Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

May 11, 1997

ADMINISTRATIVE ORDER
No. 26-A s. 1997

SUBJECT: Guidelines on Elimination of Leprosy as a Public Health Problem

I. RATIONALE:

Multi—Drug Therapy (MDT) is a proven effective cure for leprosy which renders leprosy patients non-infectious a week after starting treatment and makes home care of leprosy cases possible. MDT implementation has resulted in the continuing decline of leprosy cases throughout the world. Thus, the World Health Organization issued World Health Assembly Resolution No. 44.9 which calls for the global elimination of leprosy as a public health problem by year 2000.

The Department of Health (DOH) has committed to eliminate leprosy as a public health problem by attaining a national prevalence rate (PR) of less than 1 case per 10,000 population by 1998. As of 1996, the Philippines has a PR of 1.25/10,000 population. It is therefore imperative that all efforts be undertaken to detect all leprosy cases and treat them with MDT to achieve the leprosy elimination goal.

As per Department Circular No. 248 s. 1997 dated September 25, 1997, the National Leprosy Control Program is included as one of the priority programs of the DOH to attain the goal of eliminating leprosy as a public health problem. Thus, all Regional Health Directors, Chiefs of Sanitarium, and others concerned are directed to implement strategies/activities that will lead to the elimination of leprosy as a public health problem.

II. OBJECTIVE:

To eliminate leprosy as a public health problem by attaining a PR of less than 1 case per 10,000 population at the national level by end of 1998 and at the sub—national level by end of year 2000.

III. SCOPE/COVERAGE:

This shall be implemented nationwide by the National Leprosy Control Program (NLCP) of the Communicable Disease Control Service (CDCS) through all Regional Health Offices (RHO) and Sanitaria in coordination with all local government units particularly the Provincial Health OffiCes, as well as other government and non- government organizations concerned with leprosy.

IV. DEFINITION OF TERMS:

1. Leprosy elimination - reduction in the proportion of leprosy patients in a community to below 1 case per 10,000 population.

2. Leprosy eradication - total disappearance of the disease causing organism resulting to total and complete interruption of disease transmission (zero disease)

3. Leprosy case — a patient infected with Mycobacterium leprae and needing treatment or presently under treatment with MDT. A patient who has finished the prescribed duration of MDT treatment is considered cured and, therefore, no longer a leprosy case.

4. Multi—Drug Therapy(MDT) - a combination of 2-3 drugs (Dapsone, Rifampicin, and Clofazimine) for the treatment of leprosy.

5. Contact - an individual exposed constantly and for a prolonged period of time to a leprosy patient.

6. LEC (Leprosy Elimination Campaign) - an active casefinding strategy that encourages individuals with skin lesions to consult LEC teams which schedule skin consultations at specific barangays. This is suitable in areas with PR of 1.4 and above that are accessible and with functional health facilities.

7. SAPEL (Special Action Project for the Elimination of Leprosy) — an active casefinding strategy that utilizes trained volunteer health workers to detect Multibacillary (MB) leprosy cases and provide MDT treatment. This is implemented in hard to reach areas with PR of 1.4 and above, or where prevailing conditions hampers delivery of leprosy services by the regular health workers.

8. CAPEL (Community Action Project for the Elimination of Leprosy) - is an innovative casefinding approach which involves training of non—health personnel, particularly influentials in the community such as teachers, priest or
pastor, barangay officials, and others, to suspect leprosy in the community constituents and refer them to health centers for diagnosis and treatment. This is intended for areas with PR range of 1.0 —1.4/10,000 population.

V. ORGANIZATION/MANAGEMENT:

This guideline shall be implemented through the existing organizational framework of the NLCP as provided in the 1996 Revised Manual of ProcedUre (MOP) which also stipulates the duties and responsibilities of health workers at different implementing levels.

Further, Nursing Attendants whose items were created and were trained primarily to do leprosy work, and who are presently involved in program implementation, shall only perform the duties and responsibilities stated in the 1996 Revised MOP.

