<td>International Federation of Anti-Leprosy Association</td>
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<tr>
<td>IPR</td>
<td>Individual Personal Record</td>
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<tr>
<td>KAP</td>
<td>Knowledge, attitudes and practices</td>
</tr>
<tr>
<td>KP</td>
<td>Kalusugang Pangkalahatan</td>
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<tr>
<td>LEC</td>
<td>Leprosy elimination campaign</td>
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<td>LEM</td>
<td>Leprosy elimination monitoring</td>
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<td>LGU</td>
<td>Local Government Unit</td>
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<td>MB</td>
<td>Multibacillary Leprosy</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MDT</td>
<td>Multidrug therapy</td>
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<tr>
<td>MHO</td>
<td>Municipal Health Office</td>
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<td>MOP</td>
<td>Manual of Procedure</td>
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<td>NCDPC</td>
<td>National Center for Disease Prevention and Control</td>
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<td>NCCCL</td>
<td>National Collaborating Coordinating Committee for Leprosy</td>
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<td>NCHP</td>
<td>National Center for Health Promotion</td>
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<td>NFSDF</td>
<td>Novartis Foundation for Sustainable Development</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<td>NHIP</td>
<td>National Health Insurance Program</td>
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<td>NLAB</td>
<td>National Leprosy Advisory Board</td>
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<td>NLCP</td>
<td>National Leprosy Control Program</td>
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<tr>
<td>OPD</td>
<td>Out Patient Department</td>
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<tr>
<td>PB</td>
<td>Paucibacillary Leprosy</td>
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<tr>
<td>P/D</td>
<td>Prevalence/detection ratio</td>
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<tr>
<td>PHO</td>
<td>Public Health Office</td>
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<tr>
<td>PHT</td>
<td>Provincial Health Team</td>
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<td>PLM</td>
<td>Philippine Leprosy Mission</td>
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<tr>
<td>POD</td>
<td>Prevention of Deformity</td>
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<td>PWD</td>
<td>Persons With Disability</td>
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<tr>
<td>RHU</td>
<td>Rural Health Unit</td>
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<tr>
<td>RITM</td>
<td>Research Institute for Tropical Medicine</td>
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<tr>
<td>ROM</td>
<td>Rifampicin-Ofloxacin-Minocycline</td>
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<td>STBL</td>
<td>Stop TB and Leprosy</td>
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<tr>
<td>SSS</td>
<td>Skin Slit Smear</td>
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<td>TNA</td>
<td>Training Needs Assessment</td>
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<td>UHC</td>
<td>Universal Health Care</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>Western Pacific Regional Office</td>
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EXECUTIVE SUMMARY

The National Leprosy Control Program, since its establishment in 1986, has been very effective in eliminating leprosy as a public health threat. Moreso, leprosy control has been sustained through quality management of leprosy and addressing the psycho-socio-economic burden in the country.

Leprosy has been eliminated as a public health burden at the national level. However, pockets of cases around the country cause it to remain as the highest in terms of new cases detected in the Western Pacific Region.

Cases detected comprise 40.4% of that of the Western Pacific Region. However, the Philippines was able to achieve a yearly reduction of 3.6% new case detection rate.

MB cases from the new cases detected in the Philippines is at 94% or 1,917. This may indicate possible delay in self-reporting or in active case finding. Grade 2 Disabilities is at 4% with a 2% reduction from the previous year, indicating that self-care, prevention of impairment and disability is being addressed. Children below 15 years old among the new case detected amount to 4.6% indicating a low proportion.

Self-reported delays seeking treatment range from 0-42 months with a mean of 29 months upon observation of signs of leprosy with 49% of the cases seeking consult only after observation that the signs of their condition has exacerbated. 1 out every 4 cases would only proceed to the health center as a second course of action.

Program implementation and implementation of the NLCP policies and standards is fragmented in the peripheral level.

Displacement from education and employment play a role in hindering empowerment. Hence the need for public-private partnerships. Effective interaction and commitment between stakeholders (public and private) will result in a harmonized effort to reintegrate persons affected by leprosy to lead a normal life.

Factors that contribute to the quality of case detection, treatment compliance, monitoring and evaluation, drug management, data management are greatly affected by:

1. Communities with marginalized population who are physically and socio-economically separated from the mainstream society such as island municipalities, upland communities, hard-to-reach areas and conflict-affected areas (GIDA).
2. Ratio of health worker vis-à-vis workload
3. Knowledge and skills of health workers in recognizing early signs and symptoms of leprosy during routine and special case-finding activities
4. Inadequacies in health information system due to the:
   a. Delayed self-reporting leading to late treatment and diagnosis and presence of complications
   b. Standard reporting forms are not filled up completely thereby affecting the quality of statistical data which affects analysis of the quality of the program implementation.
5. Proper budget utilization from the NLCP to CHD in terms of conduct of monitoring and evaluation, refresher course, capability, empowerment of patients affected by leprosy, production of IEC materials.
LEPROSY CONTROL STATUS AND THE BURDEN OF LEPROSY IN THE PHILIPPINES

Objectives
This review aims to determine the status of implementation of the National Leprosy Control Program (NLCP) after the external review conducted in 2009 and the assessment of the program in 2010. It also aims to identify operational, organizational and policy issues and challenges that affect the NLCP implementation at the national and sub-national levels.

In light of the aforementioned, recommendations towards further reducing the disease burden in line with WHO Enhanced Global Strategy for Further Reducing the Disease Burden and Sustaining Leprosy Activities shall be made.

Methodology
A descriptive design was employed in the conduct of this review which commenced 28th of December 2011 and ended 30th of January 2012. With this constricted time line, review of records and documents involving epidemiologic and operational data from the National Leprosy Control Program (NLCP) office, the different Centers for Health Development (CHD) and the official data submitted by the NLCP to the World Health Organization – Western Pacific Region Office (WHO-WPRO) were done. Along with this, unstructured individual and group interviews were undertaken. A round table discussion was conducted with representatives from WHO, DOH, CHDs, RITM and CFI.

BACKGROUND

Brief Profile of the Philippines
Located in the Western Pacific Region, the Philippines is an archipelago of 7,107 islands with a land area of 300,000 square kilometers. It is divided into three island groups: Luzon, Visayas, and Mindanao further divided into 16 regions plus ARMM, 80 provinces, 138 cities, 1,496 municipalities, and 42,025 barangays.

It has an estimated population of 94,013,200 (DOH, 2011) and a population growth rate of 2.04%, one of the highest in Asia. It ranks as the 12th most populous country. The population's median age is 22.7 years with 60.9% aged from 15 to 64 years old. Life expectancy at birth is 71.38 years, 74.45 years for females and 68.45 years for males. (WHO, 2009) Of the estimated 68 million Filipinos 10 years old and over, around 96% are basically literate. (FLEMMS, 2008)

The country has a decentralized health delivery system managed by the Department of Health and implemented by the local government units in accordance with the Local Government Code of 1991.

Basic Facts about Leprosy
Leprosy is a chronic, mildly communicable disease caused by Mycobacterium leprae, an acid-fast, rod-shaped bacillus. The disease mainly affects the skin, the peripheral nerves, the eyes and mucosa of the upper respiratory tract (DOH-MOP, 2012). Diagnosis of leprosy is based on clinical signs and symptoms, especially if there is a history of contact with an untreated person with leprosy. The disease is classified depending on the skin lesion and bacillary load. This will serve as guide for prescribing the appropriate MDT regimen. Paucibacillary Leprosy (PB) is characterized by 5 or less hypo pigmented, anaesthetic skin lesions (pale or reddish), while Multibacillary Leprosy (MB) shows 6 or more lesions, nodules, plaques, thickened dermis or skin infiltration, and in some instances involvement of the nasal
mucosa. The need to use laboratory tests like Skin Slit Smear (SSS) to confirm a diagnosis is done only in rare instances in a ready referral facility (WHO, 2009).

In the early 20th century, treatment began with the injection of chaulmoogra oil, Promin in the 1940s, Dapsone pills in the 1950s and the revolutionary Multi-Drug Therapy (MDT) in the 1980s which is the accepted standard of treatment proven to be safe and effective. MDT must be started as soon as diagnosis is made. It is a combination of 2 or more anti-leprosy drug that renders a patient non-infectious within one (1) month after starting treatment according to age group. For PB, a combination of Rifampicin and Dapsone is given in 6 blister packs to be taken monthly within a maximum period of 9 months. In MB regimen, a combination of Rifampicin, Clofazimine and Dapsone is given in 12 blister packs to be taken monthly within a maximum period of 18 months. (DOH-NLCP, 2002) The appropriate dose of children under 10 years of age is based on body weight. ( Rifampicin: 10mg/kg, Clofazimine: 1 mg/ kilogram per body weight daily and 6 mg per kilogram monthly, Dapsone: 2mg/kg body weight daily. Rarely, it may be considered advisable to treat a patient with a high bacillary index for more than 12 months. (WHO-GLP, 2006) The decision may only be taken by a specialist at referral units after careful consideration of the clinical and bacteriological evidence. (WHO-GLP, 2006)

### MAGNITUDE OF THE PROBLEM

The great success of the MDT regimen paved the way to eliminating leprosy as a public health burden in most of the countries and territories around the world. Though it is true that the number of countries who record prevalence rates higher than 1 and new case detection of higher than 1000 a year decreased dramatically, a lot has to be done to ensure that leprosy will be eliminated in the remaining countries and remain to be eliminated in the countries declared as “leprosy-free” (WHO factsheet).

### GLOBAL TREND: 2006-2010

The global effort to eliminate leprosy as a public health burden has been successful over the years, from 5.2 million in 1985 to 805,000 in 1995 to 753,000 at the end of 1999 to 213,036 cases at the end of 2008 (WHO factsheet). In 1991, the World Health Assembly adopted the resolution for elimination of leprosy as a public health burden, and in 2000, leprosy elimination was achieved at the global level. It has been eliminated from 119 countries out of 122 countries where the disease was considered as a public health problem in 1985 (WHO Factsheet). The strategy for 2000-2005 was the elimination of leprosy.

