Kingdom of Cambodia

Nation Religion King

Ministry of Health

National Center for Tuberculosis - Leprosy Control

National Leprosy Elimination Programme

Strategic Plan

2011-2015

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EXECUTIVE SUMMARY

The main role and function of the National Programme for Leprosy Elimination is to plan, implement, supervise, monitor and evaluate the leprosy control activities at various levels in the country based on the national policies, goals and objectives. It also collaborates with the International and National Non Governmental Organizations (NGOs) to obtain support for programme planning and implementation.

The purpose of the National leprosy elimination Programme Strategic plan is to ensure that Leprosy Affected people are diagnosed, treated and rehabilitated effectively

The priority of the national leprosy programme must remain to uphold the quality of leprosy control to detect and treat new cases of leprosy as early as possible. This is a highly cost-effective strategy in prevention of disability and decrease of stigma in the communities. The National Strategy emphasizes quality leprosy control activities as an essential component of an effective programme. Quality is based on appropriate training of staff at every level, regular technical supervision and monitoring of key indicators. The pursuit of quality assumes the willingness of staff to make changes aimed at improving their skills and the functioning of the health services in which they work to ensure that 100% of the new cases detected complete MDT treatment on time.

Disabled leprosy patients will have access to physical and functional rehabilitation to reduce their activity limitations. Leprosy affected persons will benefit from socio-economic projects and receive training and to prevent further disabilities. National leprosy rehabilitation service, provincial and operational district supervisor will plan regularly visit and explain knowledge of leprosy to generation rehabilitation staff nearby to ensure generation rehabilitation provide service for person affected by leprosy as disable person.

Main expected results in the next 5 year (2011 to 2015) of leprosy control activities as:

1-Improved quality of leprosy control programme (case management)
2-Improved early diagnosis (case finding)
3-Improved the quality of services to people with leprosy related disabilities.
4-Improved access by people with leprosy to general rehabilitation services (networking)

Although leprosy is not a priority disease any more in Cambodia, the leprosy control programme will continue for many years. This will mean that the leprosy team will be sustained at national and sub-national levels. In high endemic areas, leprosy control needs to be strengthened. International cooperation is needed not only for technical but also for financial support for many years to come in order to sustain leprosy services of good quality

1-INTRODUCTION

Cambodia has a land area of 181,035 square kilometers in the southwestern part of the East Asia peninsula, about 20 percent of which is used for agriculture. Cambodia lies completely within the tropics with its southernmost points slightly more than 10^0 above the Equator. The country's capital city is Phnom Penh, which is located in central Cambodia. International borders are shared with Thailand and the Lao People's Democratic Republic on the west and on the north, and the socialist Republic of Vietnam on the east and southeast. The country is bounded on the southwest by the Gulf of Thailand.

In comparison with its neighbors, Cambodia is a geographically compact country administratively composed of 24 provinces, 183 districts, and 1609 communes. The country has a coastline of around 440 km and extensive mangrove forests, some of which are relatively undisturbed.

In 1996 the Ministry of Health, Cambodia, began a reform program to strengthen the health sector. An important feature of the reformed health care delivery system was the development of a new structure at district level. Originally, 71 operational districts (OD) were established; review has been made, currently 76 OD, 945 health centres and 72 health posts are in existence. Each operational district office is responsible for a network of health centers and a referral hospital

Leprosy is known to exist in Cambodia for many centuries. Leprosy patients were managed mostly by isolation in leprosoriums and treatment with dapsone in the past. In 1984, National leprosy control programme was started with an integrated approach and introduced WHO recommended multidrug therapy. National Centre for Leprosy and Dermatology was started in 1989 and the leprosy control programme was integrated with National Tuberculosis Control Programme in 1996.

A large number of new leprosy cases got accumulated without detection and treatment during civil unrest period of 1970 – 1990 due to breakdown in health infrastructure and service delivery. Technical guidelines for the programme were prepared in 1992 and control activities were intensified from 1993. It was estimated in 1995 that there were 10 000 cases in the country of which about 2500 were registered. A detailed plan of action to detect and treat all cases, in order to reach the national goal of elimination of leprosy as a public health problem (less than 1 case per 10000 population) by the year 2000, was drawn up and implemented. As a result, the elimination goal was reached by the end of 1998 at national level.