VI. POLICIES AND PROCEDURES:

In addition to the NLCP policies and procedures provided in the 1996 Revised MOP, the following guidelines shall be undertaken:

A. CASEFINDING

1. Casefinding activities shall be intensified especially in areas with PR>1/10,000 population through the following:

1.1 Contact examination

1.1.1 All contacts of new cases should be examined at the time new cases were detected and annually thereafter.
1.1.2 All contacts should be advised to seek consultation at the nearest health center for any suspicious skin lesion.

1.2 Kilatis Kutis Campaign

A routine health center activity which increases leprosy awareness in the community so that individuals with suspicious skin lesions will report voluntarily at rural health units and other government/non-government health facilities for diagnosis and treatment. This is highlighted during the annual celebration of leprosy control week every 3rd week of February.

1.3 Special Projects

These include LEC/Mini—LEC, SAPEL, and CAPEL projects that are undertaken in highly endemic provinces/municipalities (PR greater than 1 per 10,000 population). These projects are one time, time bound casefinding activities that involves 3
elements: capacity building at the local level, increasing awareness on leprosy, and community participation. Proposals are submitted to the NLCP for possible funding.

B. TREATMENT AND CASEHOLDING

1. Leprosy services shall be made available and accessible at all health facilities. There shall be at least one trained health personnel on leprosy for every rural health unit.
2. All existing and new cases shall be given the appropriate MDT regimen.
3. All patients shall be encouraged to take treatment regularly until they consume the appropriate regimen within the prescribed period.
4. Drug collection charts should always be updated.

C. HEALTH EDUCATION AND COMMUNITY INVOLVEMENT

1. Leprosy posters shall be displayed in conspicuous public places and not limited to health centers.
2. Local health units shall be encouraged to develop and produce information materials on leprosy for distribution to the public.
3. Leprosy information shall be included in all health education activities at all health centers.
4. All local government officials shall be informed of the leprosy elimination goal and encouraged to support the program by the health workers at their level.
5. Community support and participation to the program shall be solicited, encouraged and maintained.

D. MONITORING

1. Regional Health Offices shall have updated provincial prevalence maps indicating the PR and actual number of leprosy cases of all municipalities per province.
2. The Regional Coordinator shall monitor local program implementation in all provinces, especially in areas with PR >1/10,000 population, once every quarter. A copy of the monitoring report shall be furnished to the NLCP-CDCS.
3. Provincial Coordinators shall be encouraged to monitor all municipalities within their catchment area quarterly. Municipalities with PR >1/10,000 population should be monitored more frequently.

E. LOGISTICS

1. MDT drugs shall be made available at all rural health units. The Regional Coordinator shall be responsible for requesting the necessary drug supply from the NLCP.
2. No MDT drugs should expire. An annual and semi-annual report on the drug stock level at the region should be submitted to NLCP every first week of January and July, respectively.
3. NLCP forms (patient's record, central registration form, drug collection charts) shall be provided by NLCP upon request from the Regional Coordinator.

F. RECORDS AND REPORTS

1. All Central Registry shall be updated particularly on the following items:

1.1 Patients whose treatment were extended beyond the WHO prescribed fixed duration should be

considered as having completed treatment and henceforth should not be labelled as leprosy cases.
1.2 Patients still undergoing treatment for lepra reactions or other complications but have completedthe fixed duration of treatment should no longer be reported as a case.
1.3 Patients who have not collected treatment for 12 consecutive months should be followed up and considered as a defaulter only after all efforts to trace and persuade the patient to return for assessment and treatment failed. However, MB patients who have received 18 blister packs or more should be considered as having completed treatment.
1.4 Paucibacillary patients misclassified as Multibacillary who have received 6 MB blister packs or more should discontinue treatment and be considered as having completed treatment.

2. Accurate and timely statistical field reports shall be submitted one week after the end of every quarter to the NLCP-CDCS by the Regional Health Offices.

VII. EFFECTIVITY:

This order takes effect upon approval.

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Secretary of Health