



ILEP Technical Guide: Facilitating the Integration Process

**A Guide to the Integration of Leprosy Services
within the General Health System**

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Preface

Leprosy will continue to be a significant problem beyond the year 2005, even in countries where the 'elimination' target (a prevalence rate of patients on treatment below 1 per 10,000 population) has been reached at country level. New cases will continue to occur, and will need to be detected at an early stage of the disease and submitted to regular and complete treatment with multi-drug therapy (MDT). A significant proportion of patients will already show disability at diagnosis and many will be at risk of developing (further) disability after diagnosis. Leprosy services will have to be sustained for decades to come.

The International Leprosy Association/Technical Forum 2002 report states that 'to guarantee sustainable leprosy services, leprosy control programmes should be integrated in the general health services' (ILA/TF, 2002). The ILEP Medico-Social Commission had already advised in 1989 that MDT implementation should be through the general health services (ILEP, 1989). Integration is also a major component of the WHO leprosy 'elimination' strategy.

Integration means that leprosy control activities become the responsibility of the general health service (i.e. one that is multipurpose, permanent and decentralised), which is as close to the community as possible. The need for integration has been recognised in virtually all leprosy-endemic countries and an increasing number of countries have embarked on the integration of leprosy services. Several countries have shown that integration is feasible and that general health staff can deliver leprosy services effectively.

However, the change from a vertical to an integrated programme is not easy. The process must be carefully planned and must be appropriate to the specific local situation; an over-hurried, ill-planned process of integration may easily result in a deterioration in the quality of leprosy services with dramatic consequences for leprosy patients. In some countries significant problems have been encountered, usually caused by inadequate planning.

Moreover, the same mistakes tend to be repeated in different settings, despite the extensive experience that has been documented and made available in reports and publications. Much more use should be made of the lessons learned during such experiences and this is precisely why these guidelines are published. They are founded on the experience of countries that have gone through the integration process, and aim to help those embarking on or already engaged in the same process. The guide uses a flexible model to describe in a systematic way how integration can be achieved successfully. It is primarily meant for public health managers and decision-makers at national and regional levels, but I hope that it will also be useful for trainers and managers working at other administrative levels or in other programmes.

Pieter Feenstra
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List of abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
CDC	Communicable Diseases Control
DANLEP	Danish Assistance to the National Leprosy Eradication Programme
DFB	Damien Foundation Belgium
IEC	Information, Education, Communication
ILA/TF	International Leprosy Association/Technical Forum
ILEP	International Federation of Anti-Leprosy Associations
KIT	Royal Tropical Institute, The Netherlands
MB	Multibacillary
MDT	Multi-Drug Therapy
MIS	Management Information System
MoH	Ministry of Health
NGO	Non-Governmental Organisation
PHC	Primary Health Care
SWOT	Strengths, Weaknesses, Opportunities, Threats
TB	Tuberculosis
TBL	Tuberculosis and Leprosy
TDR	Special Programme for Research and Training in Tropical Diseases
TLMI	The Leprosy Mission International
WHO	World Health Organization

1 Introduction

Leprosy control and integration

Over the past two decades, the conditions in which leprosy control programmes operate have changed dramatically. The introduction of multi-drug therapy (MDT), together with the global effort to eliminate leprosy as a public health problem have had a substantial impact on leprosy control. Though the number of new patients detected has not changed globally, most are now detected in an early phase of the disease, and the number of patients on treatment has been reduced substantially.



Credit: WHO/TDR/Grump

At the same time the context within which leprosy control operates is changing, mainly as a result of reforms in the health sector and because of the increasing attention paid to other diseases such as AIDS, malaria and tuberculosis. Nevertheless, in the coming years it is likely that a substantial number of new patients will be in need of leprosy services. As a result, even though leprosy may continue to be a disease of low endemicity, and may even be rare in many areas, leprosy services - diagnosis, treatment, the prevention and care of disabilities, and rehabilitation - will need to be sustained far into the 21st century (ILA/TF, 2002).

The World Health Organization (WHO) has adopted integration into the general health system as the most appropriate strategy by which to sustain leprosy services. The WHO Expert Committee on Leprosy stresses in its seventh report that integration 'could improve the awareness of the local community, case-finding and accessibility of patients to MDT, and could help to ensure the regularity of treatment' (WHO, 1998). This is consistent with the International Leprosy Association/Technical Forum 2002 report which states that 'to guarantee sustainable leprosy services, leprosy control programmes should be integrated in the general health services' (ILA/TF, 2002). Some years prior to this in 1989, the ILEP Medico-Social Commission had advised that MDT implementation should be through the general health services (ILEP, 1989).

Several countries have already made substantial progress towards the integration of vertical leprosy control programmes into the general health services. Others are just starting. Whatever progress has been made, it is important that the process of integration is facilitated by systematic and comprehensive preparations. As indicated by the ILA/TF, the 'process of change from a vertical to an integrated programme should be carefully planned and adapted to the local situation' (ILA/TF, 2002).

Purpose of this guide

This guide aims to facilitate the process of integrating leprosy services into the general health system. It describes the integration process systematically, using a step-by-step approach and outlining for every phase the rationale behind it and appropriate methodologies for carrying it out. The guide is primarily meant for programme managers and decision-makers in the Ministry of Health and at the regional level.

Chapter 1 introduces the guide and indicates how it should be used. In Chapter 2 the concept of integration is defined and its rationale discussed. Chapters 3 and 4 together constitute the core of the guide and provide the structure of and methodology for the integration process: Chapter 3 offers a general overview of the process, while Chapter 4 describes it in terms of a series of major stages, some being subdivided further into steps. Although some steps within a stage may be addressed in parallel, it is recommended that stages should normally progress in order, as a later stage can only be properly addressed if the earlier ones have been completed. For instance, the development of a plan of action will require the use of information that has been collected and assessed during the situation analysis. Finally, while the guide outlines the reasons why each step is necessary, most emphasis is placed on describing how to carry it out.



Credit: DFB

In many leprosy-endemic countries the process of integration may already be underway, at least in terms of the initial steps. In such cases the guide can be useful in identifying how far the integration process has progressed, whether it has been satisfactory and which steps still have to be carried out or repeated. In sum, the guide can be used as:

- A manual providing information on, and an outline of methods for, the preparation and implementation of the integration process.
- A checklist of the essential steps in the integration process.
- A background document providing practical tools and references for specific aspects of integration.

It should be noted that successful integration requires transparency and commitment. These can only be achieved when all partners are involved and when the process is as participatory as possible; only through transparency can the weaknesses and constraints of leprosy control services be identified and addressed. In a successfully integrated setting, the quality of services will remain at an acceptable level while the advantages of equity, cost-effectiveness and sustainability will also be achieved.