From 2006 to 2010, the global strategy was to further reduce the burden of leprosy and sustain the leprosy control activities. Its overall goal is to provide access to quality leprosy services for all affected communities following the principles of equity and social justice. The

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<tr>
<th>INDICATOR</th>
<th>GLOBAL</th>
<th>WESTERN PACIFIC REGION</th>
<th>PHILIPPINES</th>
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</thead>
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<tr>
<td>New Cases Detected</td>
<td>228,474</td>
<td>5,055</td>
<td>2,041</td>
</tr>
<tr>
<td>Prevalence</td>
<td>192,246 (0.34)</td>
<td>8,386 (0.05)</td>
<td>2873 (0.31)</td>
</tr>
<tr>
<td>MB CASES</td>
<td>125,559</td>
<td>4,147</td>
<td>1,917</td>
</tr>
<tr>
<td>Grade 2 Disabilities</td>
<td>13,275 (0.23)</td>
<td>526 (0.03)</td>
<td>63 (0.04)</td>
</tr>
<tr>
<td>Women among New Cases</td>
<td>85375</td>
<td>1,328</td>
<td>408</td>
</tr>
<tr>
<td>Children &gt;15 Year Old</td>
<td>41296</td>
<td>404</td>
<td>94</td>
</tr>
<tr>
<td>Number of Relapses</td>
<td>2,113</td>
<td>159</td>
<td>18</td>
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</table>
control strategy shall continue to rely on early case finding and treatment with MDT (WHO SEARO, 2009).

At the beginning of 2006, the global registered prevalence was 219,826 cases and the number of new cases detected in 2005 was 296,499. From the first quarters of the years 2007 to 2011, the global registered prevalence was recorded as 224,717; 212,802; 213,036; 211,903; and 192,246, respectively as shown on Table 2. This show a declining trend in the number of leprosy cases in the world (WHO-WER, 2007-2011).

The new cases detected globally, which indicates the global burden of leprosy has been steadily decreasing as shown in Table 2. From 2006 to 2010, the number of new cases detected every years was 259, 017; 254, 525; 249, 007; 244, 796; and 228, 474, respectively with an average of 3.6% reduction yearly (WHO-WER, 2007-2011). This reduction can be attributed to the successful implementation of the strategy by Leprosy Control Programs around the world.

For years 2011 to 2015, an enhanced strategy has been prepared by the WHO and its partners around the world, emphasizing on sustained provision of high quality patient care and reducing the burden of the disease not only by detecting new cases but also by reducing disabilities, stigma and discrimination and providing social and economic rehabilitation to people affected by leprosy.

THE WESTERN PACIFIC TREND: 2006-2010

The Western Pacific region comprises of 37 countries and territories and has a population of approximately 1.8 billion as of 2010. This represents 26% of the total global population.

By 2010, leprosy was eliminated as a public health burden in 34 countries except for Marshall Islands, Kiribati and Federated State of Micronesia.

Cases from the Philippines and China constitute the majority of new MB cases detected in the region thus greatly influencing the total trend of the region as shown on table 3.

In 2006, the Philippines reported 47.14% of the total new MB cases in the region. In the next years, 2007-2010, the percentage of

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**Table 2. Leprosy Situation by WHO region 2006-2010**

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Registered prevalence at beginning of</th>
<th>New cases detected during</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>29.54</td>
<td>30.05</td>
</tr>
<tr>
<td>Americas</td>
<td>64.71</td>
<td>49.38</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>116.66</td>
<td>120.96</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>9.00</td>
<td>8.15</td>
</tr>
<tr>
<td>Total</td>
<td>224.77</td>
<td>212.80</td>
</tr>
</tbody>
</table>

NOTE: In the Philippines, the prevalence are recorded until the end of December of the inclusive year, while in the Weekly epidemiological record, the figures were recorded at the start of the next year.

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**Table 3. Trends in Detection of Leprosy in Philippines and China**

<table>
<thead>
<tr>
<th>Year</th>
<th>Philippines</th>
<th>China</th>
</tr>
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<tbody>
<tr>
<td>2006</td>
<td>2,517</td>
<td>1,506</td>
</tr>
<tr>
<td>2007</td>
<td>2,514</td>
<td>1,526</td>
</tr>
<tr>
<td>2008</td>
<td>2,373</td>
<td>1,614</td>
</tr>
<tr>
<td>2009</td>
<td>1,795</td>
<td>1,597</td>
</tr>
<tr>
<td>2010</td>
<td>2,041</td>
<td>1,324</td>
</tr>
</tbody>
</table>
new MB cases were 38%, 44.3%, 40.1% and 46.2% respectively. These proportions imply an increase in the magnitude of potential transmission source and risk for complications that can increase the disabilities.

The Philippines continue to record a high number of new cases detected with MB lesions for both adult and children at 93.92%. (WHO-WER, 2011) Though there are modest differences in the Philippine rates and the average Western Pacific Region rates, the percentage of new cases detected with grade 2 disabilities in the Region remain elevated from 2006-2010 with 10.4%, 11.4%, 7%, 14% and 12% respectively..

In 2010, both Philippines and China remain to be the biggest contributor to the number of new cases detected in the region. The Philippines constitute 40.4% while China constitutes 26.2% of the region’s new detected cases. This indicates that active transmission is prevalent and early detection activities/programs continue to be a challenge particularly in the peripheral level.

For the next 5 years, an Enhanced Strategy for Further Reducing the Disease Burden and Sustaining Leprosy Control Activities for 2011 to 2015 were drafted by program managers, WHO and its partners around the world in 2009, emphasizing reduction of the number of cases with grade-2 disabilities. This goal serves as a guide for national programmes in ensuring timely case-finding to impede progression of impairment and disability. Prompt treatment, end of stigma and discrimination together with social and economic rehabilitation of people affected by leprosy was also highlighted.

THE PHILIPPINE TREND: 2006-2010

As one of the countries to pilot MDT in 1982, the Philippines’ elimination program proved to be successful. During the establishment of the National Leprosy Control Program in 1986, the prevalence rate was 7.2 per 10,000 population. To date, the prevalence rate is down to 0.31 due to the nationwide implementation of MDT and the different strategies (eg. Kilatis Kutis Campaign, household/school screening information drive) utilized by the DOH in collaboration with other NGOs.

In 2000, a major change in policy and service delivery in Leprosy Control took place. The services for leprosy were decentralized to the general health care. By virtue Administrative Order No. 2005-0013 dated May 30, 2005, the 8 sanitaria expanded their role by being converted into general hospitals while maintaining custodial care. This is part of the integration efforts of the national government.
Though leprosy has been eliminated as public health burden at the national level, there are still pockets of cases around the country causing the Philippines to remain as the highest in terms of new cases detected in the Western Pacific region for 8 years. Among cases with a high prevalence include Ilocos Sur (Candon City, San Juan, Tagudin), Tarlac (Tarlac City), Nueva Ecija (Lupao), Metro Manila, Cebu (Cebu City), Davao del Sur (Davao City), South Cotabato (General Santos City), Basilan (Lamitan City), and Lanao del Sur (Marawi City), are among the areas with prevalence rate between 1.0 to 1.9 per 10,000 in 2010 (NLCP, 2010)(Figure 2).

Also in the same year, the recorded new case detected in the country was 2,041 (Table 1), still the highest in the whole Western Pacific region. The MB proportion for this was 1,917 or 94 % of all the new cases detected. MB leprosy is considered to be more infectious and thus, is more likely to be responsible for leprosy transmission (ILEP, 2001).

The proportion of new cases detected with grade-2 disability in 2010 was 63 (0.04) (Table 1). In the study by Chan and Honrado (2010), self reported delays seeking treatment range from 0-42 months with a mean of 29 months upon observation of signs of leprosy with 49% of the cases seeking consult only after observation that the signs of their condition has exacerbated. 1 out every 4 cases would only proceed to the health center as a second course of action.

### Table 4: 5-Year Statistical Trend on National Leprosy Control

<table>
<thead>
<tr>
<th>Elimination Indicators</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence (&gt;1 per 10,000 population)</td>
<td>3787</td>
<td>2514</td>
<td>3338</td>
<td>4079</td>
<td>2873</td>
</tr>
<tr>
<td>New Cases Detected (Bench mark 5%)</td>
<td>2517</td>
<td>2279</td>
<td>2373</td>
<td>2669</td>
<td>2041</td>
</tr>
<tr>
<td>New Cases with Grade 2 Deformities (BM 5%)</td>
<td>3.25%</td>
<td>7.7%</td>
<td>1.9%</td>
<td>3.3%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Children below 15 yrs old among new cases (BM 3%)</td>
<td>7.73%</td>
<td>4.37%</td>
<td>4.6%</td>
<td>4.49%</td>
<td>4.6%</td>
</tr>
<tr>
<td>PB/MB proportion among new cases (50:50)</td>
<td>90%</td>
<td>*60%</td>
<td>90%</td>
<td>92%</td>
<td>93.9%</td>
</tr>
</tbody>
</table>

*2007 PB/MB data differ remarkably after a modified LEC was done. (Gecosala, M.; Gajete, F.C.; Voniatis, M., 2007)
For the proportion of women among new cases, 408 (0.20) were recorded in 2010.
A high proportion of children below 15 years old may be a sign of active and recent transmission of the disease (ILEP, 2001). In most programs, the threshold between a high and a low child proportion navigates around 10% (ILEP, 2001). In the Philippines, the number of new cases detected in the children below 15 years old in 2010 was 94 or 4.6%, indicating low child proportion.

According to ILEP, if the number of relapses is higher than 5% of the number of all cases starting treatment, the situation warrants further investigation (ILEP, 2001). The Philippine figures show that relapse cases detected for 2010 was 18 or 0.9%.

**LEPROSY CONTROL ACTIVITIES**

As a response to the hyperendemicity, various areas noted to have high prevalence conducted the following leprosy elimination activities:

In the province of Ilocos Sur, there are sustained surveillance activities, household contacts surveys and “Kilatis Kutis Campaigns.” In Candon City and municipalities of San Juan and Tagudin, the Philippine Leprosy Mission conducted awareness and modified leprosy elimination campaigns.

In Tarlac City, the LGU supported the capability building of health workers thru continuous refresher courses on Patient Assessment and Self Care and Basic Leprosy Control Training.

In Nueva Ecija, there is a functional skin clinic with a skin specialist, a nursing attendant and a medical technologist actively conducting leprosy screening.

In Metro Manila, majority of new cases are detected in the medical centers with dermatology units.

In Cebu City, there is a skin clinic, a sanitarium and a research center. For the past 3 years, Davao Region had been conducting basic orientation in leprosy, self-care and rehabilitation with the assistance of the Southern Philippines Medical Center Dermatology Unit and Skin Clinic.

In SOCCSKSARGEN, basic orientations in leprosy case management among health workers at all levels were given and modified LECs were conducted in partnership with the Cotabato Sanitarium and PLM.

