Lepr Rev (1995) **66,** 335–347

News and Notes

Special Action Projects for the elimination of leprosy—SAPEL SC •

Identifying the areas that call for a rapid response

One of the key recommendations to emerge from the International Conference on the elimination of Leprosy, held in Hanoi, Viet Nam, last July, was to set up Special Action Projects which would ensure that Multidrug Therapy (MDT) truly reaches all under-served areas and populations. It was recognized that—despite the commendably high MDT coverage already attained—this represented the 'easiest' part of the task ahead. Reaching the three million leprosy patients who need MDT between now and year 2000 will be a much harder job.

The Leprosy Working Group (LWG)* which met immediately after the Conference recommended, inter alia, the creation of a Steering Committee on Special Action Projects for the Elimination of Leprosy (SAPEL SC). Seven members were elected to sit on this Committee, chosen for their expertise in dealing with both the operational and the technical problems likely to be faced by leprosy control programmes between now and the end of the century. The Committee will also include as co-opted members the chairpersons of the Leprosy Elimination Advisory Group (LEAG), the Task Force on Monitoring and Evaluation (MEE) and the Task Force on Capacity Building and Health Systems Research (CBH).

SAPEL is a new initiative, one of several mechanisms supported by WHO to bring about elimination. It is not a research programme, nor is it meant to be an exclusive initiative of WHO. International NGOs and other donor agencies will be invited to participate and to provide funding; the WHO Secretariat's role will be to coordinate and cooperate with similar activities being undertaken by other agencies.

SAPEL's objective is to identify special situations and areas requiring rapid action, and to develop and put into effect innovative and feasible strategies, mainly involving operational solutions. It hopes to become a trend-setter in accelerating MDT coverage in difficult areas. Once the special action project has been concluded, the national programme will be expected to sustain any further activities that may be required.

The Steering Committee will meet at least twice a year—it held its first meeting on 9–11 January 1995—to discuss ways of accelerating MDT coverage in special situations, and the overall progress being made towards the elimination goal. It will also review and fund proposals for special action projects submitted to it by national programme personnel.

These projects should be confined to exceptional situations where routine activities are non-existent or not proving practical, and they should complement national leprosy elimination efforts. The situations and populations that might merit special action will include:

- areas where there is no health infrastructure;
- areas where the existing health service is unable to deliver MDT;

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*Now replaced by the Leprosy Elimination Advisory Group (LEAG).

- geographically difficult-to-access areas;
- temporary breakdown of services due to hostilities or natural disasters;
- where there is no scope for rapid improvement through strengthening management capability;
- urban and peri-urban slums;
- groups of patients living in isolated communities as a consequence of social stigma;
- nomads and other migrants;
- refugee populations.

Beside the obvious aims of solving priority problems and increasing MDT coverage, SAPEL hopes to motivate staff working in the field of leprosy and develop their skills, to improve the quality of services, and to make it easier to apply the new strategies that are developed to comparable situations elsewhere.

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Message from the President on the future of ILA. Yo Yuasa

Greetings! Time passes swiftly, and it has been nearly 2 years since I became President of the International Leprosy Association (ILA). Or, looking forward, it is only 3 years until the next ILA Congress, expected to be held in Beijing, China, in the summer of 1998. It is also nearly 1 year, by the time this issue reaches you, that the ILA FORUM, a new and a trial publication of our Association, has been in existence.

The world leprosy situation is changing rapidly. 'The elimination of leprosy as a public health problem by the year 2000,' proposed by the World Health Organization (WHO) and accepted by practically all of those involved in the control of the disease as shown by the Hanoi Declaration of 1994 following the World Health Assembly Resolution of 1991, has been successful in reducing the global caseload remarkably, perhaps down 2 million, including the estimated or unregistered cases, by the second half of this year. Whatever is one's conception of leprosy problems and whatever is one's interpretation of the above figure, it is a great achievement, indeed, a positive result for which no apology is necessary.