In addition it is crucial to realize that the context in which leprosy control programmes operate is specific to each country, region or state – as a result, this guide should be used flexibly. Although efforts have been made to develop it in such a way that will be useful in different settings, the local context should always be taken into account when planning and implementing integrated services.

Finally, the guide does not intend to describe the general objectives and strategies of leprosy control, such as case-finding, case-holding, the prevention of disabilities and rehabilitation. It assumes that they will basically be the same as before, but that the way in which they are provided will be adapted to an integrated setting.

2 Integration: background and case studies

What is meant by integration?

In most countries where leprosy is endemic, activities aimed at controlling the disease began as vertical programmes. A vertical programme is organised separately from other health services, from the national level down to the operational level, and has its own specialised staff and clinics.

The underlying principle of integration is equity: optimal health care, including that for leprosy patients, consists of *general*, *continuous* and *comprehensive care*. *General* health care means that a patient receives care for a broad spectrum of common health problems, contrary to the care offered by vertical services which only provide care in relation to specific health problems. *Continuous* health care implies the constant (daily) accessibility of services, in contrast to the intermittent availability of vertical services (which may operate monthly clinics, for example). *Comprehensive* health care means that the patient is cared for by health workers who know the personal history and (family) background of the patient. Such care can only be provided by multipurpose, permanent and decentralised health services.

Integration means that the general health service assumes responsibility for leprosy control activities. This will include case-finding, treatment, the prevention of disabilities and rehabilitation, all of which are implemented at the health services delivery level, but it also includes policy making and planning, training, supervision and the identification of referral arrangements. It is therefore essential that capacity for the latter elements of leprosy control is retained at the intermediate and national level. The local context will determine how these functions are integrated.



Credit: DFB

Why integration?

For decades leprosy control activities were undertaken by specially trained and highly dedicated and motivated individuals. National authorities responsible for health services tended to depend on local and international organisations to support the programmes. However, the introduction of effective treatment in the form of MDT brought about significant changes in the management of leprosy as a disease. It also prompted the use of public health approaches for the organisation of leprosy services, reflecting the need to make MDT services more widely accessible, cost-effective and sustainable. At the same time, it was recognised that society's negative perception of the disease and of the persons affected needed to be changed.

The integration of leprosy control activities within existing general health services in endemic countries is now recognised as the best approach to bring about these changes. General health services are relatively widely distributed and close to the communities they serve, and integration will improve MDT coverage and be more cost-effective and sustainable. It may also be expected that the age-old stigma attached to the disease will be reduced as persons affected by leprosy begin to use the general health service alongside other members of the community. This of course does not mean that all supportive components will disappear; it will be important to maintain an effective network of supportive and referral services within the health system to support peripheral general health workers in maintaining an acceptable quality of service.

What have been the experiences with integration?

Efforts to integrate leprosy services have been made in several countries. In some, the process has been relatively successful and has produced satisfactory results in terms of case-finding and the quality of services delivered. In others, integration has faced obstacles and constraints. The following case studies illustrate two recent experiences, and these have been incorporated in the model that is described in Chapters 3 and 4.

Case study 1: Integration in Jigawa State, Nigeria – Building commitment among staff for the integration of leprosy services¹

Jigawa State is situated in the north of Nigeria and is divided into 27 districts. Leprosy is still a significant public health problem in Jigawa; case detection rates for 1999 and 2000 were respectively 5.5 and 1.9 per 10,000. It has a combined leprosy and tuberculosis control programme. Before integration, MDT clinics were conducted about once a week by vertical leprosy staff in 75 out of the 368 health facilities.

In 1996, the State Tuberculosis and Leprosy Control Programme Team tried to integrate leprosy control in order to enhance the accessibility and sustainability of the services. In the same year training was given to the general health staff of the Primary Health Care (PHC) units, but to limited effect. Only about 25% of the trained general health staff attended the MDT clinic sessions and less than 10% participated actively. These disappointing results were caused by a number of factors: fear of contracting the disease, the stigma of leprosy, the lack of incentives such as allowances and motorcycles which were normally given to vertical leprosy staff, and a reluctance among vertical leprosy staff to hand over responsibilities. Even when, in 1997, a special bill by the State Council was formulated indicating that leprosy patients should be treated like other patients in all health facilities in Jigawa State, there was no significant change in the participation of general health staff in leprosy services.

In 1999, a new opportunity emerged through the start of a Leprosy Elimination Campaign and a renewed effort was made to create commitment among general and vertical health staff for the integration process. As preparation for this process, the State Tuberculosis and Leprosy Control Programme Team held a special meeting with all leprosy-trained staff. This meeting indicated that most were not in favour of integration because they feared losing their status and incentives, including their motorcycles. Their fears were mainly due to a lack of knowledge concerning their future role, but these concerns were nevertheless taken seriously and discussed. Furthermore, their new responsibilities - to give technical support to the general health workers and to monitor the programme - were emphasised during the discussions.

Once the vertical staff had accepted their new roles, it was agreed that current MDT clinics would be 'handed over' to the general health staff. During the training of the general health staff a lot of effort was put into trying to reduce their fear of leprosy and to strengthen the idea that leprosy is an 'ordinary' disease.

This time the integration process was much more successful. The total number of PHC clinics providing MDT services increased to 264 out of 368 (72%) by 2000. With this development, the responsibility for routine leprosy services was devolved to the peripheral general health workers, while technical advisory tasks continued to be carried out by specialised (leprosy and TB) staff at the intermediate level.

¹ Summarised from Namadi, Visschedijk and Samson (2002).

Case study 2: Integration of leprosy services in Tamil Nadu, India²

When MDT was introduced in Tamil Nadu in 1983, leprosy services were provided through a network of 102 vertical leprosy control units managed by medical and paramedical staff numbering 3,000 and covering a population of 56 million. When in 1996 an analysis by the State Department of Health showed that provision of leprosy services through a vertical system was no longer cost-effective, a committee headed by the Director of Medical and Rural Health Services was established. This committee, consisting of various stakeholders, formulated a plan for the integration of leprosy services. In addition to cost-effectiveness, the committee based their decision on the expectation of improved sustainability of leprosy services and improved access through a network of more than 30,000 PHC workers.

In February 1997, just before the start of integration, the entire PHC system got involved in an intensive health education and case detection campaign conducted all over Tamil Nadu. This provided an entry point into leprosy work for PHC staff. Later, 22,667 medical and paramedical PHC staff were trained in leprosy and in the prevention of disabilities. Patient cards and registers were simplified and staff were taught to use a simplified monitoring system. Information, education and communication (IEC) materials were designed and produced to create awareness of the changes in service delivery. MDT regimen boards were displayed in primary health centres.