The presence of skin clinics with skin specialists and nursing attendants, sanitaria, medical centers with dermatology sections, continuous refresher courses in basic leprosy and case management together with activities like “Kilatis Kutis Campaigns”, Modified Leprosy Elimination Campaigns; contacts, household and school surveys may have contributed to the high level of cases detected.

High number of new cases continue to be detected in the municipalities of Bordeos and Nakar, Basilan, Lanao del Sur and cities of Lamitan and Marawi despite the geographic disadvantage and conflicts which has limited the mobility of health workers. Leprosy control activities planned and implemented in these areas were geared towards trainings, refresher courses to health workers and Microscopy Training for Medical Technologists.

In the 5 year period of 2006-2010, the program indicators namely case detection and prevalence have been sustained at less than 1 per 10,000 population. Treatment completion rate (TCR) or cure rate for MB is 74.8% which is below the 90% national target whereas PB is 88%, also below the national target of 95%.

Cohort analysis in leprosy was introduced in 2007. This is done by taking the cohort year in 2010 for MB from 2008 and for PB from 2009 (WHO-GLP, 2011). Cohort reporting needs to be clearly understood and practiced by the peripheral health units. (Chan & Honrado, 2010). The gathering, analyzing and collating of data is the task of the Provincial Health Office and City Health Office Leprosy Coordinators. (DOH-NLCP, 2002) However, this task is currently relegated to the CHD leprosy coordinators who is not assured of the validity of the data to be analyzed. (Gajete, F.C., 2012) For better understanding, regional coordinators
should provide mentoring on cohort analysis for health workers prior to the reporting period.

At the subnational level, all regions have achieved the benchmark of 5% Case Detection Rate (CDR) from the previous year as shown on Figure 3.

Sustained leprosy control activities through rapid surveys, passive case finding, active case finding in special situations reinforced by advocacy campaigns, refresher courses in leprosy, presence of sanitaria and medical centers together with the active participation of patient organizations, leprosy-interest groups and professional organizations all contribute to the level of case detection.

**PSYCHO-SOCIO-ECONOMIC BURDEN**

The non-medical burden due to leprosy could be largely attributed to stigma and discrimination leading to unemployment. Patient organizations and leprosy interest groups play a major role especially in the area of advocacy, awareness and community-based rehabilitation (Cunanan A., 2010). Displacement from education and employment play a role in hindering empowerment. Hence the need for public-private partnerships. Effective interaction and commitment between stakeholders (public and private) will result in a harmonized effort to reintegrate persons affected by leprosy to lead a normal life (Gajete F., 2012)

To address the psycho-socioeconomic burden, “An act providing for the Rehabilitation, Self-Development, and Self-Reliance of Disabled Persons and their integration into the mainstream of society and other purposes” came into force in 1991. This law specifically required the DOH to:

1. Institute a national health program for Persons with Disabilities (PWDs);
2. Establish medical rehabilitation centers in provincial hospitals;
3. Adopt an integrated and comprehensive approach to the health development of PWD which shall make essential health services available to them at affordable cost. This act includes persons affected by Leprosy.

Moreover, in 2006, a consensus statement, on the Prevention of Disabilities, was issued, co-sponsored by WHO, ALM and ILEP. This consensus statement is to be incorporated into the National Strategic Framework and Operational Guidelines for the implementation of health programs for PWDs. (Gajete F.C., 2009)

Further, in order to address the stigma and discrimination, the Philippine Declaration was drafted by 33 patients affected by leprosy representing Luzon, Visayas and Mindanao in support of the Global Appeal in 2007 (Figure 4). This Global Appeal continues to be reproduced and disseminated in various CHDs as part of the awareness campaign.

**THE NATIONAL LEPROSY CONTROL PROGRAM**

The program envisions empowered primary stakeholders in leprosy towards a “Leprosy-Free” Philippines with a mission to ensure provision of comprehensive, integrated quality leprosy service at all levels of health care with the active participation of persons affected by leprosy.

The program strategy is in line with the DOH health agenda “Universal Health Care” (UHC) or “Kalusugang Pangkalahatan” (KP) which optimizes six strategic instruments:

1. Service Delivery
2. Governance for Health
3. Policy, Standards and Regulation
4. Health Information System
5. Human Resources for Health
6. Health Financing

Furthermore, it is aligned with the Enhanced Global Strategy of Further Reducing the Disease Burden Due to Leprosy. The strategy has five key elements:

1. Sustaining leprosy control in all endemic countries
2. Strengthen routine and referral service
3. Ensure high quality diagnosis, case management, recording and reporting in all endemic communities
4. Establish Sentinel Surveillance System to monitor drug resistance
5. Develop procedures/ tool that are home/community-based, integrated and locally appropriate for self-care/POD, rehabilitation services.

MILESTONES and ACHIEVEMENTS

2005
- The First National Leprosy Summit was held wherein multi-sectoral leprosy-interest groups pledged support for the implementation of the NLCP. The “Dr. Jose N. Rodriguez Memorial Award” was launched wherein 4 partners were given the award, namely; WHO; Philippine Leprosy Mission, Inc; Culion Foundation, Inc and the Foundation for the Assistance to Hansenites (FAHAN). The media, print and broadcast also participated and since then, has supported the advocacy campaign of the program.
- In a Department Order signed by Secretary Francisco T. Duque in February 2005, the “Dr. Jose N. Rodriguez Memorial Award” was created as a tribute to Dr. Jose N. Rodriguez, a great leprologist considered to be the best among the advocates in the control of leprosy in the Philippines. This acknowledgement shows appreciation, gratitude and positive reinforcement to the awardees for their contribution and their noble achievements to control leprosy in their own localities.
- A Memorandum of Agreement with the Philippine Dermatological Society was forged with the DOH-NLCP to observe every second week of November to be the National Skin Disease Awareness Week. Leprosy screening is conducted in various LGUs in partnership with the local dermatologists.

2006
- The first National Scientific Forum in Leprosy was held. Various studies, papers and researchers by local leprosy experts were presented. Concurrently during this event, 10 outstanding leprosy workers (regional/provincial coordinators, a religious nun, a local chief executive) were awarded the “Dr. Jose N. Rodriguez Memorial Award”.
- A Workshop on the Consensus Statement on the Prevention of Disabilities was held in Cebu City co-sponsored by WHO, the American Leprosy Mission and ILEP was issued. This was incorporated into the National Strategic Framework and Operational Guidelines for the implementation of health programs for Persons with Disabilities wherein persons affected by leprosy with disabilities were included.

2007
- The country hosted the Forum on the Global Appeal 2007 to End the Stigma and Discrimination against People Affected by Leprosy in collaboration with the Sasakawa Memorial Health Foundation. During this time, the Philippine Declaration was drafted by 33 persons affected by leprosy representing Luzon, Visayas and Mindanao presented during the celebration of the World Leprosy Day in January 29, 2007 in support of the Global Appeal 2007 signed by 69 international and local primary stakeholders (Figure 4).
- The Reporting, Recording and Monitoring forms were reviewed and revised according to the standard WHO-GLP–NLCP forms by the regional coordinators, Chiefs of Sanitaria, WPRO and WHO-WR Medical Officers STBL. This was presented to the NCCCL for review and later approved by NLAB.
This was produced and distributed to the peripheral units.

2008

- The Draft of the Parameters and Guidelines in Declaring Leprosy Free Zone was developed by the regional leprosy coordinators, and the NCCCCL. This was approved by the NLAB and submitted to the Health Policy and Standards

2009

- The NLCP, in consultation with WPRO requested assistance in the assessment of the implementation of the program in the field. The last program review was done in 2007. This was undertaken by two senior temporary consultants of NLR-KIT from India and Netherlands in selected areas determined by the program manager. Basis of selection is the pockets of hyperendemic areas, the erratic if not delayed submission of reports; determining best practices vis-a-vis poor performance.

- The Culion Foundation Inc., with the NLCP conducted a Workshop for the Regional Coordinators, representatives from the Sanitaria, PLM and RITM on SWOT Analysis using the Logical Framework approach in formulating the LCP Strategic Plan for 2010-2013 as recommended by the external evaluators.

- The Philippines is the Ninth Member Country for the Sentinel Surveillance Network for Drug Resistance. A protocol on Sentinel Surveillance for Drug Resistance for the Philippines was developed by the Leonard Wood Memorial Research for Leprosy as Collaborating Center and Dr. Thomas Gillis facility as reference laboratory.

- An operational research was proposed and funded by the NLCP for the Research Institute for Tropical Medicine (RITM) to develop a Protocol on Epidemiological Survey in hyperendemic areas and those reporting zero cases. The records review and validation of cases showed overdiagnosis on MB cases if not misdiagnosis as other skin disease; The need for basic orientation in leprosy among barangay health workers and rural health midwives and the lack of awareness of the two-way referral system by those in the peripheral level. While a more efficient drug supply management is needed at the local government units.

- A study done by the University of Santo Tomas (UST) Ophthalmology Department on patients with Multibacillary Leprosy released from MDT showed ocular manifestations among patients at UST, Jose Reyes
Memorial Medical Center and Dr. Jose N. Rodriguez Memorial Hospital. This study won a citation and was presented in an International Ophthalmologic Symposium in Berlin, Germany.

2010

- The Leprosy and Human Dignity - South East Asia Program by The Nippon Foundation included the Philippines to the program from among five countries namely; Indonesia, Cambodia, Vietnam, and Thailand. The Publicizing Workshop was conducted and participated in by representatives from various patients’ organization; hospitals and medical centers and major partners like the PLM, CFI, Sorok UNI, the Commission on Human Rights and the National Council for Persons with Disability. It aims to empower patients affected by leprosy through their organization to actively participate in the development of policies, research protocols and implementation of leprosy control.

- The 1st International Leprosy Convention in Manila with the theme “Strengthening Bridges...Embracing Cultural Diversities” was held. The convention provided updates and emphasized the roles of the leprosy program managers, the persons affected by leprosy and other stakeholders in achieving the Millennium Development Goal for 2011-2016 and to support the Leprosy and Human Dignity Program. It was attended by 14 local and international guests and resource persons, 151 representatives of DOH, CHDs and selected provinces and municipalities from across the country.

- NLCP was included for research studies in leprosy by the Neglected Tropical Diseases Research Group.

THE SIX STRATEGIC THRUSTS OF THE NATIONAL LEPROSY CONTROL PROGRAM

The program shall be reviewed under the six strategic thrusts of the KP/ UHC Program of the Department of Health.