However, we are still far away from achieving our ultimate goal, which must be the 'eradication' of leprosy, although I am aware that some of my more cautious or, indeed, conscientious colleagues may flinch at the use of that term. In order to realize that goal three separate and different stages are necessary, each an elimination program of its own. The first stage we are currently undertaking, and hope to achieve by the year 2000, is the elimination of the disease as a public health problem, defining it as having a caseload of less than 1 in 10,000 population at a national level. The use of the prevalence rather than incidence figures, or setting the target figure of 1/10,000, has been controversial for some good reasons but, to me, they are not that important provided, and this is crucial, that we agree to go on to the second stage, which is the elimination of leprosy as a disease of individuals. Because of highly competitive demands from other health problems in public health sectors, such as tuberculosis, malaria or AIDS, to take the most obvious examples, the expected global caseload of leprosy beyond the year 2000 is unlikely to attract much attention, let alone resource allocation, from health authorities of leprosy-endemic countries, and perhaps even from WHO. But those who are seriously concerned with leprosy, which I hope include the majority of the current members of ILA, must go on extending necessary and adequate care to a not insignificant number of remaining as well as emerging patients, expected to be as many as half a million at the beginning of the next century, at a more intensive degree and individualized manner, which is not possible at present as long as the disease remains a serious public health concern. Judging from the pattern of some new cases who develop the disease much later in their lives, long after their probable exposure to the disease, seen in some countries like Japan, where leprosy is no longer a public health problem and its endemicity is coming to an end, this second elimination stage may take much longer than some of us would like to contemplate.

The third elimination stage is that of *Mycobacterium leprae* themselves from the face of the earth. Without this, there is no 'eradication' of leprosy, which is not just a disappearance of the disease but a total removal of any possibility of future re-emergence of the disease. How long will that take? No one knows, but from the known longevity of *M.leprae* as persisters in the human body and the occurrence of natural infection with *M. leprae* in some animals, such as the nine-banded armadillo or some monkeys in Africa, we may have to wait until the second half of the coming century for the eradication of the disease.

This brings me to a main concern and the reason for this message on 'The Future of ILA'. I am not spelling out my personal view of what that should be. All I am trying to point out is that these are likely to be leprosy problems needing solutions for the next 50 years or more in medical aspects alone, and I have not even mentioned problems related to social aspects of the patients and their families, which are much larger in scope and much more difficult to solve.

As I mentioned, current roles played by the public health authorities of the leprosy-endemic countries as well as by the leprosy unit of WHO are likely to be diminished substantially, and even in danger of disappearing altogether. International nongovernmental organizations, often pioneers and certainly critical supporters of the current worldwide leprosy activities, may find it difficult to continue their activities at the current levels, because the reduced global caseload may act adversely to their fund-raising efforts. After the last ILA Congress, an international group called 'IDEA' (composed of ex-leprosy patients from various countries) emerged thanks to the dedicated efforts of a few forward-looking individuals, and is expected to play a significant role in the future, but that remains to be seen. All of them, no doubt, will try to find new roles in, or new ways to tackle, the future leprosy problems in the next century. In such a situation, in my personal view at least, ILA seems to be the only global international organization whose *raison d'être*—ever since its founding in 1932—is to take a leading role in searching and shaping the future activities toward the eradication of leprosy until it is accomplished.

I am convinced that the above view of mine is shared by not a small number of the fellow members of the Association. But I am far from certain or, indeed, rather doubtful if it gets even 51% of the current members' approval, a minimal and not really satisfactory majority to take any action. The publication of the ILA FORUM was initiated under the President's prerogative because that is what I promised in my acceptance speech in Orlando. I was fairly certain of your approval, but I am not prepared to go any further without more specific approval from the majority of the members. Any major decision could be taken only at the General Meeting of the members at the next Congress, but that is a far from satisfactory occasion, because available time is usually too short and not even half of the members are present. That means that any major issues needing the members' decision, such as restructuring or new activities of the Association, must be proposed and discussed as thoroughly as possible prior to the time of the next Congress. Hence, the publication of the ILA FORUM as a possible venue for such discussions.

I am most grateful for those who have contributed an article to its first four issues, including this one. Each one of them, in its own way, was a thoughtful, interesting and useful contribution, worthy of publication. However, I am somewhat disappointed on two accounts. With only one exception, all of them are in response to my personal solicitation and not of their own initiative. Perhaps a little more time is needed for those who are taking a 'wait and see' article. By now, I hope, the objective and general nature of the ILA FORUM is apparent to warrant spontaneous contributions from the members at large. The second disappointment of mine is related to the contents or, rather, to the manner of presenting the contents. With a few exceptions, they are not provocative or challenging enough, to my taste at least, to elicit active responses from the readers, a quality quite different from the regular contributions to IL but necessary for the objective of the ILA FORUM. In the future, there could be too many contributions which require selection but, at present, we need more spontaneous contributions and I would urge any members who have anything important to say for the future of leprosy and/or the ILA, to put down that thought and send it to the Editor of IJL,, clearly indicating that it is for the ILA FORUM. This open invitation for contributions is being addressed not only to those who think some changes are necessary, as I do, but equally to those more conservative or traditional members who may think more or less a status quo is what we need. That view could be equally as valid and important to be expressed publicly, if shared by a large portion of the current members, as I suspect.