In October 1998 a study was conducted to evaluate the process and impact of integration. This study found that most personnel, including a significant proportion of former leprosy workers, had accepted integration in principle. In addition, essential indicators of leprosy performance during pre- and post-integration periods were compared in six selected districts. The study found that overall the average number of new cases had not changed significantly. Furthermore it showed that voluntary reporting was significantly higher in the post-integration period, which was attributed to the increased accessibility of leprosy services to the rural residents. The study recommended that well-defined referral systems and linkages should be established and that the knowledge, skills, attitude and motivation of workers should be strengthened by identifying training needs and by organising such training. It also noted that the level of awareness in the community regarding leprosy needed to be enhanced.

² Summarised from Department of Community Health, Vellore (2003).

3 Overview of the integration process

In this document the integration process has, more or less arbitrarily, been divided into seven stages (A-G) as follows. After an **analysis** of the current situation (A), **commitment** for integration has to be obtained from the major decision-makers (B). Next a **plan of action** for the preparation and implementation of integrated leprosy services has to be developed (C). After a period of **preparing** the health system (D), the general health services can start to **implement** integrated leprosy services (E). The implementation has to be carefully **monitored** (F) and after a few years the whole integration process should be **evaluated** (G).

Each stage consists of a number of steps, and an overview of both is given in Table 1. Each stage is represented by a section in the table. The first column of the table gives the steps involved for that stage. The second column lists the main issues to be considered while the third column gives examples of specific concerns. The methodology for undertaking each stage is described in Chapter 4.



Credit: Wellcome Trust Research Labs, Blantyre

Table 1 – Stages and steps in the integration process

Steps	Issues to be considered	Specific concerns
A. Analysing the situation		
A1. Analysing the epidemiological situation	<ul style="list-style-type: none"> • What is the current leprosy problem? • What is the expected situation in 5-10 years? 	<ul style="list-style-type: none"> • Ascertaining the exact magnitude of the leprosy problem. • Reliability of data.
A2. Analysing current leprosy services	<ul style="list-style-type: none"> • What is the state of current leprosy services (including patient-related and support services)? • What are the weaknesses and strengths of current leprosy services? • What is the current human resource capacity for leprosy services? 	<ul style="list-style-type: none"> • Availability of clear job descriptions and allocation of tasks among different health workers. • Availability of information on health seeking behaviour. • Sufficient attention given in the analysis to programme management (training, supervision, monitoring). • Clear description and analysis of the required financial resources.
A3. Analysing the health system and the degree of integration of leprosy services	<ul style="list-style-type: none"> • To what extent is the leprosy control programme already integrated? • Are there constraints within the general health service which are relevant to the integration of leprosy control? 	<ul style="list-style-type: none"> • Adequacy of the general health service in terms of population coverage. • Adequacy of the general health service in terms of human resource capacity. • Factors such as user fees that may hamper accessibility.
A4. Analysing the stakeholders	<ul style="list-style-type: none"> • Who are the relevant stakeholders? • What are their positions towards integration? • How should their commitment be secured? 	<ul style="list-style-type: none"> • Estimating the commitment of vertical leprosy staff and general health workers. • Attitude of donors/NGOs towards integration. • Community support for integration. • Patients' willingness to accept integration.
B. Ensuring the commitment of decision-makers to the principles and process of integration		
	<ul style="list-style-type: none"> • Who are the decision-makers? • Through which process can they be informed and convinced of the need for integration? • How can explicit commitment to integration be obtained? 	<ul style="list-style-type: none"> • Getting the key decision-makers involved. • Ascertaining how genuine is their commitment to integration. • Clarity of the concept of integration. • Stability of political situation. • Support from donors.

Steps	Issues to be considered	Specific concerns
C. Developing a plan of action for integration		
C1. Formulating objectives and targets	<ul style="list-style-type: none"> • What are the objectives of the integration process? • How can these objectives be translated into relevant targets? 	<ul style="list-style-type: none"> • Clarity of objectives to all stakeholders. • Setting realistic targets.
C2. Formulating a strategy for the integration process	<ul style="list-style-type: none"> • How should the process of integration be carried out? 	<ul style="list-style-type: none"> • Clarity and robustness of strategy.
C2.1. Building commitment amongst health staff	<ul style="list-style-type: none"> • How can commitment among health workers be ensured? 	<ul style="list-style-type: none"> • Sustained interest of health staff.
C2.2. Strengthening human resource capacity	<ul style="list-style-type: none"> • Which categories of staff should perform the different tasks relating to leprosy control? • How should capacity be strengthened? • How can vacancies for positions in the integrated setting relating to leprosy control be filled? 	<ul style="list-style-type: none"> • Identification of leprosy control tasks for different levels within the health service. • Level of education and experience of general health staff. • Adaptation of vertical staff to general health care setting.
C2.3. Ensuring adequate technical supervision	<ul style="list-style-type: none"> • How can technical support be maintained in an integrated setting? 	<ul style="list-style-type: none"> • Adequacy of the supervision structure. • Continuation of technical support to general health workers providing leprosy services.
C2.4. Adjusting the management information system	<ul style="list-style-type: none"> • Which indicators and targets are to be used for monitoring integrated leprosy control services? • When and how will they be measured? 	<ul style="list-style-type: none"> • Robustness and simplicity of the monitoring system. • Existence of parallel information systems.

Steps	Issues to be considered	Specific concerns
C. Developing a plan of action for integration (cont.)		
C2.5. Ensuring adequate drug supply and logistical support	<ul style="list-style-type: none"> • How will the drug distribution system work in relation to MDT and other drugs? • How will transport systems cope in the new setting? 	<ul style="list-style-type: none"> • Functionality of drug supply system. • Maintenance of guaranteed transport facility.
C2.6. Communicating the changes to the public, patients and other relevant groups	<ul style="list-style-type: none"> • How can it be ensured that patients and communities are willing to report to the general health services and that stigma is reduced? • What media should be used? • How can information be provided to other relevant groups such as traditional healers and the private sector? 	<ul style="list-style-type: none"> • Lack of awareness of integrated services. • Continuation of stigma.
C3. Developing a work plan, budget and time frame	<ul style="list-style-type: none"> • What concrete activities have to be planned and how will they be financed? 	<ul style="list-style-type: none"> • Production of a clear plan with budget.
C4. Selecting indicators to monitor the integration process	<ul style="list-style-type: none"> • Which indicators and targets are to be used for monitoring the integration process? • When and how will they be measured? 	<ul style="list-style-type: none"> • Robustness and simplicity of indicators.
C5. Finalising the plan	<ul style="list-style-type: none"> • Do the decision-makers and other important stakeholders agree with the plan for integration? • Is there sufficient financial support to start the process? 	<ul style="list-style-type: none"> • Strength of stakeholders' commitment to integration. • Adequacy of financial resources for implementing integrated leprosy services.