1. GOVERNANCE FOR HEALTH

This strategic instrument aims to establish the mechanisms for efficiency, transparency and accountability and prevent opportunities for fraud.

The lead agency in health is the DOH with regional field offices, now known as Center for Health Development (CHDs). As the national lead agency, DOH is mandated to ensure the delivery of quality health care to all participants in the health system. With the devolution of health services to the Local Government Units (LGUs), the provincial and district hospitals are under the provincial government while the municipal government manages the rural health units (RHUs) and barangay health stations (BHS). In every province, city or municipality, there is a local health board chaired by the chief executive. Its function is mainly to serve as advisory board to the local executive and the ‘sanggunian’ or local legislative council on health related matters. (DOH-NLCP, 2002)

The NLCP activities are integrated into the general health services, within the existing general health care delivery system. Conceptualization and designing program implementation scheme shall be in accordance with standards set at the national level. Training Needs Assessment (TNA) and the conduct of the corresponding training program shall be done by the CHD with technical support from the Sanitarium. Program evaluation from the National Level will be initiated by the NCDPC staff in collaboration with the CHDs thru the support of the LGUs.
Main responsibilities of the various levels of the government as regards the Leprosy Program are as follows:

**National level** - The NLCP Manager is responsible for formulating administration policies and technical guidelines, for effective program implementation, program management and data consolidation and analysis, coordinating with WHO and other international funding agencies, maintaining linkages with GOs, NGOs and other organizations. The NLCP is under the supervision of the National Center for Disease Prevention and Control (NCDPC) of the DOH.

**Regional level** - The Center for Health Development (CHD) designates a Leprosy coordinator. Its main functions are: technical assistance, program management, monitoring and evaluation, capacity building, gathering and analyzing provincial/city and referral center reports, human resource development, and resource mobilization. Also at the provincial and city/municipal levels, there are DOH representatives and Provincial Health Teams (PHTs) assisting in leprosy control activities particularly monitoring effective implementation of the program by the local government units at all levels of health care.

**Provincial level** - The function of Provincial Leprosy Coordinators, are coordination of Program activities, monitoring and supervision, technical assistance, capacity building, gathering and analyzing municipality and city reports and submission of collected data, provision of training and distribution of funding.

**City and Municipal Level** - City and Municipal Health Offices are responsible for coordinating, monitoring and supervision of NLCP activities, including data collection and analysis. The health centers are responsible for the operational aspects of the control program. Responsibilities include: examining of patients, diagnosis, and treatment, treatment of complications. (DOH-NLCP, 2002)

In 1988, the National Leprosy Advisory Board (NLAB) was formed under the Office for Public Health Services to review, recommend policy changes, provide technical supervision, devise and evaluate program goals, plans and strategies as well as collate validated data and reports for approval of the Undersecretary of Health and subsequent dissemination to the public. This is chaired by the Undersecretary for Public Service Delivery of DOH. The advisory body meets twice a year every last Friday of July and November. It includes representatives from the following agencies:

- WHO Country Representative
- WPRO
- National Center for Disease Prevention and Control- Infectious Diseases Office
- Philippine Leprosy Mission
- Leonard-Wood Foundation
- ILEP
- Culion Foundation Inc.
- Philippine Dermatological Society
- Other Leprosy Interest Groups

In July 2001, as per Department Order No. 82-I s. 2001, the National Collaborating Coordinating Committee for Leprosy (NCCCL) was created to support the NCDPC-IDO in the operationalization of policies recommended by NLAB. It ensures that actual operating procedures are consistent with DOH standard embodied in the NLCP Manual of Procedures. Members of committee serve as technical advisers to the NLCP program managers at all levels. This is chaired by the Director for National Center for Disease Prevention and Control and co-chaired by the Director of the Infectious Disease Office. The committee meets twice a year during the months of February and November in order to assess, plan and evaluate points of collaboration and coordination among the regional coordinators, chiefs of sanitaria and patient representatives. (DOH-NLCP, 2002)

For planning and evaluation purposes, national consultative meetings are held twice a year, every last Friday of July and November. Annually, program implementation reviews are done during the last quarter of the year. The review is integrated with other infectious diseases.
ASSESSMENT OF GOVERNANCE FOR HEALTH

STRENGTHS AND OPPORTUNITIES

1. Since the launch of the Health Sector Reform Agenda (HSRA) in 1999 and its implementation framework, the FOURmula One (F1) for Health in 2005, substantial gains in health sector improvements have been achieved in the areas of social health insurance coverage and benefits, execution of DPH budgets and its use to leverage LGU performance, LGU spending in health, systematic health investment planning thru the Province-wide Investment Plan for Health (PIPH)/ Citywide Investment Plan for Health (CIPH)/ Annual Operation Plan (AOP) process, capacities of government health facilities, and the implementation and monitoring of public health programs.

2. The launch of UHC by virtue of Administrative Order no. 2010-0036, can help improve, streamline, and scale up reform interventions espoused in the HSRA and implemented under F1.

3. The recognition that LGUs have the primary mandate to finance and regulate local health systems, including the provision of the right information to families and health providers can lead to ownership of the program and active participation of the LGUs.

4. Financial risk protection thru expansion in the National Health Insurance Program enrolment and benefit assures that the poor are protected from the financial impacts of health care use particularly those with disabilities and needing medical-surgical intervention and rehabilitation.

5. The Administrative Order No. 2005-0013 stating the revised roles of the sanitaria from custodial care facilities to general/ specialized hospitals expands their capacity to provide a wider range of services. The conversion and development plan also enabled the provincial /city/district hospitals to provide services for persons affected by leprosy.

6. The 2002 Manual of Procedures defines the functions of different institutions and specifies the roles/task of health workers from the national, regional, provincial, municipal and barangay officials. It also contains the policies and technical guidelines on the clinical aspects for the diagnosis and treatment of leprosy cases and operational and administrative aspects for the management of the program at all levels of health care.

7. The Provencwide Investment Plan for Health (PIPH), as it includes a Leprosy Control plan, facilitates mobilization and coordination of funding support for leveraging of services.

WEAKNESSES AND THREATS

1. The Manual of Procedures, last revised in 2002, needs to be updated in keeping with the national and global strategy.

2. NLAB and NCCCL must be reconstituted and revitalized.

3. At the national level, the program is integrated with other infectious diseases who shares support staff for other health programs. Hence, staff adequacy remains a concern.

4. Provinces and cities vary in their capacity in implementing the program. Despite designated provincial and city leprosy coordinators, many have to multitask and have other health programs to supervise. Budgetary support, management system, monitoring and evaluation, network among healthcare providers, availability of MDT is not the same across provinces and cities.

5. National and local elections may lead to leadership changes particularly in the LGU. The frequent changes of political leaders, government officials and field
health workers signify need for continuous training in basic leprosy orientation, case management—particularly on prevention of disability-self care and psycho-socio-economic rehabilitation. (Gajete, 2011)

2. **HUMAN RESOURCES FOR HEALTH**

The second strategic instrument, Human Resources for Health, ensures that all Filipinos have access to professional health care providers capable of meeting their health needs at the appropriate level of care.

The estimated number of health service providers are 90,370 physicians or 1 per every 833 people, 480,910 nurses, 43,220 dentists, and 1 hospital bed per every 769 people.

In total, there are 2,274 health centers in the country (1 for each 35-38,000 population). 80% of these provide leprosy services. The barangay health workers (BHW) screen suspect leprosy patients and refer them to the rural health midwife who in turn refers the case to the medical officer. One BHW is available for every 20 households. The BHWs are considered as an important support base for the program particularly as treatment partners.

They supervise intake of MDT and disseminate IEC materials to patients, population groups, families and community. Kilatis Kutis Campaigns (KKCs) are also organized in this level.

**ASSESSMENT OF HUMAN RESOURCES FOR HEALTH**

**STRENGTHS AND OPPORTUNITIES**

1. Eighty percent of the staff has been trained (Arif & Schreuder, 2010). The NLCP has allocated 15% of its budget, roughly 11M pesos, on trainings of the health workers at all levels to render an enhanced quality service to its stakeholders (NLCP, 2011).

2. Extensive capability building activities have been going on at all levels over the years (Arif & Schreuder, 2010). Basic Leprosy Trainings, laboratory trainings, Orientation on Leprosy, Case Management Trainings were given to doctors, nurses, municipal health officers, barangay health workers, DOH Representatives which are implemented every year.

3. Staff are motivated at all levels. (Arif & Schreuder, 2010). This can be reflected on the accomplishments and the effectiveness of the implementation of NLCP per CHD. Commitment is evidenced through signing the Global Appeal to End Stigma and Discrimination among Persons Affected by Leprosy.

4. The Health Human Resource Development Bureau (HHRDB) of the DOH is implementing the Health Human Resource Strategic Plan that addresses general human resource issues such as health staff turnover and skills development.

**THREATS AND WEAKNESSES**

1. Some health workers involved in the diagnosis have not had any leprosy training (Chan & Honrado, 2010). It is noted in their study that 50 physicians diagnosing leprosy have not undergone any training in relation to the disease.

2. Human resource constraints particularly the diminishing number of experts and skills of health personnel (NFSD, 2012). Health worker turnover is rapid.

3. **POLICY, STANDARDS AND REGULATION**

Policy, Standards and Regulation ensures equitable access to health services, essential medicines, and technologies of assured quality, availability and safety.

Leprosy cases are detected via voluntary reporting, surveys and thru the KKC. The Barangay Health Workers and midwives spearhead the campaign. Suspected cases are then brought to the rural health centers for the appropriate diagnosis and management.

Findings have shown that majority of the cases detected are thru the following modes: voluntary/self-reporting at 67%, special projects 7%, referrals 20%, active case finding 4% and contact examination at 2%. Majority of the cases presented themselves voluntarily at the health centers for assessment and physical examination. Self-reported delays in diagnoses ranged from 0-42 months while bulk of the patients (49.3%) merely sought consult upon observation that the signs of the condition have worsened. (Chan & Honrado, 2010).