Finally, one more point. The next ILA Congress will come in 3 years' time, and we should start planning seriously about it soon. A general pattern of the Congress has been established by which the pre-Congress workshops on a dozen or more subjects preceding the main Congress will again be subdivided into a number of groups according to the different specialties within the science of leprosy and leprosy control. A successful introduction of the state-of-the-art lectures and training sessions made the Congress more attractive and worth while to the field workers, who are mostly nonmembers but outnumber the members of the Association as the participants of the Congress three or even four to one. Is that a sort of Congress we want again in Beijing? Is the Congress meant to meet the needs of the members or to address the larger issues of the current and future leprosy situation?

Let us think of the objective of the Congress in terms of for whom and for what. Let us be a bit more imaginative in planning. I would like to invite the members to express their ideas on this subject. In the case of too many contributions needing selection for publication, the views for the Congress will be given priority for the next four issues up to the summer of 1996. By then we should have a clearer idea of what sort of Congress it will be in Beijing, so that more formal and earnest effort on the organization could start.

I look forward to the members' response to my request. Meanwhile I send my best wishes to all of you for success in whatever leprosy work you are currently undertaking.

Reproduced from *ILA Forum*.

Dr Mukherjee applauds leprosy research in Bombay

The Director General of Health Services Dr A. K. Mukherjee and The Deputy General of Health Services (Leprosy) Dr B. N. Mittal stressed the need for leprosy research on the residual problems still met in the field to continue, in order to maximize the advantage of the steady decline in leprosy already achieved by the National Leprosy Eradication Programme (NLEP). A function was organized by the Bombay Leprosy Project (BLP) on 24 June 1995 to honour these dignitaries at the Leela Moolgaokar Leprosy Ward of Adams Wylie Memorial Hospital, which is the nucleus of BLP's research to assist NLEP over the past 16 years. The ward is gifted for leprosy research by the Indian Red Cross Society. Dr R. Ganapati, director, highlighted how BLP took advantage of this gift to carry out research on newer drugs and disability care and outlined the future short course chemotherapy trials proposed to be undertaken using the in-patient facilities of the hospital.

A document entitled 'Can NGOs effect savings for the Donor?' giving a cost analysis of an experiment by BLP in assisting NLEP over two decades was submitted to the visitors by Mr P. Narayanaswamy, Manager-Administration of the Project. Dr Mukherjee applauded the highly significant contributions achieved at low cost and stressed the need for the continuance of such research by BLP. Dr Mittal and Dr A. R. K Pillai, President, Indian Leprosy Foundation pointed out that NLPE still needs to be guided by such research till leprosy is eliminated.

A vote of thanks was proposed by Dr C. R. Revankar, Deputy Director, BLP.

16th Anniversary of leprosy research in a Red Cross Hospital, Bombay, India

The importance of research work in leprosy undertaken by the Bombay Leprosy Project (BLP) at the Leela Moolgaokar Leprosy Ward at Adams Wylie Memorial Hospital over the past 16 years was highlighted by Dr R. Ganapati, Director, BLP at a function held in the hospital premises on Saturday, 22 July 1995 to mark the 16th Anniversary of BLP's work. He expressed his confidence in continuing the research work based on hospitalized leprosy patients elsewhere in the city, though the team of research staff is likely to be deprived of this in-patient care facility shortly, in view of the proposed demolition of the ward. He also recalled the importance given to such research by Dr A. K. Mukherjee, Director General of Health Services during his recent visit to the ward on 24 June 1995.

Dr Ganapati thanked the Bombay Branch of Indian Red Cross Society for enabling BLP to carry out the research work for 16 years.