Steps	Issues to be considered	Specific concerns
D. Preparing the health system for the implementation of integrated leprosy services		
<p>All preparatory activities as planned in stage C are now carried out. These relate particularly to step C2, in which a strategy for the integration process will have been formulated.</p>	<ul style="list-style-type: none"> • How can implementation proceed promptly after training? • Are all staff adequately trained in, and committed to, the delivery of leprosy services following the preparatory stage? • Are the MIS and technical support in place? • Are all logistics and drugs in place for the delivery of integrated leprosy services? • Have the general public, including patients, been adequately informed about the forthcoming changes? 	<ul style="list-style-type: none"> • Loss of momentum if this stage takes too long.
E. Starting the implementation of integrated leprosy services		
	<ul style="list-style-type: none"> • Have all the steps in stage D been completed? 	
F. Monitoring the implementation of integrated leprosy services		
	<ul style="list-style-type: none"> • How can early results be used to enhance commitment to integration? • Does the information collected indicate a need to make adjustments to the integrated services? • Is there a need for health systems research? 	<ul style="list-style-type: none"> • Reliability of information. • Possible opportunities to act upon the information collected.
G. Evaluating the process of integration		
	<ul style="list-style-type: none"> • Have the objectives been achieved? • Do the objectives or strategies need to be adjusted? • What lessons can be learned? 	<ul style="list-style-type: none"> • Responsibility to organise and fund evaluations.

4 Stages and steps in the integration process

This chapter describes the stages and steps of the integration process in more detail. For each stage, and for each step within that stage, a rationale (or justification) is given and the methodology described. Where relevant, references are made to supporting documents which are listed in Appendix 1.

Stage A – Analysing the situation

Justification

The integration process should begin with an analysis of the current leprosy control programme and the context within which it operates in the country. This is necessary to:

- Identify the current strengths and weaknesses of the programme.
- Identify potential opportunities for, and obstacles to the integration process.
- Formulate, based on this assessment, a plan of action.

A basic situation analysis is also necessary for generating commitment among decision-makers for integration (stage B). However, as the information and analysis for this can be less detailed than that necessary for making a plan of action (stage C), the process of commitment building may begin before the data collection and analysis have been completed.

Methodology

A number of different approaches can be used when carrying out a situation analysis. This guide concentrates on the following four areas:

- The epidemiological situation with regard to leprosy.
- The leprosy control programme.
- The health system in which the control programme will be (or may already be, to some extent) operating.
- The actors and stakeholders relevant to the integration process.

Much of the information needed for the situation analysis will be available in annual reports, project agreements and other documents. Health staff, especially supervisors, may also be a good source of information.

The situation analysis can be completed by using a SWOT analysis to identify strengths, weaknesses, opportunities and threats. This will suggest priorities to be addressed in the planning process.

Step A1 – Analysing the epidemiological situation

Justification

It is important to assess the magnitude and distribution of both the current leprosy problem and as projected in five to ten years. Such an assessment will:

- Serve as an evidence-based tool to convince decision-makers and others of the need to sustain leprosy services.
- Help to formulate and implement leprosy services in proportion to the magnitude of the problem.
- Help to plan for specific activities such as drug supply, logistics and supervision.



Credit: DFB

Methodology

A set of indicators can be used to assess the current situation and to make projections of future trends. Most of these indicators are already used by WHO and ILEP to monitor the progress of leprosy control. The ILEP publication ‘The interpretation of epidemiological indicators in leprosy’ provides guidelines for assessing the leprosy problem in a certain geographical area (ILEP, 2001).

Table 2 presents the epidemiological indicators that can be used to analyse the leprosy problem. It is useful to analyse trends for these indicators by collecting information over several years.

Table 2 – Most relevant epidemiological indicators for leprosy control

Indicator	Interpretation
Case detection and case detection rate	The most useful indicators for estimating the magnitude of the problem and the level of ongoing transmission. Case detection is also essential for calculating drug needs.
Proportion of disabled (grade 2) among newly detected cases	Gives an indication of the delay between the onset of symptoms and the start of treatment, and of the severity of the disease in new patients.
Multibacillary (MB) proportion among newly detected cases	Gives an indication of the magnitude of the potential source of transmission. It is also essential for calculating drug needs.
Proportion of children among newly detected cases	Gives an indication of the level of ongoing transmission.

Other indicators that may be used are the female proportion among newly detected cases and the prevalence and prevalence rate.

Step A2 – Analysing current leprosy services

Justification

An assessment of current leprosy services also has to be made. This should be done in both qualitative and quantitative terms and for every level of the health system. Regional differences in coverage and performance should be taken into account.

Such an assessment will help to:

- Identify the strengths and weaknesses of current leprosy control services.
- Assess how leprosy services will change in an integrated setting.
- Assess the current capacity of human resources.
- Identify training needs.

In addition, the analysis is essential for the formulation of a plan of action (stage C), for which some of the tools outlined below may also be useful.



Methodology

Different approaches can be used for assessing leprosy services. They can be analysed:

- From a *public health perspective* by using operational indicators and/or an operational model such as used in the WHO training modules for managing leprosy control programmes (WHO, 1993).
- From a *client's perspective*.
- From an *organisational perspective*.
- ***Analysing leprosy services from a public health perspective***

A useful first step in the analysis of leprosy services is to look at operational indicators which will offer a public health perspective. These include the epidemiological indicators listed in Table 2, as well as the additional indicators shown in Table 3.

Table 3 – Indicators for leprosy services

Indicator	Interpretation
MDT completion rate ('cure' rate).	Important for assessing the quality of patient management.
Proportion of health facilities involved in leprosy control, whether vertical or integrated.	Gives an indication of the accessibility and coverage of leprosy services.

These indicators can be calculated using data which is collected either routinely (such as that used to calculate the 'cure' rate), or by special means such as during supervision visits (for example, to give the proportion of health centres involved in leprosy control).

• **Analysing leprosy services from a client's perspective**

Where available, clients' assessments of leprosy services may also inform the planning process. A model for studying the client's perspective can be found in the publication 'Client Satisfaction – Guidelines for assessing the quality of leprosy services from the clients' perspective' (van Dijk, 2002).