**MDT AND OTHER SUPPORT DRUGS**

The success of global leprosy control is largely attributed to the efficacy of Multiple Drug Therapy. The coverage of the Multiple Drug Therapy program in the Philippines is almost 100% if not for problems in distribution in some areas and poor drug inventory management at the peripheral level. From 2006-2010, the following drugs have been supplied to the CHDs and hospital: 179,136 MB Adult Blister packs; 12,672 MB Child Blister packs; 12,960 PB Adult Blister packs and 6,048 PB Child Blister packs; and supplied: 14,928 MB Adult full course treatment; 1,056 MB Child full course treatment; 2,160 PB adult full course treatment; and 1,008 PB child full course treatment. The WHO-GLP recommends that the CHD’s should provide at least 10% buffer stock at the LGUs to support treatment completion and avoid cases of defaulters. In addition to this, support drugs such as clofazimine, prednisone oral tablet, vitamin B complex, ferrous sulfate tablets, ketoconazole, azithromycin were also allocated to each of the CHDs and some general hospitals. The 2010 Assessment shows that loose clofazimine is inadequate at all levels. (Arif & Shreuder, 2010) The NLCP receives limited supply of Clofazimine due to “OFF LABEL” use of said drug by other programs.

Skin ointments such as whitfield ointments, betamethasone creams, antibiotic ointments and sulfur ointments were also distributed free of charge as part of the Kilatis Kutis campaign. These ointments were prepared and distributed by Dr. Jose N. Rodriguez Memorial Hospital, Western Visayas Sanitarium and the Mindanao Central Sanitarium.

The program requires a quarterly MDT Drug Inventory Report containing the number of registered patients, number of drugs received and distributed and the remaining balance in the inventory.

To meet the challenge of containing the disease and sustaining its declining trend, the drug sensitivity pattern of MDT but most especially drug resistance in particular, its most potent drug component, Rifampicin, is currently being studied. Surveillance protocol and studies is undertaken by the Leonard Wood Memorial Center for Leprosy Research began in early 2010 recording a total of 5 relapses as of 2010. The study is on-going until 2014. (WHO-WER, 2011)

**ASSESSMENT OF POLICY, STANDARDS AND REGULATION**

**STRENGTHS AND OPPORTUNITIES**

1. “Kilatis Kutis Campaign” strategy enables healthworkers to provide screening of skin conditions from the simplest possible as allergic dermatitis to more complex leprosy. This strategy is able to reach a greater number of recipients without alarming the community. It is also promotes good
health seeking behaviors among the community and also early diagnosis & management of skin conditions.

2. The MDT which is given to leprosy diagnosed patients is free. This being free and available fosters treatment completion.

THREATS AND WEAKNESSES

1. Most of the drugs are deployed to the provincial level such that the supply at the regional level is limited (Chan & Honrado, 2010)

2. Despite availability of MDT in all centers, child drugs appear to be lacking.

3. Appropriate, responsive and effective drug distribution schemes may not be set up due to erroneous reporting (Chan & Honrado, 2010)

4. HEALTH INFORMATION SYSTEM

Health Information System is an instrument to establish a modern information system that shall:

a. Provide evidence for policy and program development

b. Support for immediate and efficient provision of health care and management of province-wide health systems

The major programmatic indicators that capture the Leprosy Control Program performance are the number of cases detected in a given area each year, the registered prevalence and the proportion of patients who complete treatment on time. Indicators used for monitoring case detection include proportion of new cases with grade-2 disability, proportion of cases of children below 15 years of age, proportion of MB among new cases and proportion of women among new cases. Recording and reporting forms which were revised in 2007 are as follows (see Appendix D to L):

1. Form 1- Patient Record Card
2. Form 2- Leprosy Treatment Register
3. Form 3- Quarterly/ Annual Statistical Report
4. Form 4- Transfer/ Referral Form
5. Form 5- Annual Cohort Analysis
6. Form 6- Monitoring Checklist
7. Form 7- MDT Inventory Form

Evaluation shows a considerable number of health facilities do not have file copies of their respective quarterly and annual reports. There are certain regions whose municipalities failed to record critical informations such as sex or the clinical classification. (Chan & Honrado, 2010) Referral sheets are hardly used (Arif & Shreuder, 2010) The standard NLCP recording and reporting forms are currently being modified.

IEC MATERIALS

According to the 2002 Manual of Procedures, conceptualization and development of prototype IEC and advocacy materials shall be the responsibility of the CHDs. Implementation of a comprehensive IEC campaign shall be the responsibility of the NCDPC and Sanitaria in coordination and cooperation with LGU.

In August 2005, the Health Promotion Plan for Leprosy was developed by the National Center for Health Promotion (NCHP). Prototypes for the advocacy materials were developed and pretested in Luzon, Visayas and Mindanao. Responsibilities in the development of these materials were entrusted to the CHDs in partnership with the LGUs and leprosy-interest groups like the Philippine Leprosy Mission.

The 2009 assessment shows that IEC materials are available but updating of these materials prove to be necessary.

In November 2010, the Philippine Leprosy Mission, in coordination with the NLCP and NCHP produced the “Basic Facts for Health Workers: Leprosy” and “Basic Facts for Health Executives: Leprosy”. These were printed in two languages (English and Pilipino) and one dialect (Ilocano). (See Appendix 2) In the same year, 7 out 17 CHDs have disseminated posters of the Philippine Declaration in support of the Global Appeal to end Stigma and Discrimination among
Persons Affected with by Leprosy, while t-shirts, flyers, stickers were developed by the CHDs and the NLCP-MOP and the GLP strategies and operational guidelines were reproduced.

ASSESSMENT FOR HEALTH INFORMATION SYSTEM

STRENGTHS AND OPPORTUNITIES
1. Training and capability building of old and new health care workers on Health Information System is on-going (NLCP, 2012).
2. Consultation is being done with CHD heads and coordinators to create a more effective tool in monitoring leprosy statistics.
3. The standard NLCP recording and reporting forms are currently being modified.
4. Current development and modernization of FHSIS may facilitate more accurate and reliable reports.
5. Updated IEC materials now are available for use in 9 regions with the target of reaching 100% availability to all 17 regions at the end of 2012 (NLCP, 2012).

THREATS AND WEAKNESSES
1. There are doubts about the quality and validity of data submitted to the NLCP (Culion Foundation Incorporated, 2012). File copies of reports are not available in the health facilities (Chan & Honrado, 2010). This makes checking for validity problematic.
2. Chan & Honrado (2010) have identified significant faults in recording statistics of leprosy. New and old cases are recorded together causing difficulty in preparing reports. Case cards and individual patient records are sometimes not available. Recording of classification, critical indicators like age, gender, and the treatment outcome are sometimes not recorded. Number of lesions were not assessed and recorded in IPRs and make cause and over reporting of MB cases.
3. Under reporting of children and female leprosy cases due to negligent recording were also observed. (Chan & Honrado, 2010).
4. Nurses/ midwives responsible in preparing the reports are responsible for writing reports for approximately 24 more different health programs. The myriad of source documents, failure to archive and appropriately file the patient records and the limited time to generate the reports may contribute to the faults in data recording and reporting.

5. HEALTH FINANCING

Health Financing is an instrument to increase resources for health that will be effectively allocated and utilized to improve the financial protection of the poor and the vulnerable sectors.

In 2006, total expenditures on health represented 3.8% of GDP. 67.1% of that came from private expenditures while 32.9% was from government. External resources accounted for 2.9% of the total. (NCSB, 2012)

To date, only 53% of the entire population is covered by the National Health Insurance Program with 42% availment rate and 34% support value or total benefit delivery ratio of 8%. As of October 2010, 892 rural health units and 99 government hospitals have yet to qualify for accreditation by Philhealth. (Aquino Health Agenda, 2010)

The funding support of the national program continues to increase, from Php 270,000 in 2004, Php 2,000,000 in 2006. In 2008, all budgets for health programs considerably increased. By 2010, the NLCP budget went up to Php 73,000,000. The increasing budget has enabled the program to increase its scale and scope. It has allowed for the provision of more capability building and technical assistance, monitoring and evaluation. Moreover, support drugs for management of
leprosy complicated cases were acquired. This increased leveraging of services to the LGUs thru the purchase of support drugs, Kilatis Kutis Campaign ointments for leprosy screening, advocacy programs and health promotion.

For 2011, The NLCP budget has been apportioned in the following category as shown figure 5.

Logistic support for each CHD varies from 1.3 to 1.8 Million. For 2011, the Department of Health sub-allotted Php 1,000,000 for each of the 8 sanitaria, and Php 300,000 for the following DOH hospitals all over the Philippines:
- Dr. Jose Reyes Memorial Medical Center
- Research Institute for Tropical Medicine
- Region I Medical Center
- National Children’s Hospital
- Southern Mindanao Medical Center
- Vicente Sotto Memorial Medical Center
- Bicol Regional Training and Teaching Hospital
- East Avenue Memorial Medical Center
- Batangas Regional Hospital
- Amang Rodriguez Memorial Medical Center
- Mariano Marcos Memorial Hospital & Medical Center

Funds sub-allotted to the Sanitaria and other hospitals as referral units shall be used in for treatment of complicated cases in leprosy, surgical and physical rehabilitation the conduct of activities related to leprosy.

Moreover, various leprosy control efforts are supported by NGO-assisted projects namely: Sasakawa Memorial Health Foundation, Novartis Foundation for Sustainable Development, Culion Foundation Inc and the Philippine Leprosy Mission.

ASSESSMENT OF HEALTH FINANCING

STRENGTHS AND OPPORTUNITIES
1. Funding support of the national government has been increasing thereby increasing its range and capacity.
2. MDT drugs remain free and support drugs continue to be acquired.
3. Leprosy control efforts are assisted by foreign assisted projects such as Sasakawa Memorial Health Foundation thru Philippine Leprosy Mission, American Leprosy Mission thru Leonard Wood Memorial Research Center and Novartis Foundation for Sustainable Development thru WHO (for MDT) as well as various NGOs like Culion Foundation and Philippine Dermatological Society as part of the Public-Private Partnership for capacity building of health workers and empowerment of persons affected by leprosy.
4. Philhealth benefits of patients are thru the sanitaria and government facilities providing leprosy services who are accredited as providers.

THREATS AND WEAKNESSES
1. The absorptive capacity of the local infrastructure to translate allocated funds into realized expenses may be a challenge.
2. Patients still incur out-of-pocket expenses in availing leprosy services such management of complications of
leprosy and other medical/surgical and physical rehabilitation

6. SERVICE DELIVERY

Service Delivery is an instrument to transform the health service delivery structure to address variations in health service utilization and health outcomes across socio-economic variables.

There are several referral centers for Leprosy: 8 sanitaria (Figure 6), 14 medical centers, 11 skin clinics, 2 research centers and 81 hospitals that are mainly provincial.

