Review of the National Leprosy Control Programme (NLCP) of the Philippines for the years 2005-2009
Report of a visit, 26th January - 8th February 2010

Development Policy & Practice
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March 1, 2010
Executive summary

In the year 2000, to meet the needs and human rights of persons affected by Leprosy, a radical change, in Leprosy control policy, was introduced. The National Leprosy Control Program (NLCP) of the Philippines moved from a vertical and centralized program to an integrated and decentralized one. With the introduction of WHO “Enhanced Global Strategy for further Reducing the Disease Burden due to Leprosy” for the plan period 2011 – 2015, the question was raised, by the Department of Health (DOH) and the WPRO, where the NLCP of Philippines stands, and where the NLCP should be heading in the coming years. The Royal Tropical Institute Amsterdam (KIT) was requested by WHO, to organize a review mission of the present program with recommendations for a new strategic national plan. Dr. Mohammad A. Arif and Dr. Pieter AM Schreuder visited the Philippines to conduct this mission from 26th of January till the 8th of February 2010. Field visits were made to randomly selected health offices, health centers, provincial & referral hospitals, sanitaria, of Ilocos Sur, Cebu and Central Luzon provinces and regions. Patients were re-examined by the team, records and reports were reviewed. The team came out with the following findings, conclusions & recommendations:

The program is well conducted and infrastructure is in place with motivated staff at all levels. Recording and reporting is complex. Completion rates are reported, but cohort analysis is ill understood. As disability recording, at start of treatment, is incomplete and not reliable, no information exists about delay in detection. Monitoring is in place but is mostly related to collection of information, but no analyses and improvement in quality of recording and reporting is done. The concept of supervision is missing. Though few centers are handling complicated cases, referral is in practice but the system is not established (no chain of referrals and feedback). MDT supply is maintained. Of most concern (and concerning all levels of the health service) and the most important from the human point of view, is the identification and management of reactions/neuritis, and POD. Leprosy may not be seen as a public health problem anymore, but it is still a serious human problem in the Philippines.
Recommendations for the Philippines Leprosy Control Program

1. It seems essential that the NLCP formulates a national strategic plan for the coming 3 – 6 years with clearly defined objectives, outputs and activities, measurable indicators and realistic targets, starting with a situational analysis, which will form a basis for identifying results to be achieved. It is recommended to use a logical framework approach.

2. The programme needs strengthening in its planning and supervision capabilities at national, regional and provincial levels through a series of training workshops (result-based management workshops) with emphasis on ‘on-the-job’ training.

3. The Leprosy programme needs improved capabilities to monitor and evaluate programme performance. It includes standardized and effective recording and reporting, using ICT technology, as much as feasible. It would also entail improved data processing, analysis at several programme levels, feedback to lower echelons and use of information for performance enhancement, including the capability to analyze individual patient data at national level.

4. The national level needs serious strengthening in view of data processing and analysis, revitalizing POD component and rehabilitation services, and developing new approaches.

5. Strengthening of the referral system is needed: specialist services should be accessible to all eligible patients. Effective counter referral strategies would ensure patient care close to home.

6. A group of facilitators to be identified and trained in training and communication skills. At the same time, at least three (North, Central and South) centers should be identified & strengthened, where routine trainings could be conducted.

7. To measure the quality of services, WHO-recommended indicators are advised. Grade 2 disabilities among new cases, as the main WHO indicator, is strongly recommended. This implies the development and maintenance of a strong supervisory system, to ensure that peripheral staff performs systematic, valid and complete patient assessments.

8. It is proposed to organize selected LECs like in 2007, to estimate the size of the Leprosy problem and its trend. Other tools should be used, like sentinel centers, which are known to provide reliable data, for changes overtime. Standardized and randomly applied monitoring visits, like LEM, to evaluate the performance of the program should be introduced.

9. There is a need to revitalize the prevention of disabilities component and related rehabilitation services. It should lead to improved case management for reactions and neuritis, and management of already existing disabilities. Referral centers are to be defined and equipped with all necessary facilities, for the management of complicated cases including self-care and exercises, with trained nurses in these aspects. Secondary and tertiary referral centers should be centers of excellence. At first instance, no patient should be allowed to develop new and/or
additional disabilities, while on and/or after release from treatment. Only when this stage is reached, centers should be identified for reconstructive surgery. EHF scoring to be introduced to measure the performance of the prevention of disability program.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ALM</td>
<td>American Leprosy Mission</td>
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<tr>
<td>BL</td>
<td>Borderline leprosy</td>
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<td>BHW</td>
<td>Barangay Health Worker</td>
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<tr>
<td>CBR</td>
<td>Community Based Rehabilitation</td>
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<tr>
<td>CDR</td>
<td>Crude Case-detection Rate</td>
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<td>ChD</td>
<td>Centers for Health Development, Regional Offices DOH</td>
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<td>DOH</td>
<td>Department of Health of the Philippines</td>
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<td>ENL</td>
<td>Erythema Nodosum Leprosum</td>
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<tr>
<td>GHS</td>
<td>General Health Services</td>
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<tr>
<td>GIS</td>
<td>Geographic Information System</td>
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<td>HIS</td>
<td>Health Information System</td>
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<tr>
<td>HSR</td>
<td>Health Systems Research</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>ILEP</td>
<td>International Federation of Anti-Leprosy Associations</td>
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<tr>
<td>LL</td>
<td>Lepromatous leprosy</td>
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<tr>
<td>LEC</td>
<td>Leprosy Elimination Campaign</td>
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<tr>
<td>LEM</td>
<td>Leprosy Elimination Monitoring</td>
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<tr>
<td>MOP</td>
<td>Manual of Procedures</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>M.O.</td>
<td>Medical Officer</td>
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<td>MB</td>
<td>Multibacillary</td>
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<td>MDT</td>
<td>Multi-drug Therapy</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>MPWs</td>
<td>Multi Purpose Workers</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NLCP</td>
<td>National Leprosy Control Programme</td>
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<tr>
<td>PB</td>
<td>Paucibacillary</td>
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<tr>
<td>PHO</td>
<td>Provincial Health Office</td>
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<tr>
<td>PHN</td>
<td>Public Health Nurse</td>
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<tr>
<td>PLM</td>
<td>Philippines Leprosy Mission</td>
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<tr>
<td>POD</td>
<td>Prevention of Disabilities</td>
</tr>
<tr>
<td>PR</td>
<td>Prevalence Rate</td>
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<tr>
<td>RFT</td>
<td>Release from (MDT) Treatment</td>
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<tr>
<td>RR</td>
<td>Reversal Reaction</td>
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<tr>
<td>ST/VMT</td>
<td>Sensory Testing/Voluntary Muscle Testing</td>
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<tr>
<td>TT</td>
<td>Tuberculoid leprosy</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TOR</td>
<td>Terms of Reference</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WPRO</td>
<td>Western Pacific Regional Office of WHO</td>
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<td>WR</td>
<td>Country Representative WHO</td>
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1 Introduction

1.1 Background

In the year 2000, to meet the needs and human rights of persons affected by Leprosy, a radical change in Leprosy control policy was introduced. The National Leprosy Control Program (NLCP) of the Philippines moved from a vertical and centralized program to an integrated and decentralized approach and the mission statement of the NLCP Philippines became: "To ensure the provision of a comprehensive, integrated quality leprosy services at all levels of health care". In the past 10 years, many efforts were made, especially to strengthen the basic health and referral services and to increase the awareness of general population about signs & symptoms of Leprosy, it's curability & availability of free MDT.

