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ENGLISH ONLY

WHO/SPC INTERCOUNTRY WORKSHOP ON TUBERCULOSIS AND LEPROSY CONTROL IN THE SOUTH PACIFIC

Convened by the

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

In collaboration with

SOUTH PACIFIC COMMISSION
NEW CALEDONIA

Suva, Fiji
7-18 July 1986

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NOTE

The views expressed in this report are those of the participants in the WHO/SPC Intercountry Workshop on Tuberculosis and Leprosy Control in the South Pacific and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the Regional Office for the Western Pacific of the World Health Organization for governments of Member States in the Region and for the participants in the WHO/SPC Intercountry Workshop on Tuberculosis and Leprosy Control in the South Pacific held in Suva, Fiji on 7 to 18 July 1986.

CONTENTS

1. INTRODUCTION

The fourth WHO/SPC intercountry workshop was held at the Twomey Memorial Hospital in Suva, Fiji, on 7 to 18 July 1986 in collaboration with the South Pacific Commission.

The local administrative arrangements were undertaken by the office of the World Health Organization Representative in collaboration with the Twomey Memorial Hospital and the Tamavua Tuberculosis Hospital. The interpretation services were provided by the South Pacific Commission.

Of the seventeen nominees from twelve countries/areas in the South Pacific, fourteen were able to participate in the workshop. The participant from Nauru, who attended the workshop, was subsidized by his Government.

The workshop was opened with a message from Director Hiroshi Nakajima WHO Regional Director for the Western Pacific, read by the Acting WHO Representative from Suva, Fiji, and an address of Dr Richard Taylor, Representative of the South Pacific Commission. The workshop was also addressed by the Permanent Secretary for Health, Fiji, Dr Bumaiwai, and Dr E.C. Daulako of the P.J. Twomey Memorial Hospital (see ANNEX 3).

2. OBJECTIVES

The objectives of the workshop were:

(1) to update information on tuberculosis and leprosy case-finding and management, as well as the latest developments in chemotherapy and immunology;

(2) to review and develop information, monitoring and evaluation in tuberculosis and leprosy control programme management; and

(3) to formulate national leprosy and tuberculosis operational plans.

3. SUMMARY OF DISCUSSIONS

3.1 Tuberculosis and leprosy situation in the Western Pacific Region [1/]

The first session of the workshop included a presentation on the tuberculosis and leprosy situation in the Western Pacific Region. The regional tuberculosis and leprosy programmes were also discussed as well as WHO's collaboration with countries in support of their leprosy and tuberculosis programmes.

[1/] Presented by Dr A. GAlvez.

3.2 Epidemiology and statistics [1/]

The epidemiological principles and methods were discussed, including their application in tuberculosis and leprosy.

The commonly used measurements of health status such as prevalence, incidence and disease ratio/rate were discussed and illustrated, and in particular the numerator and denominator to be used in the computation of specific measurement of health status.

3.3 Epidemiology of tuberculosis and leprosy [2/]

The presentation emphasized the importance of the epidemiology of tuberculosis and leprosy in determining the history, magnitude, trends and impact of the two diseases. The basic methods of epidemiological study of tuberculosis and leprosy were discussed such as surveys (sample and national surveys) including registries and observations. Different indices for tuberculosis and leprosy epidemiology were thoroughly discussed with participants including exercises in selecting relevant data for their calculation.

Participants provided clarifications on the data and formula used in calculating the various indices for epidemiology of the disease. It was considered that application of the formula would depend on the availability of organized relevant data.

Dr Lee presented the distribution of leprosy in the South Pacific and discussed the factors that influence the differences in the magnitude and distribution of the disease.

3.4 Clinical aspects of leprosy and tuberculosis [3/]

Dr Daulako gave a slide presentation on the different types of leprosy and referred to the different signs of the disease, which are influenced by body resistance. He pointed out the different skin signs and described the various types of leprosy, including the laboratory findings which support diagnosis of the disease.