The Leonard Wood Memorial Research Foundation and the Research Institute for Tropical Medicine serve as the main research centers for leprosy.

In 2005, the revised roles of the sanitaria, were published in Administrative Order # 2005-0013. Except for custodial care or caring for persons affected by leprosy and admitting leprosy patients suffering from reactions, other complications, the sanitaria became general and/or specialized (rehabilitation, dermatology, etc.) hospitals. As a consequence, provincial hospitals were required to provide services for persons affected by leprosy. The sanitaria were mandated to specifically offer their expert services as referral units for management of complicated cases in leprosy.

To date, all sanitaria are undergoing a 5-year conversion and development plan as general hospitals. In February 2006, DOH has issued a position paper on the legislative measures proposing for the conversion of existing sanitaria facilities into their appropriate facility and capability level.

Bicol Sanitarium

Located in Cabusao, Camarines Sur, it is a Philhealth accredited special hospital with a category of level 2 hospital with secondary laboratory services and level 1 x-ray and pharmacy. It has an authorized capacity of 450 beds, implementing 200 beds. It offers medical and surgical services, laboratories, dental services and public health. Its catchment area for general service facility includes Cabusao and
adjoining municipalities and Barangay Mercedes, Camarines Norte. The Sanitaria’s catchment area includes the Bicol Region, Provinces of Rizal and Quezon and Eastern Samar.

**Cotabato Sanitarium**
With an authorized bed capacity of 250, 100 beds for sanitarium services and 10 for general health services, it is categorized as level 1 hospital. The hospital offers emergency, OPD, in-patient treatment, medical-surgical services and other specialized health services. Its catchment area include in Region IX: the Municipality of Pigcawayan, City of Cotabato; and in ARMM: Sultan Kudarat and Sultan Mastura.

**Culion Sanitarium and General Hospital**
Situated in the Island of Culion, Palawan, it was one of the largest leper colonies in the first half of 1900s. Currently, it has an authorized bed capacity of 200 beds, with 150 beds for custodial care and 50 beds for general health services. Services offered include medical-surgical services, OPD and in-patient care, laboratories and other general health services. Its catchment areas include Busuanga, Coron, Culion, Linapacan, Cuyo, Agutaya, Dumaran, El Nido, and Taytay.

**Eversly Child Sanitarium**
Located in Mandaue City, Cebu, it has an authorized bed capacity of 450 implementing 250 beds for sanitarium and 100 beds for general health services. It is Philhealth accredited with 44 beds for Philhealth patients. It is categorized as Level 2 General and Specialized hospital. 48 patients work with gratuity pay. Services include general health services, and services for Hansenites that includes consultation, custodial care, counselling, social welfare and physical rehabilitation. Its catchment areas include Central Visayas: Cebu, Bohol, Negros Oriental and Siquijor.

**Mindanao Central Sanitarium**
The sanitarium is located in Pasobolong, Zamboanga City. It has an authorized bed capacity of 450, implementing 225 beds for sanitarium services and 25 for general health services. It is categorized as secondary general hospital offering in-patient and out-patient services, emergency, dental, rehabilitation services, laboratory, x-ray and pharmacy. Its catchment areas include downtown Zamboanga, Sangali, Tolosa, Victoria, Manicahan, Lanzones, Salaan, Cabaluay, Guisao, Pasobolong, Culianan, Mulu-muluan, Taluksangay, Mercedes, Talabaan, Zambowood.

**Sulu Sanitarium**
With an authorized bed capacity of 120 and an implementing bed capacity of 85, it is categorized as level I Primary Hospital. Services include general medical, pediatrics, obstetrics and gynecology, OPD and in-patient services, physical therapy, laboratory services and emergency services.

**Dr. Jose N. Rodriguez Memorial Hospital**
Situated in Tala, Caloocan, it has an authorized bed capacity of 2000 with an implementing bed capacity of 800 for sanitarium services and 200 for general health services. It has allocated 365 beds for patient with Philhealth Insurance. It is categorized as Level II Secondary Special Hospital. The Sanitarium offers the following clinical services: general/orthopedic surgery, internal medicine, dermatology and leprosy, pathology/ radiology, ophthalmology, obstetrics and gynecology, ear, nose and throat services, pediatrics; emergency and OPD services as well as rehabilitation and training. A DOH position paper released in 2006 recommends that the sanitarium be converted into a level 3 general hospital with special clinics for dermatology and research for leprosy.

**Western Visayas Sanitarium**
Located in Sta. Barbara, Iloilo, the sanitarium has an authorized bed capacity of 300-bed with an implementing bed of 150 for sanitarium
services and 50 beds for general health services. It is categorized as level-2 general hospital with 38 gratuity workers. It offers services for health emergency management, general admission, OPD, leprosy care, maternal and child care, clinical laboratory, x-ray and ECG, medical social service, pharmacy, physical rehabilitation and training and affiliations. Its catchment areas include Iloilo, Aklan, Antique, Capiz, Negros Occidental.

PARTNERS IN SERVICE

The following agencies (Figure 7) have been assisting the National Leprosy Control Program in dealing with leprosy and the problem it cause to people. They assist from screening, diagnosing and treatment of patients to rehabilitation and socio-economic empowerment of people affected by leprosy and their families. (Cunanan, 2011)

As per the 2002 NLCP-Manual of Procedure, support from partner agencies, resources and technical expertise shall be tapped by establishing an active and continuing forum for sharing information and exchange of views regarding the practice of certain professions relative to leprosy. NGOs who wish to participate in NLCP activities are required to seek accreditation at appropriate level, sign a memorandum of agreement with the authorities in the area in which they intend to work with and keep records and submit appropriate reports to NCDPC.

Last January 25, 2012, the Leprosy Stakeholders’ Symposium was organized by the
NLCP and Novartis Foundation for Sustainable Development to help in the collaboration of all these agencies and in filling the gap in services for people affected by leprosy.

NON-GOVERNMENT ORGANIZATIONS

Culion Foundation Incorporated (CFI)

The foundation was established in 1976 to attend to the well-being of Hansenites and their dependents in the Culion colony of Persons Affected by Leprosy as well as those in Palawan. Between the years 1998 to 2000, since then it has extended its helping hand by implementing projects in provinces with high leprosy prevalence rates such as Cebu, Siquijor and Tawi-tawi. (CFI, Inc., 2011) To date, CFI remains an active partner-in-service of the NLCP and its operations has extended to various regions in the Philippines.

Philippine Leprosy Mission (PLM)

The organization began in the early 1920’s as the Philippine Evangelical Leprosy Mission (PELM), a group of missionaries sent to take care of the spiritual and physical needs of Protestant patients in what was then known as the Culion Leper Colony. It is a non-stock, non-profit church-related agency dedicated to the welfare of Persons Affected by Leprosy. Among its activities include case-finding activities with Local Government Units, Department of Education, Department of Health and other volunteer organizations.

Sorok-Uni Foundation, Inc. (SUFI)

In 2002, the SUFI was established as a humanitarian organization working for and with Filipino Hansenites in stopping the stigma against leprosy. Its name inspired by Sorok Island, a leper colony in Korea. The first beneficiary of the foundation was the persons affected by Leprosy in Tala, Caloocan City where the Samaria Mission International Inc. was launched. SUFI helps by providing rehabilitation, Adult Literacy Programs and Livelihood Projects to Persons Affected by Leprosy. Its main center is in San Antonio, Quezon Province. As of today, SUFI maintains 3 shelters in the country namely: Sorok Samaria Village in Dr. Jose N. Rodriguez Memorial Hospital, Sorok Uni Village in Quezon Province and Sorok MCS Village in Mindanao Central Sanitarium. As of today, SUFI maintains 3 shelters in the country namely: Sorok Samaria Village in Dr. Jose N. Rodriguez Memorial Hospital, Sorok Uni Village in Quezon Province and Sorok MCS Village in Mindanao Central Sanitarium (Sorok Uni Foundation, Inc, 2011).

PATIENT ORGANIZATIONS

Empowerment is part of the strategy in rehabilitating persons affected with leprosy and their families. Through organizations which they themselves created and organized, they can assist in their personal development and social rehabilitation. These organizations cater to the PALs in terms of socio-psycho-biological needs.

Association of Culion Hansenites, Inc. (ACHI)

The thrust of this organization is aid the people of Culion Island in enhancing their capability to become self-sustaining and self-governing. Among its projects include swine breeding and dispersal projects, and micro-lending schemes.

Bicol Sanitarium Association of Persons with Disability, Inc. (BSAPWDI)

BSAPWDI was founded in 1996 and was SEC registered in 1998 as an association in pursuit of social-economic and spiritual growth. Among its activities include skills development training, programs for youth and family welfare, health and nutrition, education and disaster relief.

Bukal ng Buhay

Bukal ng Buhay was established in 2009 with the purpose of assisting the former clientele of the Foundation for the Assistance to Hansenites Inc. (FAHAN Inc.). The group is composed of former employees, community workers and clients of FAHAN.
Grupo ng mga Registradong Pasyente ng may Mahusay na Oryentasyon, Inc. (GRUPO)
Committed to unite and strengthen its members thru partnership, behaviour change and community-based rehabilitation; GRUPO offers projects such as job rehabilitation program, skills development training and housing programs with Gawad Kalinga.

Hansen’s Club
The Hansen’s Club is a support group for Persons Affected by Leprosy put together by the Section of Dermatology and the Medical Social Services and Nutrition Division of UPPGH. It aims to serve as a venue for patients to socialize and interact with people who share the similar experience and for them to obtain a higher level of awareness regarding the various aspects of their disease.

Star Dolls Cooperative
Starting with just 5 workers, its operations has since grown into 127 workers creating handcrafted dolls, crocheted animals, throw pillows and the like as part of a livelihood program for the underprivileged residents of Tala, majority of whom are relatives of Persons Affected by Leprosy.

Holy Family Association of Women for Economic Development, Inc. (HFAWED, Inc.)
Established in 1988, it was initially referred to as Jagobiao Christian Parents Association, Inc. or JCPAi. The organization is a charitable, non-stock, non-profit organization dedicated to serve the needs of the disadvantaged members of the community of Baranggay Jagobiao and its adjacent area, regardless of sex, age, creed and nationality.

Cooperative for Better Living (CBL)
Officially registered at the Cooperative Development Authority on May 2006, CBL has since implemented projects with a focus on livelihood programs, community development/service, capability building and spiritual enrichment of Persons Affected by Leprosy.