The operational guidelines and strategies 2005 – 2006, 2007 - 2008 and current NLCP strategy, 2009 – 2011 are anchored within the National objectives for Health 2005-2010 with four pillars of the Disease-Free Initiatives of Governance, Quality Service Delivery, Regulation and Health Financing. Goals, objectives and targets are set as a guide for the Regional/Provincial/City/Municipal levels, to help them in formulating their own health plans.

The NLCP is evaluated through the Annual Program Implementation Reviews. National Consultative meetings are held bi-annually. The 17 Regions present their accomplishments to the members of the National Collaboration Coordinating Committee for Leprosy (NCCCL). All issues including WHO reports will then be presented to the National Leprosy Advisory Board (NLAB), the policy making body of NLCP (annex 1).

The Department of Health (DOH) & NLCP together with WHO Western Pacific Regional Office (WPRO), partners and stakeholders set the road map for the NLCP, based on the WHO “Global Strategy for Further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities 2006 – 2010”, with particular attention to epidemiological data collection and operational research e.g. Prevention and treatment of complications in Leprosy at referral and peripheral units. Recently, the WHO announced for the plan period 2011 – 2015: “Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy”. The question was raised by the DOH and the WPRO, where the NLCP of Philippines was standing presently and in view of the Enhanced Global Strategy 2011 – 2015, where the NLCP should be heading. The Royal Tropical Institute Amsterdam was requested to organize a review mission of the present program with recommendations for a new strategic National plan.
1.2 Terms of Reference for the Review

1. To assess the performance of the National Leprosy Program in the last five-year period, jointly with the NLCP and the WPRO Leprosy Department.

2. To compare the implemented policies with the WHO recommended Leprosy Global Strategy 2006 - 2010 and draw conclusions from the comparison.

3. To provide recommendations to enhance the NLP performance in the coming five years, taking into consideration the recommended WHO Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy 2010 - 2015, adapting this Strategy to local circumstances and possibilities.

4. To hold a debriefing session at the Ministry of Health, on the basis of a Draft Evaluation Report, to the relevant government authorities, before departure from the Philippines.

5. To produce a final Evaluation Report, containing an Executive Summary of 1-2 pages and with a main text not exceeding 30 pages, single-spaced lines, excluding annexes, within four weeks after the debriefing session.

1.3 Review Procedure

Review of documents of NLCP, WHO and other relevant sources;
- Review Leprosy statistics, registers, records and patient cards (including POD forms), MDT supply, training manuals, manual of procedures, management and also of supervision procedures;
- Discussions with the NLCP Manager, the senior staff of the National Center for Disease Prevention and Control Department of Health, the Medical Officers Stop TB and Leprosy WPRO and WR WHO and NGOs working in the field of Leprosy;
- Meetings with Regional, Provincial Leprosy Coordinators and Municipal Health Authorities;
- Visits to sanitarium, referral hospitals, skin clinics, provincial hospitals and rural health units;
- Re-examination of patients for confirmation diagnosis and classification, the presence of nerve impairments and complications, treatment status and patient management procedures.

1.4 Program of the Visit

- Jan. 24 and 25, 2010: travel of review team from the Netherlands and India to Manila.
- Jan. 26: visit DOH, and discussions with NLCP manager and WHO-WR Medical Officer Stop TB and Leprosy.
- Jan. 27: visit WPRO/WHO and further discussions at the Infectious Disease Office DOH.
- Jan. 28: further discussions at the Infectious Disease Office DOH and meeting with the Executive Officer Culion Foundation.
- Jan. 29: visit to Dr. José N. Rodriguez Memorial Hospital and Caloocan Health Center, Tala, Metropolitan Area Manila.
- Jan. 30: further discussions at the Infectious Disease Office DOH.
- Jan. 31 – Feb. 2: Travel to Region 1, visits to CHD Ilocos Sur Province, PHO Ilocos Sur and health centers.
- Feb. 2 – Feb. 4: Travel to Cebu, visits to CHD Region 7, Cebu Skin Clinic, Leonard Wood Memorial Research Centre and Eversley Childs Sanitarium and to Cebu health centers.
- Feb. 4 – Feb. 6: Travel to Central Luzon, Region 3, visits to health centers and provincial skin clinic.
- Feb. 8: Debriefing at the Department of Health.
- Feb. 7 and 9: return journey review team.

List of contacts – annex 2.

1.5 Acknowledgements

We are grateful to the Department of Health, Philippines and WPRO for inviting us to conduct this review. We are also grateful to those who kindly supported us during these weeks. Especially to mention are Dr. Eduardo Janairo, Director National Center for Disease Prevention and Control; Dr. Jaime Lahahid, Director Infectious Disease Office; Dr Leda Hernandez, Division Chief, Diseases for Elimination as Public Health Threat. Our special thanks to Dr. Francesca Gajete, National Manager NLCP & a very stimulating companion, and Ms. Marian Briones; Dr. Woo-Jin Lew, Medical Officer STBL WHO-WR; Dr. Daniel Sagebiel, Medical Officer STBL WPRO; and Dr. Hugh Cross, ALM Consultant Prevention of Disability, who made our visits more lively and full of good experiences. We thank Dr. Henk Eggens and the Royal Tropical Institute Amsterdam for allowing us to implement this mission. We thank all the enthusiastic Leprosy coordinators, staff of the sanitaria, skin clinics and the rural health units for showing us their work and records, and letting us review their patients. Last but not the least, we are grateful to the patients & Persons Affected by Leprosy, who allowed us to interview and examine them.
2 General information

2.1 About the Philippines

The Philippines is an archipelago of 7,107 islands of which around 2000 are inhabited. It stretches from the south of China to the northern tip of Borneo (annex 3). With a land area of 299,764 sq. km, its length measures 1,850 km and its breadth about 965 km with the Philippine coastline adds up to 17,500 km. The country has over a hundred ethnic groups and a mixture of foreign influences which have molded a unique Filipino culture. The 2009 population was projected to reach 92.2 million.

The Philippines is the third largest English-speaking country in the world. The country is divided into three geographical areas: Luzon, Visayas, and Mindanao. It has 17 regions, 81 provinces, 136 cities, 1,494 municipalities, and 41,995 barangays¹ (data as of December 2007). Barangay - the smallest political unit into which, cities and municipalities, in the Philippines, are divided. It is the basic unit of the Philippine political system. It could consist of less than 1,000 inhabitants residing within the territorial limit of a city or municipality and administered by a set of elective officials, headed by a barangay chairman.