Dr Panapasa presented the different signs and symptoms of pulmonary tuberculosis. He cautioned participants that classical signs and symptoms of the disease may be absent in some cases and that some symptoms may appear more severe than others. X-ray pictures to detect the lesion in the lung were also presented. Participants were again, cautioned in the use of X-ray to support diagnosis of tuberculosis, since what the reader sees are shadows which can be produced by many lung conditions.

[1/] Presented by Dr R.W.K. Gee and Dr P. Taylor.
[2/] Presented by Dr Qian Yuan Fu and Dr J.W. Lee.
[3/] Presented by Dr E. Daulako and Dr F. Panapasa.

3.5 Case-finding and treatment in tuberculosis and leprosy[1/]

Participants noted that, for both diseases, diagnosis is based on clinical and bacteriological exmination. For leprosy, the cardinal signs are: skin lesions (such as patches, macula and discoloration) thickened nerves and loss of sensation.

For tuberculosis, the classical symptoms are: cough, hemoptysis, low grade fever, loss of weight and loss of appetite.

For both diseases, laboratory support is essential to case-finding. The demonstration of Mycobacterium leprae and Mycobacterium tuberculosis in smears of specimen for skin and sputum, respectively, confirms the diagnosis of tuberculosis or leprosy. The appearance of acid fast bacilli (AFB) in specimens also determines the infectiousness of the disease and the appropriate treatment regimen necessary.

Although an X-ray examination is probably the only way to detect early, non-symptomatic pulmonary tuberculosis, for confirmatory diagnosis the demonstration of acid fast bacilli in sputum is necessary to diagnose the case as pulmonary tuberculosis.

Once a case of tuberculosis or leprosy is detected, adequate treatment is essential. A WHO standardized regimen is available for the treatment of leprosy and tuberculosis, which makes the treatment programme simple and easily implementable at peripheral levels. This is a combination of drugs that has bacteriostatic and bactericidal action and is effective even for organisms with primary resistance to any of the drugs in the combination. It was emphasized that case-finding is not a control measure unless it is followed by an adequate treatment.

With regard to leprosy treatment, most participants felt that the paucibacillary and multibacillary treatment regimen should continue for a longer period as recommended by WHO. Also, the dosage of drug combination should be flexible and appropriate to the country's situation.

It was clarified that the WHO-recommended treatment regimen is the minimum effective regimen and that dosage and frequency can be modified depending on the country's resources, social system and culture. Most of the countries represented are using modified WHO-recommended Multidrug therapy for leprosy and tuberculosis chemotherapy.

Most countries in the South Pacific have applied short-course chemotherapy for tuberculosis using different combinations of drugs and dosage. WHO has not recommended a regimen for short-course chemotherapy for tuberculosis because of lack of sufficient scientific data to support

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[1/] Presented by Dr E. Daulako, Dr F. Panapasa, Dr J.W. Lee and Dr Qian Yuan Fu.

the policy. The participants were informed of the experience of various countries in small-scale implementation of short course chemotherapy for tuberculosis. From a comparison of drug combination and duration of treatment, it appears that in most countries or areas the cost of treatment is expensive. Participants were advised that their treatment strategy should be reviewed both to lower the cost and simplify treatment so it can be carried out by peripheral health centres.

It was emphasized that the success of tuberculosis and leprosy chemotherapy using an effective multidrug combination regimen depends on the regular intake of an adequate dosage of the drug. In short, good compliance with the regimen is necessary to ensure control and cure of the disease.

3.6. BCG vaccination[1/]

The use of tuberculin testing for epidemiological studies, clinical diagnosis and BCG assessment was discussed. Criteria for positive reaction were explained; it was noted that each country should establish its own criteria. The epidemiologist/statistician demonstrated how to determine or compute for the post-vaccination tuberculin positive reaction using available data.