• **Analysing leprosy services from an organisational perspective**

In addition to the approaches outlined above, leprosy services can also be assessed from a structural and organisational perspective. This should consider the following:

- The staff involved in leprosy control (different levels, functions and responsibilities).
- The tasks they carry out (case-finding, case-holding, the prevention of disabilities, rehabilitation, health education, training activities, supply of drugs, surveillance, monitoring, technical supervision and training). Some of these activities can be combined with those of other programmes, for example with tuberculosis or other Communicable Diseases Control (CDC) activities.
- The health facilities and institutions involved (both public and private).
- The arrangements for logistical support (such as drug supplies and transport).
- The budgetary implications for leprosy control (such as investments and recurrent costs).

When formulating the plan of action (stage C) it will be particularly important to identify who is currently responsible for which tasks and who will take responsibility for those tasks in the integrated setting. Appendix 2 gives an example of a detailed distribution of tasks before and after the integration process.

Step A3 – Analysing the health system and the degree of integration of leprosy services



Credit: Joost Burenop

Justification

Besides analysing current leprosy services, it is also necessary to analyse certain aspects of the general health system and health policy. Furthermore, some initiatives relating to integration may have been taken in the past and it may be necessary to see how far leprosy services are currently integrated in the general health system. Such an analysis will help to:

- Assess which stages and steps of the integration process still have to be passed.
- Identify possible constraints and opportunities in the health system with regard to integration.

The results of the analysis should enable a plan of action to be developed which is realistic and achievable (stage C).

Methodology

The current health system should be assessed in terms that are relevant to the process of integration. The two key questions for this purpose are:

- To what extent are leprosy services integrated at the moment and to what extent are general health workers involved in leprosy control?
- Within the health system and national health policy, what constraints to integration can be foreseen?
- ***To what extent are leprosy services integrated at the moment and to what extent are general health workers involved in leprosy control?***

The extent to which integration has already occurred can also be assessed by using indicators, and those appropriate for this purpose are shown in Table 4. These indicators, which reflect the extent of integration at the primary health services level, can also be helpful in defining targets for, and monitoring, the integration process. It is important not to confuse these indicators with those shown in Table 3, which also include coverage by vertical services.

Table 4 – Indicators of progress towards integration

The proportion of health facilities providing leprosy diagnostic and treatment services by general health workers

This indicator can be made up of one or more of the following criteria:

- Proportion of health facilities with at least one general health worker trained in leprosy.
- Proportion of health facilities offering MDT.
- Proportion of health facilities with information, education and communication (IEC) materials available to patients.
- Proportion of health facilities using a simple treatment monitoring system (such as patient record cards or a register).
- Proportion of health facilities with a national leprosy manual or guide.

In addition, the extent to which leprosy control activities are integrated at the intermediate and central levels should be assessed, for example in terms of technical supervision, analysis of data, referral facilities and drugs supply.

- ***Within the health system and national health policy, what constraints to integration can be foreseen?***

However extensive the analysis of the health system, the most crucial issue is whether there are any serious constraints to the process of integration. If so, they have to be addressed when formulating the plan of action, and in rare cases they may require that the plan be reconsidered, postponed or even cancelled. Potential obstacles related to the health system include the following:

- Are there areas where access to the general health service is limited – for example, in remote areas, areas of civil unrest or rapidly expanding urban slums where there may be staff shortages or a lack of facilities? Such areas may require special attention.
- Are there legal obstacles to integration? Will access for leprosy patients be limited by financial or administrative regulations such as user fees or health insurance? Leprosy patients belong largely to the poorer groups in society, and user fees may reduce the accessibility of services and have serious consequences for case-finding and case-holding.
- Will concurrent health sector reforms such as decentralisation have an impact on the process of integration? The implications of health sector reforms for leprosy control have to be addressed during the integration process.
- Can the general drug procurement and distribution system deliver MDT drugs satisfactorily or will the system need to be strengthened?
- Is there a need to involve the private sector in the integration process? How may this be accomplished?

Step A4 – Analysing the stakeholders

Justification

Stakeholders are individuals, groups and organisations who have an interest (or stake) in a project or programme, and the potential to influence its actions and aims (Brugha and Varvasovszky, 2000)³. An analysis of those who are involved is particularly helpful for assessing the political feasibility of integration and for further commitment building.

Methodology

There are three steps in a simple stakeholder analysis:

1. The identification of different stakeholders.
2. The identification of their position regarding the policy (in this case integration) and their arguments for it.
3. The generation of strategies and concrete activities to build their commitment to the process.

Stakeholders in the integration process may include:

- Decision-makers in the Ministry of Health.
- Donors.
- Support teams (such as Communicable Diseases Control (CDC) or tuberculosis control teams).
- Former staff of vertical leprosy programmes.
- General health workers.
- Patients and their organisations.
- The private sector.

The outcomes of this analysis will be used in the planning and preparation of the integration process.

Table 5 shows a convenient form to use when summarising the results of a stakeholder analysis. An example of a simple stakeholder analysis is given in Appendix 3.

Table 5 – Stakeholder analysis

Stakeholders	Position with regard to integration	Strategies and activities to build commitment to integration

³ More extensive information on how to conduct a stakeholder analysis can be found in Varvasovszky and Brugha (2000).

Stage B: Ensuring the commitment of decision-makers to the principles and process of integration

Justification

For integration to succeed, it is essential that all stakeholders are committed to the process; such commitment should ensure political, financial and staff support throughout the different stages. Initially, however, the emphasis will be on ensuring the



Credit: Dr. Casabianca/TLMI

commitment of decision-makers in order to start the process. This is particularly important when key policy decisions have to be made in advance, such as when some cadres have to assume new roles. Later in the process, the commitment of other stakeholders such as the health staff and the general public, including patients, has to be sought.

Methodology

The following strategies may help when trying to gain the commitment of decision-makers:

- **Identify the major decision-makers whose support for the integration process is crucial.**
These are usually the political and administrative leaders who have responsibility for health services, and the senior health services managers of a country or a state. In addition, it may be important to get support early on from stakeholders who will have to support the process financially, such as major donors.
- **Convince decision-makers of the need for integration.**
It is important to explain the need for, and advantages of integration and ensure that the basic concepts are made clear. Positive experiences from other countries or settings may be useful in reinforcing these points.
- **Obtain explicit commitment and support.**
The outcome of this process should be some form of explicit confirmation, in which all parties indicate their commitment to integration and to its broader strategies. This could be done through a written declaration which is endorsed by an official government letter or circular.