The Philippines government is basically divided into three levels: 1. National level; 2. Provinces; and 3. Cities and municipalities. The country is divided into regions for administrative convenience. These regions do not possess a separate local government but being an extension of the central government departments, with the exception of the Muslim Mindanao region, which is autonomous.

The Philippines is divided into a hierarchy of local government units (LGUs) with the province as the primary unit. Provinces are further subdivided into cities and municipalities, which are in turn, composed of barangays. Cities are divided into two groups: 1. Independent cities (including the highly urbanized cities) of which there are 38, autonomous from the provincial government; and 2. Component cities (under the provincial government). Both (component) cities and municipalities (under the provincial government) have some autonomy.

2.2 Government Health Services

The Philippine Health Care Delivery System is divided into 3 levels (organogram health services annex 4):

- **Primary** - under this level are the barangay health station and municipal rural health unit (community hospitals, health centers);
- **Secondary** - provincial/city health services, provincial/district/city hospitals;
- **Tertiary** - national health services, medical centers, teaching and training hospitals, regional health services, regional medical centers and training hospitals.

The Department of Health (DOH) is the lead agency in health. It maintains specialty hospitals and regional hospitals. At regional level the DOH is represented by the Center for Health Development (CHD), which in turn has DOH Representatives (Provincial Health Team Officers) at provincial, city and

¹ The name barangay originated from balangay, a Malay word meaning “sailboat”.[(Wikipedia)]
municipal levels (depending upon the size of population). With the devolution of health services to the Local Government Units (LGUs) in the early nineties (as mentioned before, the Leprosy control program was only decentralized in 2000), the provincial and district hospitals came under the provincial government while the municipal government manages the rural health units (RHUs) and barangay health stations (BHSs). In every province, city or municipality, there is a local health board chaired by the local chief executive. Its function is mainly to serve as advisory body to the local executive and local legislative council on health-related matters. Change of government is often followed by a change of local administrations. Mentioned as one of the weak points, at local levels, is the high turn-over of health staff.

The public sector comprises of publicly financed institutions and provides health services, including services linked to the national, provincial, cities and municipal governments. The public health services are only free at barangay level. For other services, patients have to pay. Social security, government’s health card and private medical insurance will meet part of the cost for those covered by these schemes. However, for communicable disease like Leprosy, services are free of charge.

**Main health indicators:**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Birth rate</td>
<td>24/1,000 population</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>24/1,000 life births</td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td>170/100,000 life births</td>
</tr>
<tr>
<td>Life expectation at birth for women</td>
<td>74 years</td>
</tr>
<tr>
<td>Life expectation at birth for men</td>
<td>68 years</td>
</tr>
<tr>
<td>Physicians</td>
<td>1.16 per 1,000 population</td>
</tr>
<tr>
<td>Total expenditure on health as % of GDP</td>
<td>2.9%</td>
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Literacy rate is as high as 84%.

**2.3 Leprosy in the Philippines**

2.3.1 **History of Leprosy in the Philippines**

Leprosy existed in the Philippines long before the arrival of the Spanish in the 16th century and was known locally by such terms as ‘ketong’ and ‘cizaro’. In the late 1800s, there was a fairly high prevalence of leprosy in the Philippines. Early policies to arrest the leprosy epidemic included (forceful) containment of sufferers - a segregation law came into force in 1907. The first ‘leper colony’ was established on Culion Island and opened in 1906. At its peak, Culion was home to over 5,000 people. Over the years, in total 8 sanitariums were established. The legacy of the policy of containment is that still a significant population of disabled and socially dislocated people occupies the shelter afforded by these sanitariums. The 1907 segregation law was only repealed in 1964. In 1950, Dapsone was introduced. At the same time, in most provinces Leprosy services were provided by so-called “skin clinics”, in some areas use was made of mobile clinics. In the early eighties MDT became the treatment of choice.

In 1999, "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. 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. In 2006, in Cebu, a consensus statement, on the Prevention of Disabilities, was issued, co-sponsored by WHO, ALM and ILEP. This consensus statement to be incorporated into the National Strategic Framework and Operational Guidelines for the implementation of health programs for PWDs.

In 2005, the revised roles, of the sanitaria, were published in an executive order. Except caring for persons affected by Leprosy and admitting Leprosy patients, suffering from reactions and other complications, the sanitaria became general and/or specialized (rehabilitation, dermatology, etc.) hospitals. As a consequence of the new law, provincial hospitals were required to provide services for persons affected by Leprosy, but the sanitaria are mandated to specifically offer Leprosy services as one of their expert services.

Having been a country which piloted MDT for the treatment of Leprosy, the Philippines subsequently conducted a very successful elimination program. When the NLCP was established in 1986, there were 38,570 registered Leprosy patients in the country. That number translated into a prevalence rate (PR) of 7.2 per 10,000 population. By the end of 1998, with 7,005 registered patients and a PR of 0.90, Leprosy was no longer considered a public health problem. Throughout the introduction of MDT and the elimination period, Philippines Leprosy Mission (PLM), supported by the ALM, played an important role assisting the NLCP. Later on the PLM shifted its support to activities at LGU levels. Other NGOs (e.g. Culion, FAHAN) were involved in providing care and rehabilitation and supporting DOH activities like training.

2.3.2 Control Program

In 2000, a major change took place in Leprosy control policy and delivery of services. The highly centralized Leprosy services were changed in favor of integrated and decentralized services. Leprosy control was then considered to be integral to general health care provision.

Main responsibilities of the three levels of Government regarding the Leprosy program are:

At the National level, the NLCP Coordinator 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, keeping 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. At 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 and referral center reports, human resource development, resource mobilization. Also at provincial and city/municipal levels, there are DOH representatives.

At Provincial level, the functions, of the provincial Leprosy coordinators, are co-ordination of NLCP 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.
The City and Municipality health offices are responsible for coordinating, monitoring and supervision of NLCP activities, including data collection and analysis. The health centers (mostly with medical officers) are responsible for the operational aspects of the control program (examining of patients, diagnosis, and treatment, treatment of complications). In total, there are 2274 health centers in the country (1 for each 35-38,000 population). Eighty percent of these provide leprosy services. The barangay (voluntary) health workers (BHW) screen the patients, refer them to the barangay midwife and she will refer suspects to the medical officer. At barangay level also, the remaining supervised MDT, and IEC to patients, families and community, is given. One of the barangay tasks is, also, to organize ‘Kilatus Kutis’ (skin) surveys in their area. ‘Kilatus kutis’ surveys are also sometimes called mini LECs in the Philippines. One BHW is available for every 20 households. The BHWs are more permanent (as opposed to the medical and paramedical staff) and are an important support base for the program.