Dr J. A. Ponniah, Consultant, WHO/Govt of India/National Leprosy Eradication Programme (NLEP) and the Chief Guest of the occasion admired the academic spirit and dedication of the staff of BLP for their contributions to NLEP. He will help the project to see that their exemplary work is continued without any hindrance till the goal of elimination of leprosy from the country is reached.

Undergraduate prizes offered by the Royal Society of Tropical Medicine and Hygiene, London, UK

Undergraduate project prize

The Royal Society of Tropical Medicine and Hygiene offers an annual prize of £200 for an account of work carried out in a tropical or developing country by a non-medical student of any nationality. The work will add to the knowledge of human or veterinary health or hygiene in the broadest sense. Particular attention will be directed towards originality and quality in the award of the prize. It is anticipated that the prize will act as a stimulus for the pursuit of excellence in research carried out by undergraduates.

Medical student elective prize

The Royal Society of Tropical Medicine and Hygiene offers an annual prize of £200 for an account of work carried out by a British medical student during an elective period spent in a tropical or developing country. In awarding this prize emphasis will be laid on the originality of the work and on its contribution to knowledge or understanding of tropical diseases.

Rules

1 Two prizes of £200 may be awarded annually in recognition of outstanding projects which increase knowledge of tropical medicine and hygiene in the broadest sense.
2 Candidates shall be nominated by their head of department, supervisor or Dean, with a supporting statement of up to 500 words.
3 The closing date for receipt of project reports is 31 December. The project should have been done or completed in the previous 12 months.
4 A Committee of 3 shall choose the prize winners.
5 The announcement of the prize winners will be made at the March meeting of the Society.
6 The prizes will be presented by the President of the Society at the Annual General Meeting in June or July.

Please note that the Society cannot provide funds to cover students' elective travel expenses.

Apply: Secretary, Royal Society of Tropical Medicine & Hygiene, Manson House, 26 Portland Place, London W1N 4EY.

Proceedings of the International Agency for the Prevention of Blindness, 1994

The above are the Proceedings of the Fifth General Assembly held in Berlin, 1994. Its contents includes sections on the following topics: Affordable eye care; accessible eye care; appropriate eye care; and optional workshop reports on: Assessment of vision function and quality of life as perceived by the cataract patient; Trachoma control – opportunities and constraints for integration into existing primary eye care and health care delivery systems; Ophthalmic medical personnel in prevention of blindness programmes: their training and use; and ocular leprosy – why should it concern us.

Copies are available from: WHO Publications, 1211 Geneva 27, Switzerland.

Women with leprosy in 'double jeopardy'

The following is reproduced from TDR News (Special Programme for Research and Training in Tropical Diseases, UNDP/World Bank/WHO), No. 46, November 1994, page 3:

A multiple survey of women leprosy sufferers near Bombay, India, has raised disturbing questions about their access to effective diagnosis, care and treatment—and suggested they are in 'double jeopardy'—neglected as women and rejected because of their illness.

The survey—by Seemantinee Khot and Shoba Rao—was presented by Khot at the headquarters of the World Health Organization in Geneva during the June 1994 meeting of TDR's top management body, the Joint Coordinating Board. Khot said the survey showed that women tend to neglect leprosy for longer than men, and to develop severe deformities—particularly of the hands, exposed to injury in cooking and domestic work. In leprosy colonies visited by the researchers, 70% of women had hand deformities.

Indian women dress to cover most of their body, and the tell-tale pale, insensitive skin patches of early leprosy are often detected only during child-birth—when another woman traditionally bathes the mother's body after the birth. Nearly half (48%) of the women leprosy suffers first detected the patches at this time, Khot reported.

Greater illiteracy and ignorance of the symptoms of leprosy among women also leads to fewer women seeking immediate treatment. Replies to a structured questionnaire showed that on average it took 15 months from detection of the symptoms before women sought treatment. Even if women want to visit the clinic, they say they cannot go alone, unlike men, often have no money for the bus fare, or are not allowed by the family (or their sense of duty) to take time off.

Discrimination can be extreme. Some women had been served food in the family dog's dish, and many had been physically beaten. Women were more likely than men to be socially isolated. Women were forced more than men to sit alone, eat alone, sleep alone, work alone and to avoid touching other people (all results at statistical confidence levels above 95%).

Women said that when they were forced to stop cooking for the family they felt redundant. But the most difficult adjustment was to be forced not to touch and care for children. 'It was touch, more than anything, that women longed for, and the loss of this intimate female right symbolised isolation and rejection', Khot said.