Stage C – Developing a plan of action for integration

Justification

Based on the analysis conducted in stage A, and following the start of commitment building in stage B, a plan of action should be developed. This is necessary in order to:

- Formulate and reach consensus on the objectives, strategy and budget for the integration process.
- Ensure commitment to the process.

Methodology

The aim of the plan is to act as a guide for the preparation, implementation, monitoring and evaluation of the integration process. It should indicate a time frame, a strategy, a work plan and expected outcomes. Once the plan has been sanctioned by the relevant authorities, subsequent phases can begin.

The plan of action should have the following elements:

- A situation analysis (done in stage A).
- Objectives and targets.
- A strategy.
- A detailed work plan and budget.
- Indicators to monitor the process.

While the plan requires substantial technical and managerial skills, it should be developed using a participatory approach to ensure the involvement of all major stakeholders; it is crucial to have the commitment and support that will enable the plan to be implemented. A workshop may be an appropriate means by which to do this.

Step C1 – Formulating objectives and targets

Justification

Objectives and targets have to be set to ensure that:

- The direction and expected outcomes of the integration process are clear to all partners.
- The concepts of integration are operationalised.
- Leprosy services can be monitored and evaluated.

Methodology

The objectives of integrated leprosy control are assumed to be the same as those of the former vertical programme, and only the objectives and targets of the integration process as such are discussed below.

The objectives of integration as described in the plan should refer to the desired results of the process. It is crucial that the objectives be translated into clear, realistic and specific targets so that progress towards integrated leprosy services can be monitored and evaluated. Indicators such as those shown in Table 4 can be used for this.

Step C2 – Formulating a strategy for the integration process

Justification

A detailed understanding of how leprosy services are to be delivered in the integrated context is a prerequisite for successful integration. This understanding can be used as the basis for deciding how integration can be achieved and what preparations are necessary.

Methodology

Key elements of the strategy need to be developed under each of the following headings:

- C2.1. Building commitment amongst health staff
- C2.2. Strengthening human resource capacity
- C2.3. Ensuring adequate technical supervision
- C2.4. Adjusting the management information system
- C2.5. Ensuring an adequate drug supply and logistical support
- C2.6. Communicating the changes to the public, patients and other relevant groups

C2.1. Building commitment amongst health staff

Justification

Stage B reflects the importance of ensuring the commitment of decision-makers and donors to the integration process. But for leprosy services to function adequately in an integrated setting, the commitment of those who have to provide the services is also essential.

Methodology

Health workers can only be committed to integration if they understand current trends in the epidemiology of leprosy and the implications for the sustainability of leprosy services. The advantages of integration have to be explained and health workers have to understand why it is necessary; they have to realise that leprosy is a normal disease that does not require special staff or infrastructure. Updating the knowledge of staff about leprosy will also help to overcome possible concerns regarding the stigma attached to the disease. In addition, it is important to make them realise that the implementation of leprosy-related activities will contribute minimally to their overall workload.

At the same time, vertical programme workers who become general health service employees may be resistant to the change because of presumed loss of status or loss of incentives, and will need to be fully informed and reassured as to their new role. The

need for comprehensive and clear communication to all health staff is illustrated in Case Study 1 on page 6.

Organising meetings or workshops may help raise commitment among staff. Such meetings should not only include an explanation of the integration process, but should also allow enough time for open discussions in which the concerns of health staff can be addressed.

C2.2. Strengthening human resource capacity

Justification

Integration can only be implemented successfully if there is sufficient human resource capacity within the general health system for leprosy control. Capacity will need to be adjusted and, where necessary, strengthened.

Methodology

Leprosy-related tasks have to be allocated to different categories of general health staff. Once decisions have been made regarding which leprosy services will be provided at the primary level and which at the referral level, staff requirements can be estimated. While the contribution of former vertical staff should be recognised, it may not always be possible to assimilate them in an integrated system; decisions have to be made as to which workers will be reallocated, which made redundant, and which re-deployed.

After this has been done, staff training needs have to be assessed. General health workers not only have to gain knowledge about leprosy and develop skills for diagnosis and treatment, but attention also has to be given to their attitude towards leprosy and their communication skills. For technical support staff, priority should be given to supervision and monitoring skills.

These training needs can be addressed through courses, on-the-job training and meetings with a training element; they will usually be met through the use of existing training institutions and curricula, as well as intensified technical supervision. More information about training and the development of curricula can be found in the ILEP guide ‘Training in Leprosy’ (ILEP, 2003).

It is important that in the long term some basic capacity in leprosy control is retained. Efforts should be made to incorporate training in leprosy and leprosy control activities into the curricula of medical faculties and paramedical schools.



Credit: Paul Saunderson

C2.3. Ensuring adequate technical supervision

Justification

Technical supervision is essential in maintaining the competence of staff and the quality of service delivered. It motivates staff and allows constraints to be identified at an early stage. Effective technical supervision always has a strong element of on-the-job training.

Methodology

The early phases of integration tend to require more intensive technical support in order to motivate and assist general health workers with their new tasks and responsibilities. In order to be beneficial, supervision needs to be organised in a systematic way. Supervisory tasks and the frequency of visits should be planned before the actual implementation of integrated services. General health supervisors should be trained in supervision skills with a view to fulfilling their additional responsibilities in supervising leprosy-related activities. Sometimes, especially at the more central levels of the health system, more or less specialised components of the general health service can provide such services (such as state tuberculosis and leprosy (TBL) co-ordinators or provincial CDC supervisors). Further information concerning supervision can be found in the publication 'The supervision of health personnel at district level' (Flahault et al, 1988), while more background to on-the-job training is provided in the ILEP guide 'Training in Leprosy' (ILEP, 2003).



Credit: WHO/TDR/L. Maurice

C2.4. Adjusting the management information system

Justification

The health management information system (MIS) for leprosy has to be adjusted as the general health service will not be able to record and report the quantity of data that used to be handled by the vertical programme. Since the new system should be in place before integrated leprosy services start up, all the new forms and registers must be available and distributed beforehand. The management of the simplified recording and reporting system should be included in the training of health staff (see step C2.1 on page 22).

Methodology

Decisions have to be made as to which data will be recorded and reported, with what frequency and at which level of the health system. Consideration should be given to including data required for the indicators most relevant for leprosy control as

recommended by the ILA Technical Forum (ILA/TF, 2002): the new case detection rate, the proportion of disabled (grade 2), the proportion of children and the proportion of MB cases among newly detected cases, and the MDT completion rate. These indicators are shown in Tables 2 and 3 on pages 14 and 16 respectively.