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

2.3.3 National Coordinating Bodies
(organizational frame work – annex 1)

- National Leprosy Advisory Body (NLAB): chaired by the Undersecretary for Public Service Delivery, DOH, meets twice a year. Main participants: Director Centre for Infectious Diseases, WR-WHO, WPRO, PLM (Philippines Leprosy Mission), ALM (American Leprosy Mission (involving also Leonard-Wood Foundation), ILEP representative, Culion Foundation, FAHAN, Philippines Dermatology Society (including the Leprosy Interest Group).

- National Collaborating Coordinating Committee (NCCCL): chaired by the Director National Center for Disease Prevention and Control, meets twice a year.
  - Main participants: Regional coordinators, Chiefs of sanitaria, representative patients.

- National Consultative Workshops: for the 17 regional coordinators. organized twice a year, February and November, for planning and evaluation purposes.

2.3.4 Partners:

- Philippines Leprosy Society: the professional organization of Leprosy experts. It is the organization which is entitled to take examinations and award the official recognized specialization of ‘Leprologist’. In the past few years the society has not been active.

- Dermatology Society/Leprosy Interest Group: the Leprosy Interest Group, within the Dermatology Society, is a group of dermatologists interested in Leprosy, working in medical centers and sanitaria. In general, outside the Leprosy Interest Group, there is little interest in Leprosy by dermatologists.

- WHO (WR and WPRO) provides the MDT drugs and gives financial and technical support.

- NGOs working in Philippines are:
  • Philippines Leprosy Mission, with support from American Leprosy Mission and Sasakawa Memorial Health Foundation, is dedicated to the welfare of people affected by Leprosy. PLM supports activities throughout the country and currently has a specific focus on Ilocos provinces.
• **Leonard Wood Memorial Research Foundation** and **Cebu Skin Clinic**. Supported by ALM. The Cebu skin clinic is functioning as a tertiary level referral center. Leonard Wood Memorial is an international well-known research center, presently also involved in tuberculosis research.

• **Culion Foundation**, was formerly supported mainly by ANESVAD – a Spanish NGO. The organisation did support training activities and IEC, and continues to give technical support at national level.

• **FAHAN Foundation** (Foundation for Assistance to Hansenites) to support persons affected by Leprosy. However, it’s Leprosy related activities ceased by the end of January 2010 and were partly handed over to a Korean foundation called Sorok. It’s footwear services were also closed.

• **Patient’s organisations** are mainly at the old sanitaria and have no national organisation or representation.

• **IDEA Philippines** continues to strive to be a national organisation that represents people affected by Leprosy, but the organisation is not widely endorsed.
3 Findings

3.1 Epidemiological situation

**Graphs depicting Epidemiological trends 1999 – 2008:**

Since 2002/2003, the epidemiological situation seems to be more or less stable. New case detection remains around 2300 cases a year. Detection data 2003 and prevalence data 2007 appear to be incomplete (annex 5). MB proportion is around 80-90%. From the graphs and table below and from our field visits, questions are raised on the reliability of the data specially the disability data (often this information is not recorded on the patient cards) and MDT completion rates (cohort analysis is not always understood by the peripheral health staff). The annual statistics 2009 were at the time of writing this report not yet available.

![Graph showing Leprosy Prevalence Rates and Case Detection Rates](image)

These data are from consolidated reports provided by NLCP; individual patient data are not available at national level, for more detailed analysis.
Disability Grade 2 among new leprosy cases, the Philippines, 1999-2008

Proportion PB/MB leprosy, the Philippines, 1999-2008

Leprosy cases: Proportion of children & women, the Philippines, 1999-2008
Average mode of case detection over the years 2006, 2007 and 2008: voluntary reporting 38%, house/school surveys 43%, and ‘kilatus kutis’ campaigns 19%. Contact examination seems to be important vehicle for case detection in the Philippines.

‘Kilatus kutis’ campaign: an IEC activity at barangay level is specifically directed patients with skin problems. Such patients are asked to report to the barangay health worker and the midwife on a certain day. Skin ointments are supplied free of charge. Suspected patients will be referred to the medical doctor at the rural health center.

By the end of 1998, with 7,005 registered patients and a PR of 0.90 per 10,000 population, Leprosy was no longer considered a public health problem. At that time 29 provinces had PRs higher than 1 per 10,000. By the end of 2004, there were still 5 provinces with a PR of over 1 per 10,000. By 2009, 5 provinces and 10 cities did not meet this target.

Areas with a prevalence of 1 or more per 10,000 population in 2008 are shown in the map below:

The main endemic areas are presently North and Central Luzon and Mindanao.

As can be seen from annex 6, the graph with the detection rates (per 100,000) and the prevalence rates (per 10,000) from 1986 – 2008, the detection rates hover around 3 per 100,000, with some peaks at the end of the eighties (1988 – 1990), early nineties (1993 – 1994) and 2000 – 2001. Such surges in case detection are almost always related to extra case finding activities. The prevalence rates declined sharply in the eighties and nineties, but in the past few years more or less stable. In accordance with the new Global Strategy the epidemiological situation of Leprosy would be better reflected by the use of detection rates (per 100,000) instead of prevalence rates.

<table>
<thead>
<tr>
<th>Cities</th>
<th>Population</th>
<th>New patients No. (%)</th>
<th>Det. rate/100,000</th>
<th>Gender No. (%)</th>
<th>Child &lt; 15 No. (%)</th>
<th>Gr. 2 disab. rate No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PB</td>
<td>MB</td>
<td>F</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>Cagayan de Oro</td>
<td>499,692</td>
<td>17</td>
<td>23</td>
<td>8.0</td>
<td>13(33)</td>
<td>7 (18)</td>
</tr>
<tr>
<td>Iligan</td>
<td>288,409</td>
<td>1</td>
<td>8</td>
<td>3.1</td>
<td>4 (48)</td>
<td>0 (00)</td>
</tr>
<tr>
<td>Oroquiet</td>
<td>63,947</td>
<td>0</td>
<td>3</td>
<td>4.7</td>
<td>3(100)</td>
<td>0 (00)</td>
</tr>
<tr>
<td>Total</td>
<td>852,048</td>
<td>18(35)</td>
<td>34(65)</td>
<td>6.1</td>
<td>20(38)</td>
<td>32(62)</td>
</tr>
</tbody>
</table>

It can be seen from the table of pilot LEC areas that the survey data differ remarkably from the routinely reported data (annex 5). MB proportion of 65% (routinely reported 80 – 90%), female/male ratio of 38% (routinely reported 20%), child rate of 13% (routinely reported 4.5 – 8%) and disability rate of 17% (routinely reported 2 – 3%). Such findings (survey data versus routinely collected data) are not uncommon, but there is surely a need to repeat these rapid village or LEC surveys to estimate the true extent of the Leprosy problem. Other tools, like LEM (to monitor program performance) and sentinel clinics (to provide more reliable routine data) are essential as well, to determine the scale of the problem. For LEM see: http://www.who.int/lep/monitor/LEM_Guide2000.pdf