The number of women separated from—or deserted by—their husbands was 'strikingly high'. Very few were aware of their legal rights under the Indian Marriage Act, which condemns separation or divorce due to leprosy, and gives the woman the right to alimony (a regular sum of money from the ex-husband for maintenance), Khot said.

Some of the women had been forced into prostitution. One reported that they formed the lowest class of prostitute, to whom other prostitutes referred clients suffering from sexually transmitted diseases. As a result they were paid only US$0.50 per client.

When women reach the leprosy clinic, they are faced with further problems. Only 3% of the leprosy workers are women, inhibiting the patients in showing body parts or sharing intimate problems in relationships. Furthermore 'the new multidrug therapy (MDT) regime is more complicated for illiterate, non-numerate women—simple calendars should be developed to improve compliance'. Moreover women worry more than men about the strawberry coloured urine the treatment creates.

Among many important recommendations, Khot suggested that if the prevalence target of one case per 10,000 by the year 2000 is to be met in India, and if disabled women are to be cared for, urgent improvements are needed in: gender sensitization of male leprosy workers; the number of women leprosy workers; clearer MDT dosing instructions for illiterates and non-numerates; counselling of women on their legal rights; family counselling; provision of safe cooking wares to women with nerve involvement, to reduce the rate of hand deformities; and care for women with deformities.

Further information: Dr Carol Vlassof, Special Programme for Research and Training in Tropical Diseases, WHO, 1211 Geneva 27, Switzerland.

Concern over India's leprosy rehabilitation

The following is reproduced from *The Lancet*, London, UK, Volume 343, 26 March, 1994:

The parliamentary standing committee on health has expressed dissatisfaction over rehabilitation of leprosy patients and has suggested more humane measures for its implementation under the leprosy control programme.

For many years the department of health has done almost nothing for the rehabilitation of leprosy patients; this 'virtually negates' the objective of the National Leprosy Eradication Programme (NLEP), the committee said. Critical of the department's approach in regarding long-term cases as being 'burnt out' with little scope for improvement, the committee said 'no case is a burnt out case and every patient deserves the best treatment and rehabilitation even if he/she can not be cured'. The committee recommends the adoption of a more humane approach to these people by extending hospital stay for as long as required. India, which has the world's largest number of leprosy patients, also runs the largest multiple-drug-therapy (MDT) programme. The country's National Leprosy Control Programme launched in 1955 was redesignated National Leprosy Eradication Programme in 1982 with the aim of reducing infection in the community through MDT and social and economic rehabilitation of leprosy patients. The success of NLEP is evident from the decline in the estimated number of leprosy patients from 5·5 million in 1985 to 3 million in 1992 (although 1·8 million leprosy cases were recorded in 1991). India has adopted the World Health Assembly 1991 resolution to eliminate leprosy as a public health problem by the year 2000, elimination having been defined as prevalence of leprosy to less than one case per 10,000 population, the level at which leprosy would be expected to die out.

Rehabilitation of leprosy patients received NLEP attention only recently, when a scheme was launched for establishment of district rehabilitation centres. There are 75 rehabilitation promotion units but their work is hampered by stigma against the disease. Community-based rehabilitation is still a long way off. A Union party minister some time back called for legislation to make 'discrimination' against leprosy-affected people a punishable offence, as was done with untouchability in 1955. The voluntary agency Hind Kusht Nivaran Singh has recommended inclusion of leprosy-cured people in the definition of 'handicapped' to benefit from positive discrimination. India's leprosy control programme has the participation of over 250 non-governmental organisations, some of which have contributed to the evolution and development of NLEP. They can be a major instrument for rehabilitation programmes in India.

People with leprosy are not wanted by anybody—neither relatives nor society. It is commonplace to find them begging on streets or living in isolated places, and on the river banks of religious places. The parliamentary committee has recommended the formulation of a scheme to provide them with complete care—food, clothing, shelter, and medical care.