The use of tuberculin testing for BCG assessment was discussed at length and illustrated. Emphasis was placed on how to express "positive conversion", in terms of mean size and its standard deviation for the whole vaccinated group that is tested.

The calculation of the infection rate was thoroughly discussed with reference to the unvaccinated child population.

Clarification was provided on direct BCG vaccination without the pre-tuberculin test. Studies were presented showing that BCG vaccination, if given to an infected or even diseased individual, does not induce adverse reaction or aggravate the course of the disease. For non-infected persons, BCG vaccination gives immunity.

There was a discussion on scheduling of BCG vaccination as part of the expanded programme on immunization and the packaging of BCG vaccine based on the smaller ampoule of 5 doses.

A nearby school was used to demonstrate the tuberculin test, tuberculin reading and BCG vaccination. From the data generated, the calculation of infection rate, mean size of positive tuberculin test and conversion rate were illustrated.

1/ Presented by Dr K. Mehta, Dr Sharma, Dr F. Panapasa, and Dr Qian Yuan Fu.

3.7 Laboratory diagnosis for tuberculosis and leprosy[1/]

Tuberculosis control

The laboratory procedure for tuberculosis control comprises:

- Direct microscopy
- Culture
- Identification of a typical mycobacteria
- Drug sensitivity test.

A demonstration and video showing of direct microscopy from sputum specimen to reading slides were presented. Participants noted that, in most South Pacific countries, the usual procedure is to collect sputum and prepare smears in the field units, which are sent to Central Laboratory for staining and examination. Sputum microscopy has been applied by peripheral health centres in the South Pacific as a case-finding tool.

The sputum microscopy result states the number of bacilli per field in the slide examined. Sputum conversion means that the treatment regimen given is effective. If the direct microscopy is negative, it was suggested that a culture should be made to confirm the negative result if available.

Leprosy control:

Participants noted that laboratory support for leprosy control is essential to achieve impact. Laboratory results are necessary to determine the classification of the disease and the appropriate treatment regimen to be instituted.

The discussion centered on the implication of bacterial and morphological indexes. It was noted that:

(1) The bacterial index (BI) refers to all leprosy bacilli in the smear, whether dead or alive,

(2) The morphological index (MI) is the percentage of living bacilli, which is characterized by uniformly stressed rods after counting 100.

It was pointed out that, only when the bacilli can be demonstrated (smear, sputum, tissue culture), can the diagnosis of leprosy or tuberculosis be accepted.

The other laboratory procedure in leprosy control is the histopathological examination of tissue specimen from the skin lesion of a leprous patient, which is normally done in well equipped laboratories.

[1/] Presented by Dr E. Daulako and Dr F. Panapasa and staff.

3.8 Programme evaluation[1/]

Participants noted that programme evaluation is intended to assess the degree of success that has been achieved, at a given time, in attaining the predetermined objectives.

The epidemiological and operational evaluation was considered to be the more important aspect of programme evaluation.

Examples of epidemiological evaluation detailing the process and the data needed were discussed. A more simple operational assessment was discussed making use of target against performance.

It was emphasized that evaluation should be a continuous process to determine the programme status in relation to objectives and the need to modify the programme to attain the objectives.

It was the consensus of the group that an attempt should be made to actualize the evaluation process in their respective tuberculosis and leprosy control programmes, either on a project or programme basis.

3.9 Planning of the tuberculosis/leprosy programme[2/].

Participants noted that planning is a systematic process whereby a series of deliberate steps are taken to pinpoint problems, determine the reasons for their existence, and select the most appropriate solution among available alternatives for solving each identified problem.

The basic steps of planning such as situational analysis, problem determination and plan formulation in order to solve, alleviate or eradicate the problem/s; setting of objectives, targets, strategy, approaches; implementation, evaluation, and indication of resources needed to support the plan were discussed.

The need for a plan for the tuberculosis and leprosy control programme was stressed to provide direction for the peripheral health worker in attaining objectives.