Data from the Cebu Skin Clinic:

The average number, of new patients annually, is 150, of which the MB proportion is 95%. Ninety percent of new MB patients have a positive skin smear (and 70% of these skin smears with a BI of 4 or more!). The proportion of female patients is 25%, percentage children 6%, the disability grade 2 rate at start treatment is 4.5% and at release from treatment 5%. The treatment completion rate is 98%. Although this is a tertiary referral center with a selection of patients, these data are remarkable – especially the high MB proportion and high proportion BI of 4 or more, and that the disability rates as start and release from treatment are almost similar. From the literature it is known that some patients with impairments will improve during treatment, some get worse, but the total number of patients, with impairments, stay more or less the same. Such an outcome can be expected with a good POD program. The Cebu skin clinic was the only center visited during our visit where reactions were diagnosed and treated as it should be and where POD activities (including teaching of self-care) are taught. However, they do not provide services for secondary complications like ulcer treatment. At the Cebu skin clinic a high majority of patients (90%) report voluntarily and only a small proportion is referred. At a tertiary referral center one would expect a higher proportion of patients referred.
3.2 Strategic Plans 2005-2008, and 2009-2011: its achievements

After the change, from a vertical and centralized to an integrated and decentralized control program in 2000, major efforts were made to train the health center and barangay health staff in the principles of Leprosy control. By 2005/2006, it was claimed that 80% of these health units had Leprosy trained staff, and by 2008, that 80% of all health units in the country were offering Leprosy services. This is a major achievement: to rebuild an integrated and decentralized control program from its roots in the community.

To reduce further the prevalence in those areas, not yet meeting the target, stayed the main NLCP objective. In 1997, 26 provinces had a PR of more than 1 per 10,000. By the end of 2004 still 5 provinces had a PR of more than 1. As we can see from the patient’s statistics (annex 5), the epidemiological situation has remained stable over the past 6 to 7 years.

Of the Operational Guidelines and Strategic Plan 2005 – 2008, no detailed information could be obtained.

Findings of the Review Team on the 2005/06 NLCP Objectives are as follows:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Review’s team observations</th>
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<tbody>
<tr>
<td>1</td>
<td>To enhance the capacity of health workers in quality diagnosis and case management</td>
</tr>
<tr>
<td>2</td>
<td>To ensure the provision of MDT supplies at all levels</td>
</tr>
<tr>
<td>3</td>
<td>To strengthen collaboration with partners</td>
</tr>
<tr>
<td>4</td>
<td>To intensify social mobilization and advocacy</td>
</tr>
</tbody>
</table>
The Objectives of the Plan 2009 – 2011:

1. To reduce the prevalence of leprosy in identified municipalities to at least 50% by 2010;
2. To promote full integration of leprosy service within the general health care system at all levels;
3. To incorporate the Framework of Self Care, Prevention of Deformities and Rehabilitation within the National Program for Persons with Disability; and
4. To establish Leprosy Sentinel Surveillance System for Drug Resistance in identified hyper-endemic areas in collaboration with the Field health Surveillance Information System and National Epidemiology Center.

Strategies of the Plan 2009 – 2011:

1. Integration with other infectious diseases locally and Neglected Tropical Diseases (NTD) globally together with acceptance and support of general health service at all levels of health care;
2. Strong community and political support thru ownership of the leprosy control program by the Local Government Units (Local Chief Executives);
3. Public-Private Partnership thru unity, consensus and trust between all major partners and other stakeholders in the conduct of leprosy control;

As these operational guidelines and strategy 2009 – 2010 only recently came into force (and the data 2009 are not yet available) the attainment of these objectives could not be measured and evaluated. Objective 2 is an ongoing activity, but mainly based on capacity building and objective 4 is being set in place together with the WHO and the LWMF. It would be helpful if each objective would have its own outputs and activities, indicators and targets. Regarding strategy 1: the NLCP is under the section Diseases for Elimination as Public Health Threat at national level, but at other levels of the health service this strategy has not yet been implemented. For example: joint approach to ulcer treatment for leprosy and filariasis patients (and diabetes patients) is lacking.

3.3 WHO Global Strategy 2006-2010 as applied to NLCP

The overall goal is to provide access to quality leprosy services for all affected communities following the principles of equity and social justice.

Referring to the main issues of the Global Strategy, the team has the following observations:

1. **Self-reporting:** The promotion of self-reporting is crucial to case detection. In the Philippines, except voluntary reporting, important for case detection are contact examinations and the ‘kilatus kutis’ campaigns. This policy has been in place for the past years. However, in Ilocos Sur, one of the endemic provinces, it was remarked by the provincial Leprosy coordinator that whenever special efforts were made (e.g. surveys or campaigns) new patients were found. As the disability figures are unreliable nothing can be said based on these figures about delay in detection. Another observation from Cebu is that in the past few years, almost half of the new patients of that area were diagnosed by the Cebu skin clinic and most of the patients self-reported. Did these patients report earlier at health centers or hospitals and were not
recognized as suffering from Leprosy or did they report directly to the Cebu skin clinic because of its reputation? Also from other areas, we would have liked to know at which level of the health service new patients were diagnosed – it could tell if the integrated and decentralized system really works. The application of delay questionnaires (like is happening routinely in the Stop TB campaign) would be very appropriate.

2. Diagnosis and classification: The procedures for establishing the diagnosis of Leprosy remain firmly linked to the cardinal signs of the disease, but the accuracy of diagnosis must be monitored and improved. Suggestions to improve the accuracy of diagnosis are: bacteriological confirmation where possible, re-examinations during supervision visits, by the Leprosy coordinators and randomly by LEM. Over-classification (MB classification and treatment instead of PB) happens in the Philippines. The guidelines are available in the Manual of Procedure 2002 (3rd edition) based on the WHO/Global Leprosy Program Guidelines. Except the WHO guidelines (5 or less PB, 6 or more MB), additional criteria for MB classification are used (large single lesions, lesions in the face, lesions with satellites, lesion in reaction, and in cases where the medical doctor is not sure). In one of the centers a case referred by a dermatologist with pathology report indicating TT leprosy, was recorded as MB. On asking the doctor, he was unable to define the difference between PB and MB. Also in other centers, patients with a single or few lesions were recorded as MB, without bacteriological confirmation.

Even though MB over-classification may be the case, a very high MB proportion is characteristic for the Philippines and actually characteristic for several other countries in WPRO like for example China, Japan, Guam, Samoa, Nauru.

3. Case management: Case management seems to be restricted to diagnosis and provision of MDT. The treatment of leprosy with MDT has been a continuing success, also in the Philippines. Actions related to Leprosy case management are mostly taken care of by the health nurse at the health center, doctors seem to accept the actions taken by the nurse. Some of the health centers, that the team has visited, have shown poor or incomplete recording of examinations done, skin lesions not depicted correctly, disability grading not recorded, contact examinations not recorded, etc. Procedures exist for managing irregular treatment with MDT, but are not always followed.