Zaka Imam

Report of the International Conference on the Elimination of Leprosy, Hanoi, Vietnam, July 1994

This meeting, co-sponsored by the Sasakawa Memorial Health Foundation, was attended by more than 100 participants from all parts of the world, including the 28 most endemic countries. The topics discussed included progress towards elimination, regional elimination plans, country presentations, technical issues relating to elimination and the role of non-government organizations and WHO. Under the heading 'New approaches and strategies closer to the elimination goal' (page 18):

'The Conference considered that, in order to sustain the quality of services and to minimize the resources that will be needed, the following activities are essential:

contact surveillance should be maintained as the priority of new case-detection, particularly in low endemic areas;
health education and related activities should be targeted to various health professions and policy-makers;
core expertise in leprosy and capability building should be maintained among related health professions, especially dermatologists, physiotherapists and supervisors;
to validate achievement of the elimination goal, reduction of prevalence at the beginning reflects success in decreasing the numbers of untreated cases or the size of the problem. However, when it becomes low endemic, incidence is more important in monitoring recent transmission of the disease and the efficiency of case-detection—for instance, the incidence of leprosy in children and the incidence of new cases with visible deformity;
integration of both case-detection and rehabilitation into private sectors, primary health care and general health services is the most cost-effective method;
certification of elimination is not appropriate.'

The summaries of the 28 reports by country representatives that follow are given in alphabetic order.

Bangladesh

In 1994, 22,334 leprosy patients were registered for treatment out of whom 67·5% were receiving MDT. Among new cases, 21% were already disabled at the time of detection. In November 1993, the government launched a combined tuberculosis and leprosy control programme supported by the World Bank and NGOs. The goal of this programme is to eliminate leprosy as a public health problem by the year 2000 by extending MDT coverage to all districts (thanas) by June 1997. Main difficulties faced by the programme include very high population density, poor accessibility to health services, inadequate drug supply and lack of trained personnel.

Brazil

With about 200,000 registered cases, Brazil is one of the highest endemic countries in the world.

Since 1989, the national plan has been aimed at increasing the quantitative and qualitative coverage of leprosy services and at implementing MDT gradually. Stratification of states according to epidemiological criteria was prepared in order to set priorities. The main difficulties in implementing strategy are the magnitude of the problem, the need for decentralization and the difficult-to-reach population. It is expected that all states will elaborate their plans for elimination and implement them in 1995 in order to each the highest possible MDT coverage.

Cambodia

MDT has been implemented in 16 provinces and about 2000 cases are registered for treatment. About 1000 cases are detected annually. The major difficulties in controlling leprosy are lack of health infrastructure and poor accessibility to leprosy services.

Chad

Leprosy is still an important public health problem, and the disease is under-reported. A national programme was initiated in 1992 aimed at implementing MDT in all districts. Currently about 7500 patients are registered for treatment, and 516 new cases were diagnosed in 1993. As a result of the programme, 53% of registered cases were treated with MDT and the geographic coverage increased significantly. However, accessibility to leprosy services and MDT is limited by a number of operational factors such as the lack of skilled personnel and the considerable nomad population. It is planned to implement special actions in order to reach the uncovered population and to increase MDT coverage to 100% by 1997.

China

While leprosy has been eliminated in most parts of China, there are endemic provinces where leprosy is still a public health problem. In those provinces, the strategy is to diagnose existing cases promptly and to treat them with MDT. It is expected that the prevalence will be reduced to less than 12,000 by 1995 and less than 6000 by the year 2000. Counties situated in mountainous areas and those populated by minority groups are underdeveloped and will need special action. It is also estimated that about 200,000 patients previously treated with dapsone may require further treatment with MDT in order to prevent relapses.

Colombia

The leprosy control programme is being reorganized in order to comply with the recently proposed National Plan for the elimination of leprosy as a public health problem. This plan aims at decentralizing activities and at delegating responsibilities to the departmental and municipal levels. Leprosy prevalence has decreased from 16,600 cases in 1986 to 6311 in 1993, and the number of new detected cases fell by 15% during the same period. the most endemic departments are Santander, North Santander, Cesar and Bolivar.

Côte d'Ivoire

A leprosy elimination programme was launched in 1993, and aims at implementing MDT in all health centres in order to diagnose at least 90% of the patients before they develop deformities. It is estimated that 8% of the population has no access to health services and this will require special action. The national programme is technically and financially assisted by ILEP and WHO. Currently, about 8000 patients require treatment and 2200 new cases are detected annually.