A practical approach to tuberculosis and leprosy programme planning was demonstrated. However, it was observed that more time was needed to better understand the process in order to apply it in the respective country programme.

[1/] Presented by Dr J.C. Tao, Dr Qian Yuan Fu, Dr J.W. Lee and Dr A.A. Galvez.

[2/] Presented by Dr A.A. Galvez and Dr J.C. Tao.

3.10 Recording, reporting and registration system[1/]

The importance of an effective information system, including a recording, reporting and registration system, to a successful national tuberculosis/leprosy control programme, especially as regards programme management, was emphasized.

The information system must provide not only information concerning the implementation and achievement of various tuberculosis/leprosy control measures, but also the basic data for epidemiological surveillance. Such information is essential for programme management, e.g. monitoring, supervision, assessment and evaluation of special control measures as well as the programme in general.

The record system for BCG vaccination, case-finding and the treatment programme was discussed in detail and some well-designed recording forms were provided. There was a consensus that a modified OMSLEP recording system should be adopted in the leprosy control programme, while on the tuberculosis control programme, and individual registration card and registration book would be the basic components of the central registry.

3.11 Integration of leprosy and tuberculosis through primary health care[2/]

The rationale of the integration of tuberculosis and leprosy was discussed, particularly in situations where manpower is insufficient to deliver and manage the services. The planning, implementation, evaluation of programmes and the responsibilities of health personnel at different levels of administration in the integrated tuberculosis and leprosy control programme within the existing health services were also discussed. The need for sound training and orientation before undertaking integration was emphasized. It was noted that the primary health care approach would facilitate integration of the tuberculosis and leprosy control programme.

Training of health staff and strengthening of health infrastructures should be carried out prior to integration. Integration should take place after a vertical programme ceases to operate and when the case load can be adequately handled by the existing health service personnel.

It was observed that, for most countries represented in the workshop, integration has been going on for some years at the subnational level.

[1/] Presented by Dr J.W. Lee and Dr Qian Yuan Fu.
[2/] Presented by Dr A.A. Galvez.

3.12 Operational plan formulation[1/]

This exercise was conducted based on the country reports on case-finding and treatment, case-holding, BCG vaccination, epidemiological strategies, and indices used in tuberculosis and leprosy control.

The operational planning exercise was conducted using a prepared tabulation to facilitate the process. Most of the participants were handicapped by inadequate information and knowledge of programme activities. A follow-up of their operational plan was requested.

4.13 Serodiagnosis in leprosy[2/]

The rapid diagnostic method for M. leprae infection was discussed as a new tool for detection of subclinical leprosy and monitoring of the treatment and post-treatment period. It was noted that with exposure to Mycobaterium leprae, the body will react with the production of antibodies specific to the organism. These antibodies can be detected through the antibody-antigen reaction mechanism. If the serum which contains the antibody is made to react with a specific antigen through the enzyme linked immunosorbent assay (ELISA), it gives a positive reaction. A specific antigen has been synthesized and is available for the rapid diagnostic method for M. leprae infection, which makes the method simple for field application.

The participants were informed of recent developments in the diagnostic method, and noted that:

(1) the method will permit detection of early infection and subclinical leprosy, permitting an intervention to abort the progress of clinical leprosy;

(2) it will be useful to monitor the progress of treatment as the test can detect immunological changes during treatment and preceding clinical relapse;

(3) a field trial will be conducted soon in one or two countries in the South Pacific.

5. EVALUATION OF THE WORKSHOP

An evaluation of the workshop was conducted through a questionnaire form distributed to the participants. A total of thirteen participants

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1/ Presented by Dr A.A. Galvez.
2/ Presented by Dr J.W. Lee.

received the questionnaires (summary of questionnaire in ANNEX 4). Regarding the attainment of objectives, ten participants indicated that objectives 1 and 2 had been attained and three abstained. Regarding objective 3, eight confirmed attainment of the objective and two indicated that not enough time and information were available to enable participants to draft the plan immediately.