4. Demand post RFT: A high demand for Leprosy services post treatment is noticed, especially patients with late reactions, wounds and other complications. In some countries post treatment attendance can be up to 1/3 of total demand. From the Philippines we do not have these figures.

5. Neuritis, reactions, prevention of disabilities, rehabilitation:
- Global Strategy - Emphasis on the assessment of disability at diagnosis, so that those at particular risk can be recognized and managed appropriately. In many instances no proper disability recording is done at diagnosis and often no record is made.
- Global Strategy - Leprosy reactions are a serious complication affecting some patients. A key decision for program managers is to determine how and at which level of the health system leprosy
Reactions are to be managed in their country. In most centers we visited, neuritis and reactions are not diagnosed in time and managed properly. In general, Sensory Testing (ST) & Voluntary Muscle Testing (VMT) are not done regularly and it seems that complaints of patients about numbness or weakness are not taken seriously. Anti-reactional (RR) treatment is only started when the signs and symptoms are obvious, but even during treatment with prednisone, ST/VMT are mostly not checked. Of the two sanitaria and two skin clinics we visited, only one fulfilled the ST/VMT requirements. We saw several patients in several centers, who developed serious disabilities while on treatment or after MDT treatment.

- **Global Strategy** - There is a need for much greater coverage with basic POD activities. This is an important component of ‘quality leprosy services’ emphasized in the Global Strategy. No self-care is taught, no skin care or exercises promoted. Only in one skin clinic POD has been implemented.

- **Global Strategy** - Rehabilitation may include a medical component (such as reconstructive surgery) but its scope is much broader. It is likely that some people affected by leprosy would benefit from socio-economic rehabilitation (for example, vocational training or a small loan). Staff in the health services need to be familiar with what is being done in the locality, and know, how and where to refer people who need these services: What would be the use of a rehabilitation program if even not the most basic conditions are met, namely to prevent that patients develop new and/or additional disabilities while on treatment and while on surveillance. POD, the key component to reduce stigma, is mostly non-existing.

6. **Access to leprosy services**: If leprosy services are easily accessible in most parts of the country, we do not know. Restrictions must exist in case of smaller islands, mountainous areas and in some places because of security concerns. There exists an extended health infrastructure network starting at the household (BHW), the barangay midwife, rural health center (medical officer) and above. However for specialised services e.g. for treatment of reaction, neuritis, one has to travel to city, provincial or regional hospitals and referral centers. We understood that not all provinces and even regions offer such services.

7. **Referral System**: Emphasis is needed for an effective referral system, as part of an integrated program, both for acute and for chronic care. Which activities can be carried out at the primary health care level and for which aspects of the care, patients will have to be referred. Procedures and criteria are mentioned in the Manual of Procedures (MOP). Though referral forms have been designed (MOP) but are not used very much. Occasionally, referrals are made on the designed format, however feedback to the referee is seldom received. Hence a functioning ‘referral system’ has yet to be established. Complicated cases often visit the well known hospitals of their own and do not pass through the health center.

8. **Recording & Reporting**: Recording and reporting are essential to maintain quality in any program. The indicators selected in the Global Strategy are useful for monitoring and evaluation, and they determine which data must be recorded including monitoring POD activities. Integration has taken place since the year 2000 but the records and reports are not simplified. Many records, at most centers, were not completed as required. For example: disability status and contacts
examined were not recorded. Filling up of complex forms and registers is too much an expectation under an integrated setup and peripheral staff finds it cumbersome to maintain them. Recording of patients in the treatment register includes new and old patients both, which must be leading to extra attention/labour by the reporting unit, to segregate data. This will also be affecting calculation of indicators including completion rates. This may lead to counting difficulties and sometimes mistakes.

9. **Program management** is a broad subject; the topics covered in the Global Strategy are those that are central to the running of integrated Leprosy control services, including supervision, supply of MDT, partnerships, training and program evaluation.
- The present national programme manager is competent and experienced in Leprosy. She is enthusiastic with an eager desire to uplift the program, but is alone with no support staff, most of the time busy compiling reports herself, having hardly any time to make field visits. It is difficult to manage a program in such a large country with many islands, communication problems and devolution.
- At national level, review meetings take place twice a year, which is understandable considering distances and geographical structure of Philippines. Regional level review meetings take place only once a year.
- The well designed Manual of Procedures (MOP) is available throughout. Also WHO operational guidelines, Manual of Training, of Laboratory & Manual on Leprosy, are available, which indicate good intentions of the programme.
- The previous strategic plans have in general broadly defined objectives, with no clearly defined outputs and activities, indicators and targets. Such plans and its objectives are difficult to evaluate.

10. **Monitoring and supervision:** Provincial & regional coordinators are responsible for monitoring and supervising: in some areas they are visiting the centers regularly, but in others, are not able to perform such visits either because no permission is granted or due to lack of mobility. On interacting with the coordinators, funds crunch was shown to be the main problem. Funds are available from national level but they are not always passed on to the Leprosy coordinators. Reimbursements are meagre and the fixed allowance is not sufficient to meet the expenses incurred by the staff. Those coordinators we met were well-motivated. However, the true meaning and understanding of supervision (guidance, coaching, on the job training, support) is missing. No reports are made of these visits, no recommendations, and no follow-up.

11. **Drug Supply management:** In general the drug supply seems to be streamlined. Though there is no request and supply system, it goes ad-hoc but is being managed well. Mostly long life MB Adult BCPs were available in all the centers visited. Staff has confidence that in case of eventuality or detection of other group of patient, emergency MDT stocks could be procured from neighbouring centers. At the national level, the drug stock status is received from the periphery together with the quarterly reports. Drugs are sent in time but sometimes, because of common pool of sending MDT with all other medicines, the drug store managers wait for request from other programmes, leading to delay in supplies. It happens sometimes that supplies from WHO are delayed and not always the number of blister packs requested are...
supplied (e.g. PB Adult and PB Child instead of MB Child). However, in emergencies, WPRO provides drugs from their buffer stock.

12. IEC: IEC for spreading awareness and passive reporting is done but in patchy manner and it seems sporadically. Posters have been designed, pamphlet, leaflets are available but the team could not find any major IEC activity while touring around nor any billboard observed. On World Leprosy Day (Jan 29, in the Philippines) and during the National Leprosy Awareness Week (actually 3rd week in February), activities are organized by LGUs.

13. Capacity Building: Since the start of the integrated program extensive training activities have been organised. Starting with training for trainers, followed by training of health staff and BHW. As reported by 2005, 80% of the health staff had received training, and by 2008, 80% of the health units were offering Leprosy services. Capacity building is an ongoing activity. There seems to be a high turn-over of staff. We did not observe any training program, but noticed a lack of certain skills especially regarding ST/VMT and POD. On-the-job training during monitoring & supervisory visits, by provincial leprosy coordinators, is essential to fill the gaps in knowledge and skills, however this was not observed.