Egypt

MDT was implemented in 1985 and currently 3338 patients are under treatment. However, leprosy could be under-reported and the diagnosis is still being made very late as evidenced by the high proportion of patients disabled at diagnosis (26%). The national programme aims at integrating leprosy services into PHC units. Main difficulties are related to high stigma, including among health staff, and the high proportion of patients defaulting before completion of treatment.

Ethiopia

Since the implementation of MDT in 1984, the leprosy prevalence has been reduced tremendously. However, more than 15,000 cases are still requiring treatment and about 4000 new cases are detected annually. It is expected that MDT coverage will reach 100% by 1995 despite the difficulties posed by geographical inaccessibility. Efforts are being made to decrease the defaulter rate and to improve early case-finding.

Guinea

Leprosy in Guinea is an important problem, with about 4000 new cases detected annually. The government, in collaboration with WHO and NGOs, initiated and implemented a national plan aiming at the elimination of leprosy. Since 1992, the MDT coverage has been close to 100%. The main components of the programme have been integrated into general health services. The prevalence and detection of leprosy remain very high and new difficulties have emerged with the influx of refugees in the eastern part of the country.

India

With about one million registered cases, India contributes 60% of the leprosy burden in the world. About half a million new cases are detected annually. MDT was implemented in 1982 and its nationwide expansion had a tremendous impact on the leprosy situation, with many states reporting a more than 50% decline in the number of new cases detected. However, considering the magnitude of the problem, the objectives of the national plan were revised in order to make MDT accessible to all patients. This plan has received financial support from the World Bank and by the end of 1994 it is expected to cover all districts with MDT.

Indonesia

All districts (303) are implementing MDT and about 70,000 patients are registered for treatment, out of whom 66% are treated with MDT. The number of newly detected cases increased from 9348 in 1990 to 17,693 in 1993 as a result of the expansion of the programme activities. Leprosy control activities are integrated into general health services. The national plan for elimination of leprosy aims at reaching 100% MDT coverage by 1995. The main difficulty is geographical inaccessibility (17,500 islands), making operational costs very high.

Iran

Leprosy is in the elimination phase in this country. No new cases have been reported from nine out of the 25 provinces. After detailed review of registers and patients, the current prevalence is 2346 and 147 new cases were detected in 1993. All patients are treated with MDT. During the elimination phase, it is planned to intensify case-finding activities in an integrated manner and to provide rehabilitative services to persons disabled because of leprosy.

Korea

Detailed statistics on leprosy in Korea show that leprosy has already been eliminated as a public health problem, therefore activities are now mainly focused on the rehabilitation of more than 22,000 persons registered as having a previous history of leprosy.

Madagascar

The National Plan for elimination of leprosy was elaborated in 1991 in collaboration with the WHO and NGOs. Since its implementation, case-detection and MDT coverage have increased significantly. Out of 9557 patients registered for treatment, 98% are being treated with MDT. One of the main difficulties in maintaining high MDT coverage is the geographical inaccessibility. However, the intensified programme has been able to organize leprosy control activities in 193 health districts. It is planned to further decentralize activities, and to strengthen the prevention of disabilities and the rehabilitation of already disabled cases.

Mali

The elimination programme is now a fully integrated one. Out of 11,000 registered cases, about 40% are treated with MDT. While MDT has been implemented in all eight regions, the coverage is still low in four of them. In order to reach the elimination goal, it is planned to intensify leprosy control activities. The main problems are poor health services coverage and difficult-to-access areas. It is expected that the case-detection rate will increase until 1996 as the programme is still expanding to previously uncovered areas.

Mexico

The programme for elimination of leprosy has recorded that, out of 9532 registered cases, 7052 are being treated with MDT. After implementation of MDT an increase in case-detection has been observed. However, the proportion of cases already disabled at detection is still very high, about 30%. The national plan for elimination was implemented in 1992 and aims at integrating leprosy control at the most peripheral level.

Mozambique

Fifteen years of civil war have had severe consequences for the health structures and organization in this country. Today, with the return of peace, about five million displaced people are returning to their original districts. In this context, leprosy is one of the major health problems and high priority is being given to the disease. A special elimination programme was initiated and, in 1990, leprosy and tuberculosis control programmes were merged. At the end of 1993, 13,119 patients were registered and 2339 new cases were diagnosed. MDT coverage increased significantly during the last three years to reach 45·5%. However, MDT is not available for 36% of districts. It is planned to reach full coverage by the end of 1997. Since 1992, the Ministry of Health has been rehabilitating health facilities destroyed during the war and is taking special action regarding the five million displaced people returning to the country.