Negative Barrio Welfare Association, Inc.
In the 1930’s, many Persons with Leprosy (PWL) settled in the Cebu. After the World War II and the success of the Dapsone medicine, the community became bigger and was eventually declared by health authorities as a negative village. Those declared negative of Hansen’s disease from the Eversly Childs Sanitarium were sent to the Negative Village. To date, it has an Early Child Care Development Center in partnership with the American Leprosy Mission and Philippine Leprosy Mission.

Bagong Pag-asa Cooperative (BPC)
BPS is an organization of Persons Affected by Leprosy who were former patients of the Cotabato Sanitarium. On April 2000, BPS was officially registered at the Cooperative Development Authority (CDA). Together with PLM, BPC has active operations such as hog-raising, cattle-raising, fruit-nearing seedlings loan and educational assistance. It is recognized as a Good Standing cooperative in the entire province.

Cotabato Sanitarium Hansenites Multi-Purpose Cooperative (CSHMPC)
Located within the compound of the Cotabato Sanitarium, its membership is composed of Persons Affected by Leprosy who are under custodial care of the sanitaria and those living within the peripheral communities. To date, it has a membership of 44. It initially began as a Hansenites Club. It is now actively operating as an independent group.

Interactive Society Leprosy Association of Muslim (ISLAM)
Established in October 2007, ISLAM boasts of 43 active members coming from various tribes such as Tausugs, Yakans, Badjaos and Samas. Among the projects of the association include educational assistance, a social credit system, a water system project, sanitation projects and housing loans.

Persons Affected by Leprosy Organization in Mindanao Area, Inc. (PALOMA)
Organized in coordination with the Philippine Leprosy Mission, PALOMA was duly registered with the SEC on July 2000. It has 42 members consisting of Persons Affected by Leprosy and persons with leprosy who reside at the Mindanao Central Sanitarium compound. It aims to promote the economic welfare of its members thru income generating projects and activities.

**Sulu Women’s Negative Hansenites Cooperative, Inc.**

SEC registered last July 2004, its membership consists of persons with leprosy and persons affected by leprosy residing within the Sulu Sanitarium compound. It has 17 active members, all of them declared free from leprosy although some suffer severe deformities secondary to the disease. Present projects include retail stores, educational assistance under the support of PLM.

**Sulu Pedicab Drivers Cooperative, Inc.**

The cooperative started on March 2001 with 54 members. To date, it has 17 active members who primarily engage in pedicab driving. These members are former in-patients of the sanitarium.

These organizations shall be part of a patient coalition as part of the thrust of the NLCP to pursue public-private partnership in order to empower them as active participants in the conduct of the leprosy control program.

**ASSESSMENT OF SERVICE DELIVERY**

**STRENGTHS AND OPPORTUNITIES**

1. With the revised roles of the 8 Sanitaria, more services are available to patients and their families.
2. Administrative Order No. 5 s. 2000 states that medical centers, regional, provincial and district hospitals must integrate leprosy services. Of the total 43,279 LGUs, 70% of the facilities are able to provide services for leprosy with the target of reaching 100% by 2016. (NLCP, 2012).
3. The presence of the various leprosy interest groups and organizations shows a strong sense of “community ownership” among patients affected by leprosy.
4. Patient organizations and interest groups can help disseminate information, identify leprosy patients thus facilitating early detection and timely treatment.
5. Stigma and discrimination can also be addressed thru the efforts of the patient groups and organizations.

**THREATS AND WEAKNESSES**

1. Strategic approaches are not fully adjusted to changes in leprosy situation and health system realities (NFSD, 2012).
2. Most health care providers are located in the urban centers. Population to health care provider ratio is high in areas such as ARMM and geographically isolated and depressed areas (GIDA).

**ISSUES AND CHALLENGES**

**National**

- There are still pockets of new cases detected in some municipalities in the 16 regions of the country including ARMM. 
- Sustainability of NLCP activities at the peripheral level with corresponding ownership of the program by the LGUs
- Difficulty in accomplishing patient’s record particularly on Eye, Hand and Feet Scoring (EHFS) and Nerve Function Assessments
- Consistency and timeliness of statistical data with FHSIS, 
- Monitoring and Evaluation: Use of the NLCP Monitoring Checklist by the program coordinators at the
regional and provincial level with corresponding feedback mechanism;
- Monthly clinical progress/assessment/plan recorded in the patients record by LGU physician
- Need for more leprosy experts to conduct program review and assessment, statistical data and research analysis
- Harmonized policies, guidelines, plans and programs among primary stakeholders, major partners and other stakeholders (GOs/NGOs with regards to social and economic well-being of persons affected with leprosy.

Regional/ CHD Level
- Multiple roles of regional coordinators appear to be counterproductive in implementing the health programs.
- Supervision and monitoring in several provinces and municipalities is difficult if not impossible due to geographically isolated and disadvantaged conflict areas
- Difficulties in data management (NLCP forms, cohort analysis, records keeping/ tracking from the primary level to the central office)
- Coordination between the CHDs and the LGUs remain a concern particularly on the prioritization of different programs.
- Monitoring at the provincial and municipal/rural level not done due to unavailable if not incomplete reporting/recording/ monitoring forms in some CHDs.

Peripheral Level
- Implementation of tasks definitions of health workers (MOP 2002)
- Functional Health Boards to promulgate resolutions in relation to new DOH-NLCP policies and guidelines
- Conduct /recording of post treatment evaluation and subsequent plan of action
- Health education/counselling for treatment compliance/defaults, self care and POD
- Supervision and monitoring of leprosy program activities in their catchment areas from bottom to top level.
- Transportation, supply and storage issues of MDT drugs remain a challenge.
- Incomplete recording and unreliable reports on statistical data of leprosy. Children and women are underreported if not unreported at all (Chan & Honrado, 2010).
- Most disabilities are neither assessed nor recorded in the IPR. (Chan & Honrado, 2010) leading to difficulty in managing the complications.
- Over diagnosis of MB cases or under diagnosis of PB cases were identified as a result of Chan and Honrado (2010) and a tendency to over classify the disease (Arif & Schreuder, 2010).
- Cohort analysis is not understood and not practiced (Arif & Schreuder, 2010). Cohort analysis is an essential indicator of treatment outcome. That is, the number of cases who successfully finished MDT treatment.
- There is a need for an effective and efficient referral system (NLCP 2012)
- Knowledge and attitudes of health workers and communities relative to stigma and discrimination remain a concern. (NFSD, 2012).
- Strengthening of partnership between LGUs and major stakeholders. (Gajete, NLCP 2006)

RECOMMENDATIONS FOR FUTURE DIRECTIONS

National Level
- Reconstitute the National Leprosy Advisory Board (NLAB) and the National
Collaborating Coordinating Committee in Leprosy (NCCCL)

- Develop Strategic Plans and objectives aligned with the National Objectives for Health (NOH), WHO-GLP and MDG 6 with specific targets
- Research Grants: epidemiological and operational studies in leprosy specifically, research on stigma, discrimination and health seeking behaviors.
- Regular Program Review by external evaluators every 3 years; yearly among peers based on the Work and Financial Plan (WFP)
- Provision of technical assistance on data processing and analysis
- Install computerized reporting system integrated with the other health programs in coordination with FHSIS
- Policies on establishing referral units in every region/province/cities/district/municipalities
- Regular updating of roster of leprosy experts and trainers for capability building of health workers at all level particularly on monitoring and program evaluation
- Cleaning of data – validation of records and validation of cases
- Target mapping and find sources of budget.

Regional level

- Organize LEC and LEM applicable in their localities
- Develop policies on a two-way referral system
- Establish referral units with mandates to manage complications in leprosy; reconstructive surgery and physical rehabilitation in their catchment areas
- Regular conduct of supervision and evaluation on drug management and cohort analysis
- Establish areas where intensified, sustained and cluster approaches are applicable for equitable access to logistic resources and leveraging of services in coordination with NLCP for fund support

Referral Level

- Policies and Guidelines as referral units
- Establish facilities for reconstructive surgery, rehabilitation services, footwear and other implements
- Provide and maintain roster of trainers in basic orientation in leprosy, management of neuritis leprosy reactions, complicated cases in leprosy and laboratory microscopy on Slit Skin Smear (SSS) and nerve biopsy.

Peripheral level

- Integration of leprosy service into the general care and school curricula
- Refresher courses in basic leprosy, case management of leprosy reactions, neuritis, POD, self care, counseling, health education and social mobilization
- Quarterly conduct of monitoring of drug management, review and analysis of records
- Partnership with patient organizations and stakeholders from the government and non government organization for the psycho-socio-economic rehabilitation of persons affected by leprosy and advocacy awareness campaigns
- Maintain a roster of patients who completed treatment for household contact surveys, particularly those with Grade 2 disability
- Conduct an operational and/or health system research.
REFERENCES:


http://www.who.int/lep/en


APPENDIX
# GLOBAL STRATEGY FOR FURTHER REDUCING THE LEPROSY BURDEN AND SUSTAINING LEPROSY CONTROL ACTIVITIES

## WESTERN PACIFIC REGION

### APPENDIX A

<table>
<thead>
<tr>
<th>COUNTRY:</th>
<th>YEAR:</th>
<th>POPULATION</th>
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<tbody>
<tr>
<td>Philippines</td>
<td>2010</td>
<td>94,013,200</td>
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<table>
<thead>
<tr>
<th>NEW CASES DETECTED DURING THE YEAR</th>
<th>CASES REGISTERED AT THE END OF YEAR</th>
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<tbody>
<tr>
<td>MB</td>
<td>PB</td>
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<tr>
<td>1917</td>
<td>124</td>
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<table>
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<tr>
<th>NEW CASES DETECTED DURING THE YEAR</th>
<th>NUMBER OF RELAPSES</th>
<th>TREATMENT COMPLETION (CURE RATE)</th>
<th>COHORT YEAR</th>
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<tbody>
<tr>
<td>FEMALE</td>
<td>CHILDREN UNDER 15 YEARS OF AGE</td>
<td>WITH GRADE 2 DISABILITY</td>
<td>MB</td>
</tr>
<tr>
<td>408</td>
<td>94</td>
<td>86</td>
<td><strong>18</strong> for validation with Leonard Wood Memorial Research</td>
</tr>
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### INTEGRATION