Once such decisions have been made, the required forms and registers have to be developed. The recording and reporting system should become part of the general health MIS and should therefore be entirely appropriate to that system.

C2.5. Ensuring an adequate drug supply and logistical support



Credit: WHO/TDR/Grump

Justification

Leprosy services can only be delivered to patients given adequate support in terms of the drug supply, laboratory and other equipment, and transport.

Methodology

Immediately after the reallocation and training of staff, and before integrated services are implemented, the following preparations should be made:

- Drugs (MDT and steroids) have to be distributed within the integrated system.
- Reliable, integrated transport and logistical support have to be available.
- Laboratory reagents and other consumables have to be available and distributed where procedures such as slit skin smears and surgery are part of the leprosy control programme - usually a function of the referral level.

The provision of such support requires detailed planning and co-ordination beforehand.

C2.6. Communicating the changes to the public, patients and other relevant groups

Justification

Through integration, leprosy services can be made more accessible to the local population. However, the community (including patients) has to be made aware that leprosy-related services are available free of cost at the nearest health facility. Above all, the general public should appreciate leprosy patients as members of the community who should have equal access to the general health service; efforts to destigmatise the disease should be given a high priority.



Credit: TLMI

Methodology

Information, education and communication (IEC) activities have to be planned to inform the general public, patients and other relevant groups such as traditional healers and the private sector that leprosy services are integrated and can be provided by nearly all general health facilities. The start of integrated services can be highlighted through a press release, an official letter or a special celebration. In addition, IEC activities should motivate patients to come to these clinics when they suspect leprosy (and should also motivate traditional healers and other health providers to refer suspects). Of course, more general messages in relation to leprosy can also be included, relating to the early signs, the need for treatment, the availability of free drugs and the prevention of disabilities.

The media through which IEC messages are disseminated will depend on the local context. Many different methods can be used for public education, including:

- Talks to communities and community leaders.
- Radio and TV messages.
- Street dramas, puppet shows, posters and pamphlets.
- Talks at schools, clinics and other locations.

Step C3 – Developing a work plan, budget and time frame

Justification

In order to translate the strategy into a concrete plan of activities, a work plan which includes a time schedule and budget has to be developed.

Methodology

The work plan can be developed according to the system that is routinely used when planning. It should indicate all necessary activities, a time schedule, the persons

responsible and a budget. Preparatory activities such as training and health education campaigns (see stage D) should also be included.

Usually the integration process will be implemented at the same time throughout the state or country. It is, however, possible to phase the process according to administrative areas, whereby the experience gained in the first areas will be used to improve the strategy for subsequent areas.

Step C4 – Selecting indicators to monitor the integration process

Justification

Besides adjusting the MIS to include the monitoring of integrated leprosy services (step C2.4), progress towards the objectives and targets of the integration process should also be assessed. Such monitoring should indicate the presence of any constraints to integration which can then be addressed as necessary.

Methodology

Such a monitoring system needs to be as simple as possible and can be based on the indicators presented in Table 4 on page 18. Health systems research procedures may also inform the process, if additional information is required.

Step C5 – Finalising the plan

Justification

Before the work plan and budget can be put into practice and the preparatory activities can begin, the plan for integration must be made clear to all partners, and the necessary financial support secured.

Methodology

Before the actual implementation of integrated services, it is often useful to discuss the general outline of the plan with the main actors, and adjustments can then be made as necessary. There should also be guaranteed funding for the plan; where necessary, negotiations will have to be conducted, and a one-day meeting with the most relevant stakeholders may provide the opportunity to do this. Subsequently the starting date for implementation of the work plan (including preparation) can be fixed and communicated to all parties involved.

If possible, an official government circular or letter relaying the decision to integrate leprosy services should be drawn up and widely circulated to staff, health facilities and institutions. This communication should include the dates of the preparatory period (stage D) and the actual starting date of integrated leprosy services (stage E).

Stage D – Preparing the health system for the implementation of integrated leprosy services

Justification

Before the actual implementation of integrated leprosy services, it is important that all the necessary preparations are made so that the conditions for successful integration are fulfilled. Human resource capacity and the support functions should be established, and the public and patients informed.

Methodology

All the preparatory activities as planned in step C2, ‘Formulating a strategy for the integration process’, should now be carried out: building commitment among staff, organising human resources and supervision, adjusting the management information system, organising the support services, and communicating with the public. It is important that this stage does not take too long and is immediately followed by the actual start of implementation of integrated leprosy services - a period of three months is usually adequate.



Credit: TLMI

Stage E – Starting the implementation of integrated leprosy services

Justification

The implementation of leprosy services by the general health system can only start after the conditions for effective integration have been fulfilled. These are that:

- All health staff are committed to the integration process.
- Health workers have received training for their new tasks and responsibilities.
- Technical supervision has been organised.
- The recording and reporting system is in place.
- The other supportive functions for leprosy control have been established (such as drug supply and logistics).
- The general public and patients have been informed and educated about the integration of leprosy services.

Methodology

The starting date will have been fixed before the preparatory phase was started (stage D) and should have been widely communicated by the government through the circular outlined in step C5. The general health staff will then implement all leprosy-related activities as defined in the plan of action.

Stage F – Monitoring the implementation of integrated leprosy services

Justification

During implementation, the integrated leprosy services have to be accurately monitored in order to assess progress and identify possible constraints.

Methodology

Although the monitoring of the integration process is different from monitoring the performance of integrated leprosy services, some of the indicators used for the latter are also appropriate for the former. The indicators listed in Table 4 on page 18 are especially useful for this purpose. Monitoring is also important if there is to be a phased expansion of the number of health facilities implementing integrated leprosy services. In this case, integrated services are implemented in one area, while other areas are still in the preparatory stages.



Credit: TLMI

Adaptations will have to be made as necessary - for instance, in relation to the job descriptions of health staff. It may also be possible that more training for certain categories of staff is required or that technical supervision has to be intensified during the initial period.

Stage G – Evaluating the process of integration

Justification

While monitoring should be a continuous activity, an evaluation can be carried out after the completion of the integration process in order to assess and, where necessary, modify the integrated leprosy services. Furthermore, lessons can be learned which can be applied in the future or in other settings.

Methodology

An evaluation should be based on the objectives and targets defined for the process. It could be carried out a few years after implementation has started and should if possible involve external experts.

The basic steps for an evaluation are as follows.

- A decision is made to conduct an evaluation, and a team and date are identified.
- The Terms of Reference, methodology and time frame are drawn up.
- The evaluation is carried out:
 - information and materials are collected through different evaluation tools (questionnaires, surveys, discussions, records analysis);
 - the information is analysed;
 - a report is prepared and recommendations made.
- Recommendations from the evaluation are acted upon.