Myanmar

Leprosy continues to be an important health problem. Formerly, it was addressed through a vertical programme until 1991. Since then, the programme has been integrated into basic health services and, out of 40,254 patients, 46% are being treated with MDT; 9432 new cases were detected in 1993. It is planned to reach full MDT coverage by the end of 1996. The main difficulties are lack of trained personnel and inadequate drug supply. Standardized national guidelines are being developed in order to simplify diagnosis and treatment procedures at the peripheral level. Special actions will be required in some isolated provinces and townships.

Nepal

While leprosy is prevalent throughout the country, there are more cases in the areas of the plains. At the moment, out of 18,000 registered patients, 15,000 are under MDT in 70 districts. MDT is not available in five districts, mainly because of their geographic situation. It is planned to conduct a national evaluation of the programme in 1995 and to reorient activities towards elimination of the disease.

Niger

Leprosy continues to pose serious problems in this country. Because of the low density of population and lack of health infrastructure, only 30% of the leprosy patients have access to MDT. To date, about 6500 patients are registered for treatment and 800 new cases are diagnosed annually. In 1992, the national plan was revised in order to expand MDT coverage and to strengthen leprosy control activities. It is planned to reach 100% coverage by the end of 1995 by implementing MDT in all existing services and by using special action, including mobile teams, to reach difficult-to-access population.

Nigeria

The National Programme was launched in 1991 and, since its implementation, the registered cases have decreased from 200,000 to 28,500. In contrast, case-detection increased from 3000 to 6000 because of intensified activities. MDT coverage has increased from 11% to 72%. Leprosy services are now available in all local government areas of each state. While leprosy is being eliminated in some districts, some others will require intensified efforts.

Pakistan

Elimination of leprosy is well under way in Pakistan and, out of registered 7000 cases, more than 80% are treated with MDT. However, the disability rate among new cases is still very high, about 25%, and the proportion of MB cases is increasing. In this situation of low prevalence, it is becoming difficult to maintain regularity of treatment and tracing of defaulters. Intensified health education will be necessary to maintain community awareness.

Papua New Guinea

The health system has been decentralized since 1992, and the leprosy control programme has been combined with other disease control programmes at provincial level. About 600 new cases are detected annually. Although it is planned to expand MDT in all provinces, accessibility to MDT is still low and only 34% of cases benefited from it in 1993. Monitoring and control of MDT drug use, in conjunction with an improved information system, remain a continuing concern for the programme.

Philippines

Currently about 15,000 cases are registered, and 3442 new cases were detected in 1993. MDT coverage reaches close to 100%. It is expected that leprosy will be eliminated by the end of 1988. However, the programme is facing difficulties because of restructuring which has led to problems with supervision, monitoring and drug supply.

Thailand

Leprosy is close to the elimination target following 10 years of intense MDT implementation. Since 1990, the MDT coverage has been maintained at 95% or more. The challenge is to maintain high quality of services under low endemic circumstances. But 35 out of 75 provinces have been reporting a prevalence rate below 1 per 10,000 for the last three years and the case-detection rate is continuously declining.

Vietnam

Leprosy is conceived in this country as a social disease, with more than 8000 registered cases and 3200 new cases detected annually. Leprosy control services are integrated into dermatology services and general services. However, 26% of the districts are not covered by the programme. About 2000 high endemic villages are located in mountainous areas without proper leprosy services. MDT coverage has increased from 10% in 1983 to 92% in 1993. This has helped to improve the epidemiological situation and has favourably changed the community's outlook and attitudes towards the disease; it is planned to intensify activities in high endemic and difficult-to-access areas.

Zaire

Leprosy is a serious problem in Zaire, with more than 8000 registered cases and 3600 new cases a year. Leprosy control activities are difficult to organize in the current political and social context. The programme coverage has decreased from 62% of the population to 36%. The situation is becoming even more complicated because of the problem of refugees in the eastern part of the country. Considering the lack of resources, poor accessibility, shortage of drugs and political unrest, leprosy control activities are very difficult to organize. While MDT coverage is reasonably high in some health districts, the situation is far from satisfactory in others. Leprosy elimination will require increased collaboration and the implementation of special action in difficult areas.