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News and Notes

Global plan of action for the elimination of leprosy, updated 1996, WHO

The Contents and part of the text of the above document (WHO/LEP/96.8) are reproduced below:

1 Introduction

This update to the Global Plan of Action first adopted in Hanoi in 1994 contains no major technical changes, but rather refocuses attention on the main element of that first plan, namely, the need to ensure MDT is within reach of all patients even at village level.

Over the last two years since the Plan of Action was first formulated, enough evidence has been accumulated from endemic countries to show that MDT is the most effective tool now available for eliminating the disease. Progress varies between countries depending on MDT coverage and the overall management of the national elimination programme. Data from well-organized programmes show that where MDT is properly applied, the incidence of the disease can decrease by as much as 5–10% per year. Moreover, leprosy of consequence and the number of new patients showing disabilities attributable to leprosy is also significantly decreasing. However, despite strong political commitment many endemic countries are not yet in a position to provide this very effective technology to all populations in need. This is mainly because geographic coverage of MDT services in some countries is still not wide enough, treatment is inflexible or remains too sophisticated, or is carried out only by specialised workers. What is required is a more simplified approach to treatment, making as much use as possible of general health workers at village level, and making access to MDT for the patient flexible and uncomplicated. We can no longer rely on the simple assumption that a community level 'demand' for MDT will somehow be reflected by an immediate 'supply' response from more central levels.

Rather, the best way to stimulate public awareness of the disease and the effectiveness of its treatment is to have MDT always available at a local level.

Without some new approach of this kind, there is increasing evidence to show that elimination of the disease will be difficult to achieve in some major endemic countries (or significant regions within these countries) by the year 2000. The new approach required needs to remain simple but well-organized and systematic. At its most basic, it involves developing activities to be implemented at national and sub-national levels aimed at decentralizing as much as possible the diagnosis and treatment of the disease.

There are four basic elements to this new approach: firstly, the national Leprosy Elimination Campaigns (LEC) will stimulate public awareness of the disease at the community level and help detect 'hidden' cases of consequence (i.e. MB cases and those patients with multiple lesions); second, ensuring that MDT is available and readily accessible to patients at the community level; third, Special Action Projects (SAPEL) will tackle difficult-to-access areas where normal services cannot be applied; and fourth, monitoring the impact of this approach at the community level and strengthening existing information systems so that the progress being made towards elimination can be evaluated by district, regional and national managers of the programme. This implies looking at the problem at a micro level rather than relying on aggregated data at a regional or national level, which can mask many anomalies. Because of the progress made so far, this is now considered feasible: the eventual aim being to count down the progress being made towards elimination by focusing on the individual leprosy patients themselves.

2 The global strategy

A global strategy is essential if the envisaged goal is to be achieved. Its time-limited nature warrants constant review of the progress being made and the application of flexible approaches, particularly in areas where special problems are faced. The technical basis of the strategy, as defined in 1991, remains unchanged: elimination is to be achieved by the detection of patients and their treatment with MDT. Disability prevention and rehabilitation are also important, although not directly related to the elimination goal.

2.1 OBJECTIVE

The global strategy aims at reducing the prevalence of leprosy below one case per 10,000 population by rapidly curing patients with MDT, reducing the transmission of *Mycobacterium leprae* in the community and thereby reducing the occurrence of physical and social disabilities related to the disease.

2.2 APPROACH

The major focus, at the time of first implementing the strategy, was to reach all prevalent cases with MDT and to cure them. By continuously reducing the source of infection, it was expected that transmission of the disease will be significantly reduced over a period of time. In 1996, considering that almost all registered cases have been or are being treated with MDT, the global reduction of the known prevalence pool has reached its maximum limit. Knowing the uneven distribution of leprosy and the variations of leprosy control services, it is now crucial to focus on the most peripheral levels and to plan for reaching elimination at national and sub-national levels. To progress further towards elimination, it is essential to develop new approaches aiming at diagnosing and curing the hidden prevalence. The existence of the hidden prevalence is mainly due to a) poor MDT services coverage, b) too rigid or sophisticated an approach to leprosy control, c) poor accessibility to MDT treatment.

Therefore, it is recommended that endemic countries give high priority to four major activities as follows:

- Organization of national elimination campaigns using simplified procedures for diagnosing leprosy of consequence;
- Decentralization of MDT services to the most peripheral level;
- Innovative approaches to the delivery of MDT drugs that will ensure an equitable distribution to underserved populations;
- Close monitoring and evaluation of elimination at the most peripheral level.

2.3 TARGETS

At the beginning of 1996, the global prevalence was about 950,000 and the annual detection around 560,000. Over the next 4 years, it is expected that 2 million patients (1·2 million incident cases and 800,000 backlog cases) have to be diagnosed and cured in order to achieve elimination. Thus, including the patients already on treatment, it is estimated that about 2·9 million patients will need MDT between 1996 and the year 2000.