As an example, the case study on page 7 gives a summary of the findings and recommendations of an evaluation conducted in Tamil Nadu, India following integration.

Appendices

Appendix 1 – References and further reading

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Appendix 2 – An example⁴ of distribution of tasks in leprosy control

Leprosy control tasks	Who does it currently?	Who should do it in an integrated situation?	What other adjustments are required?
Peripheral level			
Community education	Village health worker (VHW)	VHW	
Identify suspects	General health worker (GHW)	GHW	
Examine suspects	District leprosy worker (DLW)	GHW	Simplified guidelines
Refer suspects	All GHWs	Community health worker (CHW)	Involvement of CHWs in leprosy control
Diagnose and classify	DLW	GHW	
Fill in patient card	DLW	GHW	
Register patients in unit register	DLW	GHW	
Prescribe MDT	DLW	GHW	
Administer supervised dose	DLW	GHW	
Give drugs for self-intake	DLW	GHW	
Give health education to patients about treatment	DLW	GHW	Production of pamphlets for patients
Retrieve defaulters	DLW	GHW/CHW	
Educate patients about prevention of disabilities	DLW	GHW	
Identify side effects of treatment	DLW	GHW	
Deal with side effects	DLW	GHW at referral level	
Check nerve function	DLW	GHW	Simplified guidelines
Identify reactions	DLW	GHW	Simplified guidelines
Deal with nerve function worsening and reactions (= treat or refer)	DLW	GHW at referral level	
Treat ulcers	DLW	GHW	
Train patients in ulcer self-care	DLW	GHW, DLW	
Report transfers	DLW	GHW, district CDC supervisor	
Release from treatment (RFT)	DLW	GHW	
Give health education to patients upon RFT	DLW	GHW	
Keep the unit register	DLW	GHW	Production of additional registers
Prepare the health unit report	DLW	GHW	Production of simple framework for health unit report

⁴ This is a fictional example and does not necessarily reflect a real situation.

Leprosy control tasks	Who does it currently?	Who should do it in an integrated situation?	What other adjustments are required?
Peripheral level (cont.)			
Examine contacts	DLW	GHW	
Order the required drugs	DLW	GHW, 'pharmacist' of health facility	
Manage the drug stock	DLW	GHW, 'pharmacist' of health facility	
Take skin smear	DLW	Laboratory staff	
Examine skin smear	Lab. staff	Lab. staff	
Keep laboratory register	Lab. staff	Lab. staff	
Order the required quantity of reagents and lab supplies	Lab. staff	Lab. staff	
Adjust prescription to smear result, if taken	DLW	GHW	
Intermediate and central level			
Supervision and on-the-job training	DLW	District CDC supervisor*	New supervision schedule, which incorporates technical support and on-the-job training
Provision of drugs and logistics	DLW	Central Medical Store	Formulation of clear logistical guidelines
Identifying training needs and organising training and meetings	Provincial leprosy team	District CDC supervisor, provincial leprosy & TB team	
Compilation and analysis of data	Provincial leprosy team	Provincial leprosy & TB team, national leprosy unit	
Policy making and planning	National leprosy unit and provincial leprosy team	National leprosy unit, provincial leprosy & TB team	New leprosy manual
Patient education, community education	National leprosy unit and provincial leprosy team	GHW, district CDC staff, provincial leprosy & TB team, national leprosy unit	
Incorporation of training in basic curricula	National leprosy unit in collaboration with universities and training institutions	National leprosy unit in collaboration with universities and training institutions	Ensuring that leprosy receives attention in basic curriculum of general health staff
Research	National leprosy unit in collaboration with research institutions	National leprosy unit in collaboration with research institutions	

*In some settings supervision will be conducted by general supervisors or by combined tuberculosis/leprosy supervisors. In other settings the district leprosy supervisor may have more responsibilities than for leprosy alone. The local context will determine the most suitable option.

Key:

- VHW Village health worker
- GHW General health worker
- DLW District leprosy worker
- CDC Communicable Diseases Control

Appendix 3 – An example⁵ of a simple stakeholder analysis

Stakeholders	Position with regard to integration	Strategies and activities to build commitment to integration
MoH/Central Unit	In favour of integration.	<ul style="list-style-type: none"> To be utilised as facilitators and participants in the process of integration.
State government	Against integration, because they think that leprosy control requires special services and involves extra costs.	<ul style="list-style-type: none"> Workshop to convince them of the advantages of integration. Regular contacts and advocacy meetings. Official document which indicates agreement about integration.
State Tuberculosis Control Team	In favour of integration.	<ul style="list-style-type: none"> Training for leprosy control may be combined with tuberculosis.
General health workers	Against integration, because they are afraid of the extra work load and of the stigma attached to leprosy patients.	<ul style="list-style-type: none"> They have to be persuaded of the advantages of integration – this aspect to be included in training. An official circular to be sent to all staff. The tasks of general health staff to be well described. Intensive supervision necessary in the period after integration.
Vertical leprosy staff	Very much opposed because they are afraid of losing special privileges (motorbike, allowances).	<ul style="list-style-type: none"> They have to be convinced of the need for integration. Where possible efforts may be made to ensure that certain privileges can be kept. Meetings and training sessions to be organised to get their commitment and train them in their new role.
Community and patients	Are basically in favour but some feel that the quality of leprosy services may be reduced.	<ul style="list-style-type: none"> They have to be convinced that adequate services can be found in nearby health facilities – this can be achieved through health education campaigns.
NGOs/donors	Are opposed because they feel that the quality of leprosy services may be reduced.	<ul style="list-style-type: none"> They have to be convinced that quality can be maintained while accessibility, efficiency and sustainability are increased. They can be asked to support in particular the training of general health staff.

⁵ This is a fictional example and does not necessarily reflect a real situation.

The integration of leprosy control programmes into the general health system is now recognised as the most important strategy by which to sustain health services for people affected by leprosy. An increasing number of countries have embarked on the integration process and several have shown that leprosy services can be delivered effectively by the general health system.

However, the change from a vertical to an integrated programme is not easy and has in many cases been beset by problems. This guide draws on the experience of countries that have already gone through the integration process to help those embarking on or already engaged in the same process. It uses a step-by-step approach to describe the preparations that are so necessary for integration to be successful, emphasising the importance of planning and at the same time highlighting common pitfalls. It also outlines how to monitor and evaluate the process once integrated services have been implemented.

The guide will prove a valuable tool for public health managers and decision-makers at national and regional levels, as well as for trainers and managers working at other levels.