Instruction on the spot, with a minimum of transport to centres where the conditions and facilities might be far superior to those of real life in the village, was thought to be important, but it was recognized that there might be difficulties in teaching the basic clinical signs of leprosy and its adverse reactions, in the absence of a suitable group of patients.

On the matter of leprosy in relation to other diseases, it was thought that leprosy should usually be brought into PHC after it had been established and shown to work for various other diseases or services, and that – with some exceptions – it was unlikely that leprosy could initiate PHC. The importance of supervision was discussed at some length, with the conclusion that its most significant component would probably come from ‘district’ level, but that it might be necessary to enlist personnel devoted almost exclusively to the supervision of PHC, in view of the usually heavy workload of those already working in district hospitals. Participants agreed that some element of vertical or specialized expertise would be needed in leprosy for many years to come, probably from district level upwards, and that there would be a continuing need for referral centres, able to diagnose, treat and generally manage all aspects of complications in leprosy.

The meeting ended with a discussion on the magnitude of the task created by the aim of health for all by the year 2000, in the area of medical and para-medical education and the provision of suitable health learning materials. It was thought that appropriate education, together with the necessary change of attitude, might well take 10 years. Meanwhile, it was important to collect a great deal more data on the integration of leprosy, and other diseases of similar importance, in those areas of the world which are practising, or claim to be practising, PHC. Indeed, perhaps the most important upshot of this meeting was the realization that there should now be available much more information on the effectiveness (or otherwise) of some aspects of PHC, including experience with leprosy.

**NON-GOVERNMENT ORGANIZATIONS GROUP ON PHC; DECEMBER 1981, GENEVA**

This was held on 4 December 1981 at the Ecumenical Centre in Geneva and co-ordinated by the Christian Medical Commission, with Dr Stuart Kingma as Chairman. Apart from UNICEF and WHO, the participants included a representative (Mr Bert Zielhuis from Amsterdam) of the International Federation of Anti-leprosy Associations. The Agenda included – ‘The role of NGO’s in formulating strategies for health for all by the year 2000’; Progress report on the Health Resources Group for PHC: PHC team leadership training by WHO; Health education; Pharmaceutical supplies to developing countries and UNICEF development of education kits (Address for copies of the minutes is not clear, but application could be made to CMC, 150 route de Ferney, 1211 Geneva 20, Switzerland.).

**ILEP AND PHC: REPORT ON AD HOC WORKING GROUP NO. 6 — BONN, 11TH DECEMBER 1981**

**Inventory of PHC Projects With a Leprosy Component**

In response to an enquiry to all ILEP Member-Associations, details were obtained from a total of 21 projects, providing either PHC, comprehensive health care or community health services of which leprosy control was a component. There were 9 in Africa, 2 in South America, and 10 in Asia. Defining PHC as ‘characterized by community participation, employment of village health workers, and integration with social and economic development’, projects combining PHC and leprosy control were identified as follows:

1. In Africa: Tanzania, Sierra Leone, Nigeria, Mali and the Sudan. Only in the Sudan is the PHC project fully integrated with leprosy control.
2. In South America: the village of Vila Nova, Sao Luis province, Brazil, comprises 2,200