The main role and function of the National Programme for Leprosy Elimination is to plan, implement, supervise, monitor and evaluate the leprosy control activities at various levels in the country based on the national policies, goals and objectives. It also collaborates with the International and National Non Governmental Organizations (NGOs) to obtain support for programme planning and implementation.

"Campagne Internationale de l'Ordre de Malte contre la Lepre" (CIOMAL), Netherlands Leprosy relief (NLR) and World Health Organization (WHO), Odre de Malta France (OMF) support the programme besides others.

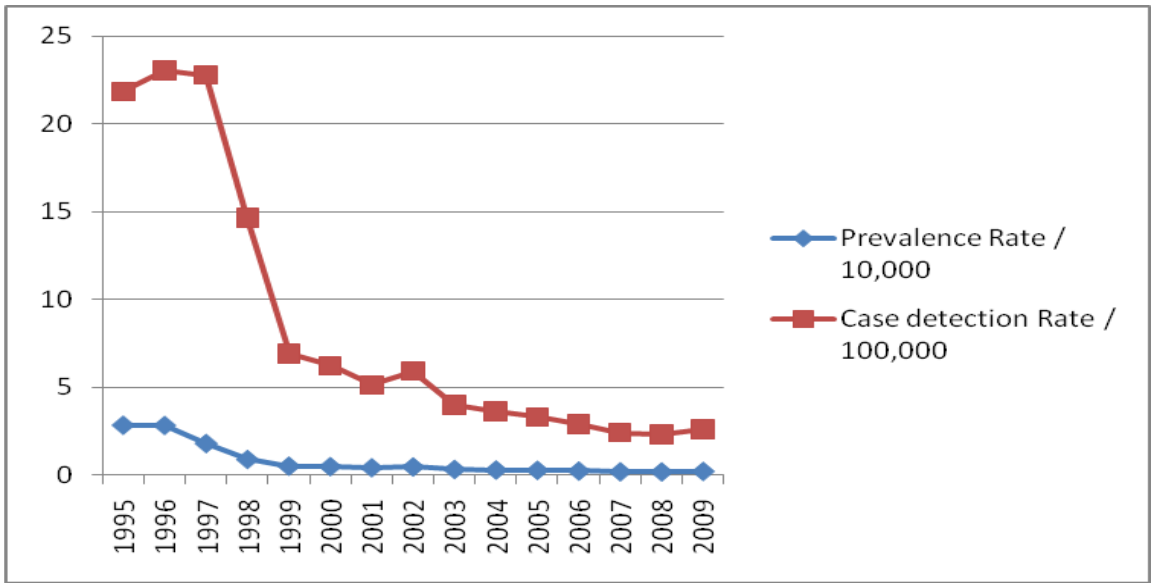
2-SITUATION ANALYSIS

The programme achieved the national goal of elimination of leprosy (prevalence of less than 1 case per 10000 population) at national level by the end of 1998. At the end of 2009, there were 283 registered cases under treatment with a prevalence rate of 0.19/10000, a further decline from 1998 (Table and Figure 1). Elimination was achieved at provincial level in 23 provinces covering 99.65% of the country's population. However, there are pockets within the provinces at district and health centre level with prevalence rate more than 1/10000.

Table 1: Trend of new case detection and prevalence in Cambodia (1990-2009

Year	Population 000s	Newly detected cases		Registered cases	
		Number	Rate per100,000	Number	Rate per10,000
1995	10,155	2219	21.84	2886	2.84
1996	10,442	2404	23.02	2960	2.83
1997	10,706	2438	22.77	1921	1.8
1998	11,426	1609	14.62	984	0.89
1999	11,437	790	6.91	584	0.51
2000	11,722	747	6.22	582	0.48
2001	12,143	634	5.12	526	0.42
2002	12,313	740	5.9	588	0.46
2003	12,620	509	3.97	409	0.32
2004	12,934	461	3.6	370	0.29
2005	13,256	429	3.3	348	0.27
2006	13,586	376	2.9	305	0.23
2007	13,924	315	2.4	257	0.19
2008	14,271	306	2.3	242	0.18
2009	14,626	351	2.6	283	0.21