The majority of participants were satisfied with the method and outcome of the workshop. However, a few noted that there was not enough time for exchange of knowledge and experiences; working papers were too detailed and unnecessary; presentations were too general; and no group discussion was held as planned.

Regarding the organization of the meeting, eight participants were satisfied and four indicated that the duration of one week was sufficient; the duration of the presentation should be limited and more time made available for the practical aspects and statistics.

Regarding the administrative aspects, there were the usual observations about accommodation, delay in per diem payment, late notification of the preparation of the country report and delay in air ticket confirmation.

The majority of participants expressed the need to continue with the series of WHO/SPC workshops on tuberculosis and leprosy control in the South Pacific from which everyone benefited. However, there should be more exercises and informal discussions with consultants, and shorter presentations during the session.

ANNEX 1

LIST OF PARTICIPANTS, TEMPORARY ADVISERS, CONSULTANT AND SECRETARIAT

1. PARTICIPANTS

AMERICAN SAMOA	Dr Edgar C. Reid Assistant Director of Special Public Health Control Programmes TB, Hansen's Disease, STD, Filariasis, Hepatitis Lyndon Baines Johnson Tropical Medical Center Pago-pago
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ANNEX 2

CURRICULUM AND TIMETABLE

MONDAY, 7 July 1986

8:00 a.m.	Registration
8:30 a.m.	1. Opening ceremony
9:00 a.m.	2. Tuberculosis and leprosy situation in WPRO by Dr A. Galvez, Dr Qian Yuan Fu and Dr J.W. Lee
9:30 a.m.	COFFEE BREAK
10:00 a.m.	2. Tuberculosis and leprosy situation in WPRO by Dr A. Galvez, Dr Qian Yuan Fu and Dr J.W. Lee (continuation)
12:00 noon	LUNCH BREAK
1:30 p.m.	3. Country report and future plan for leprosy and tuberculosis control programme (6 countries)

TUESDAY, 8 July 1986

8:00 a.m.	4. General epidemiology and statistics by Dr R. Taylor and Dr R.W.K. Gee
9:30 a.m.	COFFEE BREAK
10:00 a.m.	5. Exercise on rates and ratio
12:00 noon	LUNCH BREAK
1:30 p.m.	6. Demonstration - Tuberculin test - BCG vaccination

Annex 2

WEDNESDAY, 9 JULY 1986

8:00 a.m.	7. Epidemiology of tuberculosis and leprosy by Dr Qian Yuan Fu and Dr J.W. Lee
9:30 a.m.	COFFEE BREAK
10:00 a.m.	7. Epidemiology of tuberculosis and leprosy by Dr Qian Yuan Fu and Dr J.W. Lee (Continuation)
12:00 noon	LUNCH BREAK
1:30 p.m.	8. Country report and future plan for leprosy/ tuberculosis control programme (6 countries)

THURSDAY, 10 July 1986

8:00 a.m.	9. BCG vaccination by Dr H.D. Mehta
8:30 a.m.	10. Clinical aspect of tuberculosis and leprosy by Dr Qian Yuan Fu, Dr J.W. Lee, Dr F.T. Panapasa and Dr E.C. Daulako)
9:30 a.m.	COFFEE BREAK
10:00 a.m.	11. Signs, symptoms and case-finding by Dr F.T. Panapasa and Dr E.C. Daulako
12:00 noon	LUNCH BREAK
1:30 p.m.	12. Panel discussion - BCG vaccination

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FRIDAY, 11 July 1986

8:00 a.m.	13. Treatment, case-holding, follow-up and supervision by Dr Qian Yuan Fu and Dr J.W. Lee
9:30 a.m.	COFFEE BREAK
10:00 a.m.	13. Treatment, case-holding, follow-up and supervision by Dr Qian Yuan Fu and Dr J.W. Lee (continuation)
12:00 noon	LUNCH BREAK
1:30 p.m.	14. Demonstration - Tuberculin test reading - Analysis of results - Evaluation of BCG programme