<table>
<thead>
<tr>
<th>Proportion of general health facilities providing Leprosy Services</th>
<th>Number of Referral Centers***</th>
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<tbody>
<tr>
<td>Local Government Units (Health centers) - 100%</td>
<td>Sanitaria – 8</td>
</tr>
<tr>
<td>Government Hospitals - 80%</td>
<td>Regional Hospitals –17</td>
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<tr>
<td>Medical Centers – 14</td>
<td>Prov/City – 60</td>
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<tr>
<td>Private Partner Hospitals – 20</td>
<td></td>
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</tbody>
</table>

*Only for countries collecting single lesion PB data  
**Health facilities as defined by the national authority  
***Whether at Intermediate or central level functioning as integrated referral center for validation of leprosy diagnosis and management of leprosy complications
FLOw OF REPORTING

NCDPC- NLCP

Center for Health Development

Provincial Health Officer/ City Health Officer

Rural Health Unit

Baranggay Health Unit

Sanitaria

Skin Clinic

DOH Representative
Organizational Framework

- DOH
- NLAB
- NCCCL
- NCDPC
- IDO
- CHDs
- Sanitaria/Hospitals
  - Skin Clinic
- CHO
- PHO
- BHW
- MHO
<table>
<thead>
<tr>
<th>Name</th>
<th>Age/Fit</th>
<th>Address</th>
<th>Identification</th>
<th>Type of Person</th>
<th>MDT Drug Distribution</th>
<th>Reaction</th>
<th>Treatment Outcome</th>
<th>MDT Grading</th>
<th>MRF Scoring</th>
<th>Remarks</th>
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### NATIONAL LEPROSY CONTROL PROGRAM

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**QUARTERLY/ANNUAL REPORT CY **

**CHD**

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**APPENDIX E Form 3**

<table>
<thead>
<tr>
<th>Protocol/ City/ Municipality</th>
<th>Patients</th>
<th>Reg'd Date</th>
<th>Beginning Qtr</th>
<th>NEW CASES</th>
<th>WITH PREVIOUS TREATMENT</th>
<th>Treatment Compliance</th>
<th>MOVEMENT of PATIENTS</th>
<th>Mortality</th>
<th>Cost of treating cases as a percentage of the total amount spent</th>
<th>Cases at the End of the Period</th>
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</tbody>
</table>

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Proposed/Submitted:

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<table>
<thead>
<tr>
<th>Province/ City/ Mun.</th>
<th>Total # of New Registered Cases</th>
<th>Type</th>
<th>Year</th>
<th># of Patients Cured</th>
<th>Cure Rate</th>
<th># of Patients Defaulted</th>
<th>Default Rate</th>
<th># of Patients Transferred Out</th>
<th>Transferred Out Rate</th>
<th># of Patients Died</th>
<th>Death Rate</th>
<th>Total # of Patients Evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td>PB</td>
<td></td>
<td></td>
<td>2008</td>
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<td>MB</td>
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<td>2007</td>
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</table>

*MB (Registered: 25 - 36 months earlier)*
*PB (Registered: 13 - 24 months earlier)*
# Quarter/Annual Report

## MDT Drug Inventory Report

### As of ____________

**Name of Facility:** __________________________

**Reported by:** __________________________

**Date Reported:** __________________________

<table>
<thead>
<tr>
<th>No. of Registered Patients</th>
<th>Drugs</th>
<th>Beginning Balance</th>
<th>Received</th>
<th>Distributed</th>
<th>Remaining Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Date</td>
<td>No. of Drugs</td>
<td>Exp. Date</td>
<td>Date</td>
</tr>
<tr>
<td>MB Adult</td>
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<tr>
<td>PB Adult</td>
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<tr>
<td>MB Child</td>
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<tr>
<td>PB Child</td>
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<tr>
<td>Others</td>
<td></td>
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<tr>
<td>Leprosy Support Drugs</td>
<td></td>
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<tr>
<td>Clofazimine</td>
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<tr>
<td>Prednisone</td>
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<tr>
<td>Vitamin B</td>
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<tr>
<td>Ferrous Sulfate</td>
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<tr>
<td>Skin Ointments</td>
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<td>SO</td>
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<td>IEC Materials</td>
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<td>Ipecac</td>
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<tr>
<td>Tarpadine</td>
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<tr>
<td>Others</td>
<td></td>
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</tbody>
</table>
## APPENDIX H FORM 6 MONITORING CHECKLIST

### EPIDEMIOLOGICAL INDICATOR

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number</th>
<th>YES</th>
<th>NO</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Absolute no. of new cases detected thru:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Self-reporting</td>
<td></td>
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<td></td>
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<tr>
<td>b. Household contact exam</td>
<td></td>
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<tr>
<td>c. Special projects</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>d. Referral</td>
<td></td>
<td></td>
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<tr>
<td>2. Characteristics:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. No. of MB</td>
<td></td>
<td></td>
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<tr>
<td>b. Children &lt; 15 yrs. Old</td>
<td></td>
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<tr>
<td>c. With grade 2 disabilities</td>
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<tr>
<td>d. No. of female cases</td>
<td></td>
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<tr>
<td>3. No. of Registered Cases</td>
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<tr>
<td>a. No. of MB</td>
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<tr>
<td>b. No. of PB</td>
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<tr>
<td>c. With grade 2 disabilities</td>
<td></td>
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</tbody>
</table>

### PATIENT CARE INDICATOR

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number</th>
<th>YES</th>
<th>NO</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No. of patients completed treatment on time</td>
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<tr>
<td>2. No. of patients defaulting</td>
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<tr>
<td>3. No. of patients receiving extended treatment</td>
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<tr>
<td>4. No. of patients with reactions</td>
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<tr>
<td>5. No. of patients with reaction managed</td>
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<tr>
<td>6. No. of relapse cases</td>
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<tr>
<td>7. No. of patients from Grade 0/Grade 1/2</td>
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<tr>
<td>8. No. of patients receiving rehabilitative care</td>
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<tr>
<td>9. No. of patients referred</td>
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</tbody>
</table>

### PROGRAM INDICATOR

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number</th>
<th>YES</th>
<th>NO</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No. of cases correctly diagnosed and classified</td>
<td></td>
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<tr>
<td>2. No. of drugs received and utilized</td>
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<tr>
<td>MB - Adult</td>
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<tr>
<td>MB - Child</td>
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<tr>
<td>PB - Adult</td>
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<tr>
<td>PB - Child</td>
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<tr>
<td>3. No. of trained health staff</td>
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<tr>
<td>Identify staff trained</td>
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<tr>
<td>4. Record/report</td>
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<tr>
<td>a. Properly and completely filled up</td>
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<tr>
<td>b. Timely submission</td>
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<tr>
<td>c. Accuracy of submitted report</td>
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<tr>
<td>5. Availability of IEC materials</td>
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<tr>
<td>a. Poster</td>
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<td>b. Leaflet</td>
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<tr>
<td>c. Flip Chart</td>
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<tr>
<td>d. AVP</td>
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<tr>
<td>6. Conduct of Health Promotion activities</td>
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<tr>
<td>Identify documented activities</td>
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<tr>
<td>7. Presence of existing referral facilities</td>
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<tr>
<td>If yes, how many</td>
<td></td>
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<tr>
<td>8. Support of LGU and other stakeholders</td>
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<tr>
<td>State the support given.</td>
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</table>
APPENDIX I NLCP FORM 4 MDT IMPLEMENTATION REFERRAL/TRANSFER FORM

MDT IMPLEMENTATION
REFERRAL/TRANSFER FORMS

TO
Address
Date

Re: Name of Patient
Address
MDT Date Started

Purpose

Date Referred

MDT Class
PB
MB

Date Transferred

Referred by:

Name and Signature

Important
Please fill up the ACKNOWLEDGEMENT FORM below and send back to referring/ transferring agency/clinic immediately.

Designation

ACKNOWLEDGEMENT FORM

Date

FROM

Re: Name of Patient
Address
Action Taken

Date Patient Attended
Date Patient Registered in the new Clinic

Attended by:

Name and Signature

Designation

Instructions

Referrals should be sent on this form. If there are no printed forms, written referrals on bond or ruled papers should at least follow this format. Patient number refers to the number assigned to the patient in the Central Registration Form of the referring unit.
# Central Registration Form

<table>
<thead>
<tr>
<th>No</th>
<th>NAME</th>
<th>AGE</th>
<th>SEX</th>
<th>ADDRESS</th>
<th>Patient Status</th>
<th>WHO Disability Grading</th>
<th>MDT</th>
<th>Date MDT</th>
<th>Movement of Patient</th>
<th>Date MDT Completed</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td>Old New</td>
<td>PB MB</td>
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<td>T/O T/I Died Lost</td>
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**Instructions:**

The CRF is a permanent record form which should contain the names and relevant data about each patient. Names of diagnosed patients are listed in the chronological order of time when they were first diagnosed. Numbers assigned to them are their permanent ID numbers when they are given treatment (RHU, BHS). Each unit will have a permanent numbering system from number 1 to whatever number it takes through the years. The Provincial Leprosy Coordinator, therefore, will have a list with as many numbers 1 and so on as there are units under her. This will ensure continuity of numbering in each unit and facilitate checking by coordinators. NUMBERS IN THE DRUG COLLECTION CHART SHOULD BE THE SAME AS THE NUMBER IN THE CRF.

*Old – Patients who had leprosy treatment before MDT*

*New – Patients who have never been treated before being registered*
APPENDIX K NLCP FORM 1 PATIENT RECORD CARD

**Body Charting**

Legend:
(Write only the letter on the affected area)

A – well defined patch
B – plaque
C – tender nerve
D – ill defined patch
E – nodules

**EHF Score**

<table>
<thead>
<tr>
<th>EYES</th>
<th>HANDS</th>
<th>FEET</th>
<th>TOTAL</th>
<th>WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEFT</td>
<td>RIGHT</td>
<td>LEFT</td>
<td>RIGHT</td>
<td>RIGHT</td>
</tr>
<tr>
<td>0</td>
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<td>0</td>
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<tr>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**Sensory Testing:**

/ - if with sensation
x - if without sensation

**Nerve Function Assessment**

**Voluntary Muscle Testing:**

S – Strong
W – Weak
P – Paralyzed

<table>
<thead>
<tr>
<th>UPON DX</th>
<th>UPON TC</th>
</tr>
</thead>
<tbody>
<tr>
<td>RIGHT</td>
<td>LEFT</td>
</tr>
<tr>
<td>Tight Eye Closure</td>
<td>Little Finger Out</td>
</tr>
<tr>
<td>Thumb Up</td>
<td>Wrist Up</td>
</tr>
</tbody>
</table>