Figure 1: Trend of new case detection and prevalence in Cambodia (1999-2009)



The National Central Database for leprosy has been designed and installed. This allows for central registration of all cases and provides a wealth of information in assessment of epidemiological patterns, performance of the program including management of reactions and drug supply which will help to target improvements and future activities. Cohort analyses for PB patients have been implemented at 100% for those having started MDT in 2008 and at 94.53% for MB patients having started MDT in 2007.

There are a considerable number of cured leprosy patients with deformities and disabilities who need to be rehabilitated. An action programme to rehabilitate disabled leprosy patients is being implemented. Over years, a large number of health staff working at central, provincial, district and health centre level was trained in leprosy. The MDT drugs are obtained free of cost. Community awareness about leprosy and its control is created and maintained by orientation training to community leaders and by special campaigns using mass media.

Achieving elimination of leprosy at district level, establishment of a cost-effective surveillance system integrated with surveillance for other diseases, rehabilitation of the needy disabled leprosy patients, maintenance of knowledge and skills of staff at various levels to diagnose and manage leprosy cases and sustaining community awareness will be the priority areas during post elimination period.

2-1 WHAT IS THE PROBLEM?

It has become clear from the experience in other countries that the Leprosy Elimination strategy adopted world-wide has had a significant impact on prevalence,

mainly from operational changes such as shortening the length of treatment. Case finding remains high where leprosy control activities are sustained. It is not yet known how long a leprosy programme will have to be maintained before a true decline in new case detection rates will occur. This means that leprosy control activities will have to be sustained in Cambodia for a considerable period of time after the elimination target has been reached.

In the low endemic region, the main issues is maintain the awareness of leprosy to health worker and village health support group, the activity focus on awareness through mass media campaign as using local radio, poster and leaflet……And in high endemic situation, there are two methods of case detection, active and voluntary. Active case detection is not recommended, except in hard to reach areas where the health infrastructure is inadequate. The programme should encourage people suspected with leprosy to report voluntarily. Similarly, household contacts of confirmed leprosy patients should also be encouraged to report voluntarily for examination.

Coverage by the health service is not yet complete. There are presently no security problems, but health coverage problems still exist as not all areas have the physical infrastructure of a Health Centre. Consequently, there are still groups in the population without adequate, permanent health care institutions within easy walking distance as, for example, some minority groups :

- Cham minority
- Vietnamese minorities
- Mountain tribes

In this situation, the awareness leprosy campaign can be cooperated with staff in those communities that they are can speak and explain with their language.

Low-prevalence areas have had a surveillance system introduced. It is not clear whether reportedly low-prevalence areas in Cambodia have only a few cases due to a genuine low incidence or whether this is related to insufficient activities.

In a low endemic situation, it can be expected that only contacts of leprosy patients may be potential leprosy suspects. Poster, leaflets should be kept at all health facilities, distribute to community through volunteer health support group and using mass media through local radio to maintains awareness of leprosy. Finally, ensure high quality services to people affected by leprosy.

But in high endemic areas, the awareness of leprosy in the community is low as well. Health education activities are limited and few mass media participate in it. Misconceptions about leprosy widely exist in the community leading to social stigma and discrimination.

This proves that a lot more efforts and resources need to be invested in high endemic area in order to raise the awareness of the population about leprosy and maintain the leprosy awareness in the communities to ensure to timely detection of all new case,

decrease of disability grad II and move forward to the complete elimination of the disease.

The programme should:

-Improve of leprosy awareness to general health workers in the disseminating the educational message on leprosy especially in places. This could be done through community campaign.

-Provide health education message through mass media campaign by selected channel of radio and TV.

-Ensure to maintain leprosy awareness in the community for timely detection and decrease the stigma in general population and

-Provide high quality services to people affected by leprosy.