MONDAY, 14 JULY 1986

8:00 a.m.	15. Planning of national tuberculosis/leprosy control programme by Dr R. Taylor and Dr A. Galvez
9:30 a.m.	COFFEE BREAK
10:00 a.m.	15 Planning of national tuberculosis/leprosy control programme by Dr R. Taylor and Dr A. Galvez (continuation)
12:00 noon	LUNCH BREAK
1:30 p.m.	16. Demonstration of laboratory procedures for case-finding

Annex 2

TUESDAY, 15 JULY 1986

8:00 a.m.	17. Management of national tuberculosis/leprosy programme
9:30 a.m.	COFFEE BREAK
10:00 a.m.	18. Recording, reporting, monitoring and evaluation by Dr Qian, Dr J.W. Lee and Dr J.C. Tao
11:00 a.m.	19. Health education by Dr E.C. Daulako and Dr F.T. Panapasa
12:00 noon	LUNCH BREAK
1:30 p.m.	20. Operational plan formulation by Dr A. Galvez, Dr J.C. Tao, Dr R. Taylor and Dr J.W. Lee

WEDNESDAY, 16 July 1986

8:00 a.m.	21. Evaluation of national leprosy/tuberculosis programme by Dr J.C. Tao, Dr Qian Yuan Fu, Dr J.W. Lee and Dr R. Taylor
9:30 a.m.	COFFEE BREAK
10:00 a.m.	22. Integration of tuberculosis/leprosy to general health services by Dr A. Galvez
12:00 noon	LUNCH BREAK
1:30 p.m.	23. Evaluation of tuberculosis/leprosy programme by Dr Qian, Dr J.C. Tao, Dr J.W. Lee and Dr Daulako

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THURSDAY, 17 JULY 1986

8:00 a.m.	24. Primary Health Care and Health for All by Year 2000 by Dr C. Palmer and Dr A. Galvez
9:30 a.m.	COFFEE BREAK
10:00 a.m.	25. Workshop on identified problem on tuberculosis and leprosy control programme by Dr J.C. Tao and Dr R. Taylor
12:00 noon	LUNCH BREAK
1:30 p.m.	26. Operational plan formulation by Dr A. Galvez, Dr J.C. Tao, Dr R. Taylor and Dr J.W. Lee

FRIDAY, 18 July 1986

8:00 a.m.	27. Operational plan formulation - (selected country)
9:30 a.m.	COFFEE BREAK
10:00 a.m.	28. Panel discussion for the workshop on identified problem
12:00 noon	LUNCH BREAK
1:30 p.m.	29. Open forum on the draft report of the workshop
2:30 p.m.	30. Evaluation of the course
3:30 p.m	31. Closing ceremony