14. Curriculum medical/paramedical school and postgraduate courses: When it comes to medical or paramedical schools and even postgraduate dermatology courses, Leprosy seems only to be discussed as a differential diagnosis, but not taught as a disease. In some primary and secondary schools Leprosy is included in teaching about public health and communicable diseases.

15. NGOs: The role of NGOs has changed in the past years and they are less and less involved in Leprosy related activities. Partly this is due to the difficulties working with a decentralized system. Previously, before 2000, PLM worked directly with the Central Government. By now, it has to close agreements with each separate LGU. Few NGOs are supporting partly, like Culion foundation, because of lack of funds.
4 Conclusions and Recommendations

4.1 Conclusions

The emphasis of the Enhanced strategy for further reducing the disease burden due to Leprosy (Plan Period 2011 - 2015) remains on sustaining the provisions for quality patient care that are equitably distributed, affordable and easily accessible. We also like to refer to "Issues and Challenges, Epidemiological Review of Leprosy in the Western Pacific Region 2007".

Our conclusions will be discussed in line with the main strategies of this enhanced strategy 2011 – 2015:

1. Sustaining political commitment at national & local government levels: Political commitment is seen at all levels, however, in the light of upcoming elections when many authorities will change with subsequent change in staffing, sustaining and renewing political support is essential. There is a fast turn-over of skilled or trained staff at the peripheral level which poses difficulties in ensuring wider coverage of Leprosy services. Sustained political commitment and adequate resources from the national government is essential; partnerships and collaboration with NGOs are needed to pursue quality Leprosy control activities, further reduce the disease burden, and support socio-economic rehabilitation.

2. Documents and strategic plans: Documents and plans are available but without clear measurable indicators and targets. It is important to formulate a national strategic plan for the coming 3 – 6 years with clearly defined objectives, outputs and activities, measurable indicators and realistic targets. A plan for 6 years would be in line with the presidential, and as such administrative term of the DOH.

3. Strengthening routine and referral services: Routine services are in place but there is a need to improve recording & reporting and program management including planning, monitoring and supervision. In many provinces there is no referral center and a functioning referral system is not in place. Many existing referral centers do not provide quality care especially concerning prevention of disability. Strengthening integration of Leprosy services into the general health services through capacity building (the importance of on-the-job training is stressed) is needed to ensure quality diagnosis, treatment, and management of complications, particularly in previously endemic areas. In many areas (smaller islands) accessibility is restricted because of poor communications and vast distances and in some places because of security concerns.

4. IEC: Continuing public awareness is needed through sustained advocacy and IEC activities. Early self-reporting of cases in the community can be promoted by spreading awareness that Leprosy is a curable disease with MDT drugs that are available and safe and free at health centres; further, IEC activities should emphasize that social activities should emphasize that stigma and discrimination of people affected with Leprosy has no place in the society today.
5. **Using indicator, Grade 2 disabilities per 100,000 population:**
First priority is to record disabilities routinely and correctly at the start of the treatment, then only ensure that this indicator is included.

6. **Improving case finding:** The Philippines may be divided into three zones (J. Visschedijk et al. Mycobacterium leprae – millennium resistant! Tropical Medicine and International Health. Volume 5 No 6 PP388-399 June 2000):

- **Areas with high case detection rates** of 10 or more per 100,000 population. Blanket approach may include i.e year round ‘kilatus kutis’ campaign, full population coverage for IEC and support & strengthening of all service delivery points.
- **Areas with moderate case detection** with rates of 1-9/100,000 population. Cluster approach, special attention to the areas where cases are reported.
- **Areas with low case detection** with rates less than 1 /100,000 population. Using only outbreak approach where if a suspected case is reported, a team of experts may visit the health center, give on the job training to health workers and then proceed for extended contact examination in that area. This outbreak approach may also be used in difficult to reach areas and suburban areas. These approaches could be applied after proper application of GIS mapping showing strata wise case clustering

7. **Improving quality of clinical services:**
- Services for diagnosis & treatment of Leprosy do exist, but proper monitoring and supervision (including on-the-job training) is lacking.
- Over-classification of MB exists in some areas and there is a need to re-emphasise on correct grouping between PB & MB.
- There is a large number of patients who were declared cured but require care after cure for the treatment of complications such as reactions, plantar ulcers and other disabilities.

8. **Improving quality and availability of skin smear services:** There is a need to improve existing services for slit skin smear examination and to install this at all secondary level referral centers. A quality control system should be developed as well.

9. **Research:** Where possible research should be promoted. This could be carried out in cooperation with interested sociology and psychology departments of universities, physiotherapy and nursing schools. There are several well validated questionnaires, which could easily be used like delay in diagnosis (patient and doctor delay), patient satisfaction, SALSA (to determine the level of patient’s ability), P scale (to determine the level of acceptance in the society) and stigma questionnaire.

10. **Improving the management of acute and chronic complications, including prevention of disabilities and enhancing provision of rehabilitative services through well organized referral system:**
- First step is to detect cases early. As disability recording at diagnosis is often not done and/or not properly recorded. Disability Grade II indicator can presently not be used as an indicator for delay in detection.
- **ST/VMT** are mostly not done, but should be **routinely practised** at all levels and repeatedly, at least at start of treatment and then every three months. **Any suspicion** of reaction/neuritis or any
minor complaint (numbness, weakness, pain in the area of nerves etc.) by the patient should be taken seriously. ST/VMT should be done and if loss of sensation or weakness found the anti-reaction treatment should be started immediately without delay. During anti-reaction treatment, ST/VMT should be repeated at least every month and the doses of anti-reaction treatment (prednisolone) may be adjusted/tapered depending on the improvement in ST/VMT.

- Simple self care procedures must be taught to the patients, with reaction, anaesthetic or weak hands, feet and eyes.

- Of the two sanitaria and two skin clinics visited only one skin clinic practised all of above. One cannot expect the basic health services to provide quality care if secondary and tertiary referral centers do not show a good example. All referral centers of repute should become centers of excellence and not ignore ST/VMT and POD like is happening now.

- As one of the indicator, for the quality of care during MDT treatment, EHF scoring is proposed; to measure at start, at RFT and possibly during surveillance as well. The EHF scoring refers to the WHO disability grading of each eye (right and left with scoring 0-2), hand (right and left with scoring 0-2) and foot (right and left with scoring 0-2) separately and then add all together (from 0 – 12). This scoring is more sensitive in detecting changes overtime compared to the recording of only the maximum WHO grade per patient.

11. Supporting initiatives to promote CBR:

- There is a large number of cured cases who need physical and socio-economic rehabilitation because of disabilities developed from the disease.

- Institutionalised rehabilitation cannot be called CBR. The Concept of CBR is yet to be brought in to the system. In Negros, there are initiatives in this direction (WHO).