2-2 MAIN STAKEHOLDERS

The owner of the leprosy control programme is the government at various levels. The implementing institutions are more focused on leprosy control itself. Leprosy is a low priority for decision makers at various levels. Advocacy to these stakeholders is difficult but important.

International Non Government Organizations gradually withdraw from leprosy control in Cambodia due to the low endemic situation of leprosy.

Unfortunately, the situation is that:

1- There is low endemic situation,

2- Inputs in health care are increasing,

3- Inputs in leprosy control are not increasing (even reduced in some areas).

All in all, this means that the input in leprosy is actually decreasing. This is also a result of the fact that leprosy has decreased compared to 15 years ago and that, according to some officials, leprosy is a chronic disease and nothing will happen even if the programme would be stopped.

Most of the national NGO's collaborating with the Ministry of Social affairs, Veterans and Youth rehabilitation (MoSVY) focus their rehabilitation activities on victims of mines rather than leprosy-affected persons.

2-3 EVALUATION OUTCOMES

The priority of the national leprosy programme must remain to uphold the quality of leprosy control to detect and treat new cases of leprosy as early as possible. This is a highly cost-effective strategy in prevention of disability and decrease of stigma in the communities.

National supervisors must work closely with provincial leprosy supervisors to ensure that operational district supervisors (ODS) regularity visit health centres, perform contact examinations and check registers, clinical files and other documents and control the availability of MDT in OD pharmacies.

The incidence of leprosy in Cambodia is low (± 350 new patients/year), with some districts having hardly any new patients for a number of years. A new control and supervision strategy will be introduced in 2011 mostly in high endemic region as all contact will be visite and complete to examine in next 5 year, all new cases detected completed MDT treatment on time and level of Grade II disability is reduced to 9% by 2015. However, that is still need to maintain leprosy awareness in the low endemic region and these cases have to be diagnosed and managed correctly and communities where such cases occur have to be identified in order to take appropriate measures and sustain elimination status. Together with the idea to decentralise rehabilitation services (starting with the Batambang Foot-Care Unit supported by Ordre de Malta France), this new strategy will make more efficient use of available human and financial resources.

2-4 ANALYSIS RESULTS FROM WORKSHOP

The outcomes of the preparatory workshop show that a focus in needed focus on the quality of leprosy control, the management of the programme, quality of services to people with leprosy disabilities, and access by those people to governmental and non-governmental rehabilitation services.

As disease prevalence goes down and less and less number of cases or no cases are seen and managed by staff at various levels of the ongoing control programme, it is likely that the expertise to diagnose and manage leprosy cases also goes down. Integration of leprosy services into general health services is important to sustain leprosy services. Integration encompasses numerous elements including training general health staff and equipping health facilities to undertake case detection and management, supervision, implementing information systems and fostering good drug management practice. Since the integration of leprosy control activities within general health services is an important activity in all countries, the process should be sustained and promoted. Utilizing existing health care facilities and personnel will make the program sustainable during the post elimination period and will ensure good coverage, better accessibility and cost effectiveness.

Diagnosis of leprosy is primarily based on clinical findings. As the number of cases continues to decrease, the expertise to diagnose leprosy will deteriorate, especially at peripheral health facilities and leprosy awareness in the community and among health staff will decline. Therefore, confirmation of diagnosis may have to be shifted from the peripheral to the referral level and staff at the peripheral health facilities should refer all suspected cases of leprosy and cases with complications to referral health facilities and follow up these cases as per the advice from their referral health facilities.

A new strategy will be introduced in 2011-2015 mostly in high endemic region as all contact will be visit and complete to examine in next 5 year, all new cases detected completed MDT treatment on time and level of Grade II disability is reduced to 9% by 2015

Timely detection and correct diagnosis of cases is very important for preventing transmission as well as for reducing the risk of disability. However, cases are often detected very late after the onset of clinical symptoms and signs of the disease. There are many reasons for this such as: ignorance about the signs and symptoms of disease; lack of skills among general medical practitioners to diagnose leprosy, social stigma; accessibility and affordability of health services and certain cultural beliefs and practices.