ANNEX 3

MESSAGE OF DR M. BIUMAIWAI
PERMANENT SECRETARY FOR HEALTH, FIJI

Dr Gee, the representative of World Health Organization, members of the WHO Office in Suva, Dr Taylor representing the South Pacific Commission, the representative of the World Health Organization in Manila, Participants, Ladies and Gentlemen. I welcome the opportunity to be with you this morning at the opening of the World Health Organization/South Pacific Commission Intercountry Workshop on Leprosy and Tuberculosis. I would like, first of all, on behalf of my Ministry and the Government of Fiji to thank the World Health Organization/South Pacific Commission for providing funds to enable the participants to attend this important meeting. It is therefore with great plessure that I extend to you all a very warm welcome to Fiji at the Twomey Memorial Hospital. I believe that this meeting will present a good opportunity for your group to review a country to country situations on both leprosy and tuberculosis. We believe that the integration of both control programmes in the general health services and orientation towards primary health is now a priority to most of our countries in our part of the world. Leprosy and tuberculosis are still prevalent in most countries in our Region. Although, both diseases have shown declining trend, the decline in most cases is slow. The tehcnology used for controlling these diseases is better developed in tuberculosis compared to leprosy, However, we believe that investigations are still required for both diseases. It is our firm belief that our available technology does not reach sufficient people living in perphery together with poor implementation of case-finding and case-holding activities are probably the main contributing factors for slow decline in both diseases. I would like to say a few words emphasizing leprosy. Leprosy has been recognized although for 200,000 years and the complex infectious disease found a century ago to be caused by a bacterium is not completely understood, but considerable progress has been made in the last forty years or so that today we can treat the majority of cases without undue difficulty and counteract most of the fears generated by the foreclosed surrounding this disease. While we actually progress today, we must also recognize a variety of factos that are known to cause failure in many programmes designed to control the disease such as funds, trained personnel, length of treatment required, etc. It is also not easy to maintain treatment before prolonged interval, even in the best control programmes occasionally patients may be discouraged by the prospect of taking treatment for life. Furthermore, although other patients of control diseases such as diabetes and epilepsy may have a similar problem, adverse effects of the discontinuing therapy are quickly apparent. Patients with Hansen's disease on the other hand may go for prolong intervals before relapse occures harming themselves with further nerve and skin damage and becoming infectious for others once again. The regular intake of dapsone by follow up of such patients, thus make control difficult to increase the

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danger of sulphone resistance M. leprae occurring. It is frequently claimed that Hansen's disease should be approached as any other disease. This being so concepts concerning therapy should be those valid in infectious disease in general concerning perculiarities is specific to the chronic infectious diseases for which the principal model is tuberculosis and some characterisistic specific to M. leprae and Hansen diseases. While we are appreciating the development of technology in these areas, we must also not lose sight of the fact that medical personnel and field health workers who meet patients regularly are the key problem people in all health care. The best way to tackle leprosy or any disease for that matter is to detect and treat patients early and regularly. We must recognize those with signs of early nerve damage and treat the disease in the hopeful way. We must not give up even those who have complete anaesthesia and paralysis we must teach them to live safely without damaging themselves further. This is not easy, time and patience are needed as we teach and as the patients slowly learns when they begin to succeed, the patients should be encouraged. If we fail, show him that we are concerned. Success depends mainly on good relations between us and our patients. On the basis of the points I've covered, we can probably suggest that this point in time that operational studies are indicated in all fields. The deliberations, therefore, during the next two weeks will be very important for the control of two diseases in our part of the world. I would like to assure everyone here that you have the full support of my Ministry and the staff of the Leprosy Training Centre here at Twomey Memorial Hospital. The facilities here are yours for two weeks. Please make use of them. May I wish the participants, consultants and resource personnel a very successful workshop and now I have the honour of officially opening the workshop.

ANNEX 4

EVALUATION OF THE WHO/SPC INTERCOUNTRY WORKSHOP
ON TUBERCULOSIS AND LEPROSY CONTROL IN THE SOUTH PACIFIC

		YES	NO
1.	Educational gains		
1.1	Were the following objectives met?		
	(a) to update their information tuberculosis and leprosy case findings and management, as well as the latest developments in chemotherapy and immunology:	10	0
	(b) to review and develop information, monitoring and evaluation in tuberculosis and leprosy control programme management; and	10	0
	(c) to formulate a national leprosy and tuberculosis operational plan for their country.	8	2
	If no, please described:		
	Time and information available not enough to be able to immediately draft a plan.		
1.2	Have new skills or cencepts been learnt at the meeting	12	1
1.3	Can these skills and concepts be applied in your country	12	0
2.	Process and outcome		
2.1	Were you able to express your ideas or problems at the meeting?	13	0
2.2	Was there enough opportunity to exchange knowledge and experience with other participants?	12	1

If response to any of the above is no, give comments as appropriate:

Time given is not enough.