- Efforts should be made to establish links with the social sector and communities so that rehabilitation of persons affected by Leprosy can be combined with other disabilities.

- At least self care by formation of self care groups could be promoted and is more realistic than CBR.

12. Drug supply:

- Though the MDT management is functioning reasonably well, more ad hoc than streamlined. There have been no shortages.

- No supply of loose Clofazimine from WHO or non availability in the market is serious problem, which should be tackled as a priority.

- Some regions and provinces seem not to have prednisolone, for management of reactions, which could lead to a high risk of developing disabilities.

13. Surveillance for drug resistance: One center Leonard Wood Memorial Foundation has been identified as surveillance center in collaboration with DOH and WHO.

14. Developing sustainable training strategies: At least three centers should be identified and strengthened so that these centers could be utilised routinely for any kind of training on Leprosy. Cebu Skin Clinic could be one of them. These courses should include clinical as well as managerial aspects of the programme. Trainings, in clinical Leprosy with emphasis on early detection of reactions & POD, planning,
monitoring & supervision, are urgently needed. There is a need for training of trainers in communication and training skills.

15. **Fostering relationship with Partners:** It seems that the past years cooperation with NGOs and other partners have declined, which should be reversed in our opinion.
- More active involvement of ILEP and ILEP partners is needed.
- Philippines Leprosy Society be re-energized and examinations for Leprologists be revived.
- Close co-operation to be sought from other professional societies especially dermatological society and if possible to organise Leprosy sessions during neurology, orthopaedic, public health & dermatology conferences, as well as nurses and physiotherapists meetings.
- WHO's role in supporting Leprosy should be enhanced.
- Social sector should be roped in more vigorously.
- Private practitioners, local clubs, other institutions should be involved.
- Keep local NGO's interest in Leprosy alive.
- Wherever there are patient's groups, should be motivated for the cause.

16. **Health Information System:** Recording and reporting to be made simple and as far as possible computerized. So that all individual data could be compiled at central level. There should be a system where in card, register, reports are so designed that they can be fed into the computers as well as hard copy be sent to the center. All primary information (demographic and disease) be stored in computerised form with special code, so that at a later stage whole information system may be computerised, which could be accessed even from the center
- **Case card:** One simplified case card be made for normal patients without disability & complications, and another, additional card be made for patients with complications (reactions, disability). On this card reaction and disability management can be depicted and follow up can be recorded. In majority of the cases the simplified card will be used and in cases of complications additional card can be stapled with the simplified card.
- **Treatment register:** Only forms are used for recording. One simplified treatment register be made, only for new cases, old cases can be recorded on a separate register. This register for new cases should have new registration number with start of new year i.e. for year 2010 the number should start like 1/10, 2/10....etc. This will help in counting denominator for cohort reporting. The register should include places for notification of dates of individual monthly dose. The team could see the initiation in this direction in one of the provinces visited.
- **Reporting:** Too many reporting formats may be reduced to few on which compiled data from treatment registers be reported. Care may be taken to ensure that all required indicators are calculated

17. **The epidemiology of the disease** itself is a challenge. To date, there is no direct way to measure the level of infection and incidence of the disease in the community. This is complicated by very long incubation period and the process of self-healing of many single lesions, as well as the tendency for patients to hide the disease because of social stigma. An indirect way to determine the size of the Leprosy problem would be a prevalence survey. As total population surveys are very costly and
time consuming, more simple and less expensive methods have been developed like **Rapid Village Survey** or Leprosy Elimination Campaign. Well accessible and quality centers could be made in sentinel surveillance centers to measure changes over time.

*Surveillance in this context is defined as “ongoing” systematic collection, analysis and interpretation of data and the distribution to those who need to know.*

**4.2 Recommendations for the Philippines National Leprosy Control Program**

1. It seems essential that the NLCP formulates a national strategic plan for the coming 3 – 6 years with clearly defined objectives, outputs and activities, measurable indicators and realistic targets, starting with a situational analysis, which will form a basis for identifying results to be achieved. It is recommended to use a logical framework approach.

2. The programme needs strengthening in its planning and supervision capabilities at national, regional and provincial levels through a series of training workshops (result-based management workshops) with emphasis on-the-job training.

3. The Leprosy programme needs improved capabilities to monitor and evaluate programme performance. It includes standardized and effective recording and reporting using ICT technology as much as feasible. It would also entail improved data processing, analysis on several programme levels, feedback to lower echelons and use of information for performance enhancement, including the capability to analyze individual patient data at national level.

4. The national level needs serious strengthening in view of data processing and analysis, revitalizing POD component and rehabilitation services, and developing new approaches.

5. Strengthening of the referral system is needed: specialist services should be accessible to all eligible patients. Effective counter referral strategies would ensure patient care close to home.

6. A group of facilitators to be identified and trained in training and communication skills. At the same time at least three (North, Central and South) centers should be identified & strengthened where routine trainings could be conducted.

7. To measure the quality of services WHO-recommended indicators are advised. Grade 2 disabilities among new cases, as the main WHO indicator, is strongly recommended. This implies the development and maintenance of a strong supervisory system to ensure that peripheral staff performs systematic, valid and complete patient assessments.

8. It is proposed to organize selected LECs like in 2007 to estimate the size of the Leprosy problem and its trend. Other tools should be used, like sentinel centers, which are known to provide reliable data, for changes overtime. Standardized and randomly applied monitoring visits, like LEM, to evaluate the performance of the program should be introduced.
9. There is a need to revitalize the prevention of disabilities component and related rehabilitation services. It should lead to improved case management for reactions and neuritis, and management of already existing disabilities. Referral centers are to be defined and equipped with all necessary facilities for the management of complicated cases including self-care and exercises with trained nurses in these aspects. Secondary and tertiary referral centers should be centers of excellence. **At first instance no patient should be allowed to develop new and/or additional disabilities while on treatment and after release from treatment.** Only when this is reached, centers should be identified for reconstructive surgery. EHF scoring to be introduced to measure the performance of the prevention of disability program.
Annex 1: National Coordinating Bodies

Manual of Procedures, Department of Health, National Leprosy Control Program, 2002:

National Leprosy Advisory Body (NLAB)
1. Reviews, recommends policy changes, redirection and expansion for National Leprosy Control Program.
2. Provides overall technical supervision of the NLCP implementation.
3. Devices and evaluates program goal, plans and strategies.
4. Receives validated reports and collated data and present these to the Undersecretary of Health for approval and subsequent dissemination to the public.

National Collaboration Coordinating Committee for Leprosy (NCCCL)
1. Supports the Center for Infectious Disease in the operationalization of policy recommended by National Leprosy Advisory Board.
2. Ensures that actual operating procedures are consistent with DOH standard embodied in NLCP MOP.
3. Serves as Technical Advisors to NLCP Coordinator at all levels.
Annex 2: Contacts

**World Health Organization**
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Mrs. Normanday Saure, Nursing Attendant

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NGOs

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