2-5 CONCLUSIONS

Although leprosy is not a priority disease any more in Cambodia, the leprosy control programme will continue for many years. This will mean that the leprosy team will be sustained at national and sub-national levels. In high endemic areas, leprosy control needs to be strengthened. International cooperation is needed not only for technical but also for financial support for many years to come in order to sustain leprosy services of good quality

Since elimination of leprosy as a public health problem was only an interim goal aimed at reducing the disease burden, new cases of leprosy would continue to occur with transmission of infection occurring at low levels. Epidemiologically, the distribution of the disease is not uniform. Hence, pockets of endemicity still exist at sub-national level. Because of the very few cases in the community following elimination, the expertise to diagnose leprosy, and leprosy awareness in the population at large, is likely to decline. As a result, new cases may occur in the community without being detected and treated in time. When the disease is no longer a public health problem there is a danger of complacency and low priority which could lead to lack of political commitment and insufficient resources. Consequently, there is a need for a revised strategy to ensure that new cases are timely detected and treated by promoting integration process of leprosy services into general health services

3- OBJECTIVES (PURPOSE/RESULTS)

3-1 OVERALL OBJECTIVE

Objective 9 of the Health Strategic Plan 2008 – 2015 reads: To reduce burden of other communicable diseases.

3-2 PURPOSE

The purpose of the National leprosy elimination Programme Strategic plan is to ensure that Leprosy Affected people are diagnosed, treated and rehabilitated effectively

3-3 LOG-FRAME MATRIX

Please read the annex 1 concerning the logical framework of the National Leprosy Elimination Programme 5 years Strategic Plan (2011-2015)

4- RESULT AREAS

4-1 CASE FINDING

The National Strategy emphasizes quality leprosy control activities as an essential component of an effective programme. Quality is based on appropriate training of staff at every level, regular technical supervision and monitoring of key indicators. The pursuit of quality assumes the willingness of staff to make changes aimed at improving their skills and the functioning of the health services in which they work to ensure that 100% of the new cases detected complete MDT treatment on time.

Efforts to improve case detection are focused on facilitating self-referral by people who develop leprosy. This is done by increasing awareness of the early signs and symptoms of leprosy among the general public through mass media campaign.

Barriers which prevent people reporting for examination should be removed as:

- Lack of awareness that leprosy is treatable and that treatment is free and available locally.
- Fear is also a common barrier.
- Gender, ethnic group and poverty
- Physical barriers

The operational district supervisor will register all contact from patient clinical form to provincial supervisor and national centre and they will plan to visit 20% per year start from 2011-2015 and all contact examinations will be verify through contact record of patient clinical form and monitoring confirm with cross check to contact person by the province, national team and all contact examination will be register in centre database.

In the end of 2015, 90% Contact examinations will be implemented by the operational district leprosy supervisors and the level of disability grade II will be reduce to 9%.

4-2 CASE HOLDING

The National Central Database for leprosy has been designed and installed. This allows for central registration of all cases and provides a wealth of information in assessment of epidemiological patterns, performance of the program including management of reactions and drug supply which will help to target improvements and future activities.

Case holding is high in Cambodia, at around 98% of new cases completed MDT treatment on time.

All levels down to health centre level report 6-monthly. Patients are notified per health centre as the operational district supervisor collects the details from health centre. Every operational district and province reports regularly country-wide.

A clinical form was clearer clinical follow-up of patients, to improve diagnosis and treatment of reactions. Cohort analysis can now continue via central register.

Supervision from national to province to operational district is very consistent and regular. Some health centres are visited but this is not yet consistently done for all health centres.

4-3 IMPROVED QUALITY SERVICES TO PEOPLE WITH LEPROSY DISABILITIES

Comprehensive leprosy rehabilitation requires a wide range of services from surgery and assisting devices to vocational training and micro-finance. An effective network should include governmental, non governmental, private and community based organizations.

Disabled leprosy patients will have access to physical and functional rehabilitation to reduce their activity limitations. Leprosy affected persons will benefit from socio-economic projects and receive training and to prevent further disabilities.