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2.3	Were you satisfied with all working papers provided?	12	1
	If no, please explain for specific paper(s):		
	Some are too detailed and unnecessary.		
2.4	Specify which of the working papers distributed for the workshop are suitable for wider distribution:		
	(a) Treatment of tuberculosis and leprosy	4	
	(b) Evaluation of the national tuberculosis programme	4	
	(c) Planning of programme	4	
	(d) Record, reporting, registration	3	
	(e) Epidemiology of tuberculosis and leprosy	6	
	(f) Basic epidemiological indicators	2	
	(g) Integration of tuberculosis to primary health care	1	
	(h) Case-finding	1	
	(i) Multidrug therapy	1	
	(j) BCG vaccination	1	
	(k) Leprosy control	1	
	(l) Leprosy in Lillipus	1	
	(m) Notes on general epidemiology	1	
	(n) Definition and type of leprosy	1	
	(o) All country report	1	
2.5	Did you have enough time to study the working papers?	9	4
	If no, did you receive the working papers sufficiently in advance?		
	The working papers were received too late. All working papers should be available at the beginning or, if possible, before the workshop.		

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2.6	Were methods of introduction and presentation of different topics satisfactory?	12	1
	If no, explain your response:		
	The presentation is too general without adaptation to problems or little connection to South Pacific Islands. Slides should be simplified. Some presentations are hard to follow due to pronunciation.		
2.7	Were you fully satisfied with discussions -		
	(a) at the plenary session?	13	0
	(b) at the group session?	5	2
	If no, please explain:		
	(b) There was no group discussion as planned.		
2.8	Field visits		
2.8.1	If there were field visits as part of the workshop, were they useful to meet the objectives?	10	0
	If no, explain your response:		
2.8.2	If there were no field visits, do you consider field visits would have been useful to meet the workshop objectives?	2	2
	If yes, explain your response:		
3.	Organization of the meeting		
	Were the duration and scheduling of different activities lectures, group discussions, etc. - satisfactory	8	4
	If no, please describe:		
	(a) One week duration would be sufficient.	2	
	(b) The duration of each presentation was too limited because every topic are essential.	1	

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	(c) For each topic half an hour would be satisfactory.	1	
	(d) Have more time on practical aspect and statistics	1	
4.	Administrative aspect		
	Are organization or administrative arrangements for travel, accommodation, per diem, meeting room, secretarial support and interpretation satisfactory?	6	6
	If no, please describe:		
	(a) Problem of accommodation (hotel).	5	
	(b) Delay in return of air ticket re-confirmation of travel.	1	
	(c) Delay of payment of per diem.	1	
	(d) Notifying participants for preparing country report is too late.	1	
5.	Your overall conclusion		
	Do you feel that -		
	(a) Such workshops should be held regularly?	10	0
	(b) Your attendance was worthwhile to you personally	9	0
	(c) Your participation was worthwhile to your country?	9	0
	Comments (if any):		
6.	Is there any better way to achieve the workshop's objectives?	4	4
	If yes, please describe briefly:		
	(a) More exercises should be conducted.	1	
	(b) Shorter meeting informal discussion with consultants.	1	
	(c) A short and less theoretical workshop would be better.	1	

Annex 4

7. What follow-up activities, if any, would you recommend:

(a) by national government -

(1) Government should response well to WHO set up policy for tuberculosis and leprosy control.

(b) by WHO -

(1) Follow-up the progress of tuberculosis and leprosy control based on country reports. 3

(2) WHO should organize an epidemiological workshop on tuberculosis and leprosy.

(3) Repeat the workshop in Kiribati or Solomon Islands.

(4) WHO tuberculosis epidemiologists pay regular visit to islands at least every 3 years.

8. How many meetings - WHO and others - have you attended in your professional capacity outside your country over the last twelve months?

(a) None: 7

(b) One: 3

(c) Two: 2