National leprosy rehabilitation service, provincial and operational district supervisor will plan regularly visit and explain knowledge of leprosy to generation rehabilitation staff nearby to ensure generation rehabilitation provide service for person affected by leprosy as disable person

4-4 IMPROVED ACCESS BY PEOPLE WITH LEPROSY TO GENERAL REHABILITATION SERVICES

Networking will also be of importance with other organizations involved in supporting rehabilitation services. MoSYV should take initiatives towards rehabilitation services for people affected by leprosy living with disabilities.

4-5 CONTINUATION OF LEPROSY SERVICES ENSURED

As disease prevalence goes down and less and less number of cases or no cases are seen and managed by staff at various levels of the ongoing control programme, it is likely that the expertise to diagnose and manage leprosy cases also goes down. This may be further accentuated by the tendency of the disease to cluster when reaching low endemic levels and as a result the cases that occur may be limited to few areas. However, new cases are likely to occur during post elimination period for a considerably long period because of the long incubation period of the disease. These cases have to be diagnosed and managed correctly and the areas and communities where such cases occur have to be identified in order to take appropriate measures and sustain elimination status.

The government, particularly the Ministry of Health (MoH), is the owner of the programme, and should coordinate national and international donor support.

Furthermore, both the MOH and MoSVY should, within the next years, integrate in their yearly budgets the needed financial resources to start contributing to the core costs of the leprosy programme.

4-6 PROGRAMME MANAGEMENT ENSURED

The supervisor should be aware of his own tasks and responsibilities, as well as those of the people he has to supervise. Before each visit, the supervisor should review the assessment made during the last visit, to note any points that need further attention. After each visit, a description of the findings, both positive and negative, with recommendations, should be included in the feedback to the supervised staff and to their direct superior.

To ensure capacity building for supervisor through management training with WHO module

The annual meeting and regional meetings will be held as scheduled, the central database will record all new cases and all due reports will be received and submitted on time.

Evaluation is the systematic assessment of a programmer's performance after a specified period of implementation. It compares achievements with the intended outcomes that have been defined in the strategic plan.

The NLEP will be responsible for the implementation of the project, under the overall guidance of the Director of the National Centre for Tuberculosis and Leprosy Control. The actual implementation of leprosy control activities and leprosy care is the responsibility of provincial, operational district and prefectural health services, monitored by the NLEP.

4-7 SUSTAINABILITY

For sustainability leprosy activities from 2011 to 2015:

The Campagne Internationale de l'Ordre de Malte contre la Lepre (CIOMAL) continued to provide funding agency for the program. CIOMAL also provided expert surgeons. All the activities related to supervision of province and OD supervisor to health centre, prevention and management of disabilities including reconstructive surgery and activity cost of central team and also provided stationary to run the office of national center.

Netherlands leprosy Relief supported to monitoring and supervision activities including transport maintenance and travel, ODs refresher training course and self case training course, case finding campaign, Information Education Communication materials, mass media campaign through local radio, provincial and operational district regional workshops and workshop on national leprosy strategic plan 2011 -2015.

World Health Organization (WHO) provided support for implementation of integration of leprosy control activities into general health services as part of the Strategy to Sustain Leprosy Services following elimination in Asia and the Pacific, annual leprosy seminar to provincial health director and MDT drugs have been supplied free of cost throughout the year.

Ordre de Malta France (OMF) will plan to support rehabilitation insensitive foot care unit in Battambnag referral hospital, Battambang province.

National Centre for Tuberculosis and leprosy Control, Ministry of Health plan to continue support national leprosy programme to implement control activity and leprosy continues to be a notifiable disease along with other notifiable diseases in the country.

5- IMPLEMENTATION ARRANGEMENTS

During its implementation, the project will be monitored by NLEP and by partners at various levels, including experts in project management and leprosy, as indicated by MOH.

The project will be monitored on the process of implementation, achievement of results and project purposes, in terms of schedule, quantity and quality. Verifiable indicators will be used to do this. The results of monitoring will be used to improve planning and implementation of the next steps of the project.

At the end of the second year of the project, a mid-term review will be conducted. The results will be used to revise the operational plan.

At the end of the project, an end evaluation will be conducted to assess the achievements of the project. Reports will be sent to MOH, NLR and relevant partners. The result will also be used to assess the need for consequent steps of the leprosy control programme in Cambodia.

International experts sent by NLR will be the key evaluator for both evaluations.

6- RISKS ANALYSIS

Main expected results in the next 5 year (2011 to 2015) of leprosy control activities as:

1-Improved quality of leprosy control programme (case management)
2-Improved early diagnosis (case finding)
3-Improved the quality of services to people with leprosy related disabilities.
4-Improved access by people with leprosy to general rehabilitation services (networking)

This cannot be achieved if:

1. Limited support from other organizations
2. Stigma (community and support organizations)
3. Frequent transfers of OD supervisors

Analysis of external factors

1. Government support for Control activities will continue in next 5 years
2. New case detection rates continue to decrease steadily in next 5 years
3. Needed new training can be realized to new recruit staff
4. Networking with other international NGOs or local NGOs, to share the tasks and funding for a comprehensive rehabilitation approach, will be possible and accepted
5. Lack of knowledge of leprosy in the community
6. Lack of governmental funding
7. Decrease in external funding

7- ANNEXES

7-1 Logical frame Matrix

National Leprosy Elimination programme Strategic Plan (2011 to 2015)

	Intervention logic	Objectively verifiable indicators	Sources of verification	
Goal	Burden of other communicable diseases reduced	-Reduced morbidity		
Project Purpose	-Leprosy Affected people are diagnosed, treated and rehabilitated effectively	1-100% of new cases completed MDT treatment on time.	1-Database cohort analysis report	

Results				
	1-Improved quality of leprosy control programme (case management)	1- 100% of planned supervision activities implemented 2-100% of new cases detected completed MDT treatment on time.	- database -supervision, activity reports -cohort analysis reports	**Risks for results:** 1,2,3,4,5 -Limited support from other organizations -Stigma (community and support organizations) -Frequent transfers of OD supervisors
	2-Improved early diagnosis (case finding)	1- 90% of the "contacts are visited and examined" 2- Level of Grade II disability is reduced to 9% by 2015.	-patients case and database - Supervisors ' reports	
	3-Improved the quality of services to people with leprosy related disabilities.	1-1250 disabled leprosy patients had access to physical and functional rehabilitation to reduce their activity limitations. 2- Between 600 - 700 leprosy affected persons benefitted from socio economic projects between 2011 and 2015. 3- 2000 leprosy-affected persons received training and managed to prevent further disabilities between 2011 and 2015.	- patients register or record -reports from training centre - monthly reports -Report from communities or Socio Economic Rehabilitation programmes	
	4-Improved	1-Increased	-Support	

	access by people with leprosy to general rehabilitation services (networking)	number of governmental and non-governmental institutions (10 institutions) that provide services to leprosy-affected people.	organizations, administration annual reports -MoSVY annual rehabilitation report	
	5-Continuation of leprosy services ensured (Expanding the resource base)	1-An average 30% of NLEP's budget originates from new donors by 2015.	-Funds provided by different partners -MOH/MOSVY's contributions funding -Financial reports	
	6-Programme management ensured	1-75% of planned supervision visits were carried out by 2015. 2-100% of due reports submitted. 3-90% of new patient records entered at the end of each year. 4-The annual meeting and the 2 regional meeting per year were held as scheduled	-Monthly plans -Supervision reports -Count of reports received -Count of reports submitted -6 monthly report from provinces -Count of records entered on computer -Annual plan -Meeting minutes -Annual progress and planning reports	

7-2 References:

1-Eighth edition of the Cambodian Statistical Yearbook produced by the National Institute of Statistics (NIS) of the Ministry of Planning

2-COMPLEMENTARY PACKAGE OF ACTIVITIES Guidelines for the Referral Hospital (for 2003 - 2007) Ministry of Health

3-Health Strategic Plan 2008 to 2015, Ministry of Health

4-Statistic of National Leprosy Elimination programme