It is estimated that:

- 1·25 million patients, in addition to the 950,000 already under treatment in 1996, will be treated through already existing health services, assuming that they are maintaining the same level of performance;
- 650,000 patients have to be diagnosed and treated through a campaign approach;
- 100,000 patients have to be diagnosed and treated through a SAPEL approach.

Considering that more than 95% of the patients live in 16 major endemic countries, the global plan of action aims at intensifying elimination activities for diagnosing and curing the patients as follows:

1996–2000	Estimated number of cases to be treated through existing health services	Estimated number of cases to be treated through LEC	Estimated number of cases to be treated through SAPEL	Total
COUNTRY				
India	1,100,000	350,000	50,000	1,500,000
Brazil	15,000	95,000	5000	115,000
Indonesia	30,000	25,000	3000	58,000
Bangladesh	20,000	25,000	5000	50,000
Myanmar	7000	15,000	2000	24,000
Nigeria	3000	25,000	5000	33,000
Nepal	2500	20,000	2000	24,500
Mozambique	2000	8000	5000	15,000
Zaire	4000	18,000	5000	27,000
Ethiopia	7500	8000	3000	18,500
Madagascar	4000	12,000	2000	18,000
Sudan	5000	8000	3000	16,000
Philippines	5000	6000	1000	12,000
Cambodia	3500	8000	2000	13,500
Guinea	4500	7000	1000	12,500
Tanzania	5000	3000	1000	9000
Total	1,218,000	633,000	95,000	1,946,000

6 Additional resources needed for all planned activities

Budgetary estimates are based on the latest available information on the cost of MDT drugs and transport, and the average cost of detecting new cases through LEC and SAPEL mechanisms in 1995

and 1996. There is a considerable cost advantage to be gained if these major activities are fully funded and implemented within as short a time scale as possible (perhaps in part by a reallocation of some existing resources). This is because they will result in a reduced caseload, fewer chronic or complicated cases, and a consequent reduction in the need to fund the treatment of disabilities and rehabilitation.

Additional resource needs for 1996–2000 (Million US$)	Country level activities	Activities supported by WHO	Total
MDT Implementation	56	4	60
Leprosy Elimination Campaigns (LEC)	182	8	190
Special Action Projects (SAPEL)	28	2	30
MDT Drug Supply & Management	25	40	65
Leprosy Elimination Monitoring and Geographic Information Systems	6	2	8
Capacity Building and Health Systems Research	2	2	4
Community action & rehabilitation of patients*	10	0	10
Total	309	58	367

* There is only limited information on the cost of this activity. It may vary considerably from one health system to another.

7 Conclusions

WHO's intensified plan of action for elimination goes beyond the basic strategy first formulated in Hanoi in 1994, by aiming to extend MDT services to the community level:

- LEC will create awareness of the disease within communities, and thus accelerate the detection of 'hidden' cases of consequence;
- WHO will encourage national programmes to make MDT available and readily accessible to all patients at the community level;
- SAPEL will tackle difficult-to-access areas where normal services cannot be applied;
- the impact of this new community-based approach will be monitored at district, regional and national levels in order that progress being made towards elimination can be evaluated.

WHO believes that this community-based approach is essential, if the goal of achieving the elimination of leprosy as a public health problem by the year 2000 is to remain within reach.

For further information write to: WHO Action Programme for the Elimination of Leprosy, 1211-Geneva, Switzerland.

Integration of leprosy elimination activities into general health services—informal consultation, WHO

The above Consultation was held in Geneva, 12–13 April 1996. The participating experts were Dr G. A. Alabi (Nigeria), Dr P. Feenstra (Netherlands), Professor J. Grosset (France), Dr A. C. McDougall (United Kingdom), Dr C. Pirayanvaraporn (Thailand) and Dr C. K. Rao (India).

The Consultation was opened by Dr S. K. Noordeen, Director, Action Programme for the Elimination of Leprosy, who said that this consultation should provide guidelines on the best approaches for involving the general health services in accelerating the progress towards the goal. He concluded by indicating that the outcome of this consultation would be considered at the forthcoming Second International Conference on the Elimination of Leprosy in New Delhi, India, in October 1996 and the ensuing meeting of the 7th Expert Committee on Leprosy, planned in 1997.

The objectives of the consultation were:

1 To review experiences in implementing leprosy elimination activities at the most peripheral levels.
2 To review the advantages and disadvantages of combined programmes as compared with integrated leprosy elimination programmes.
3 To identify the prerequisites, obstacles and constraints to integration of leprosy elimination activities into the general health services.
4 To discuss and develop approaches for accelerating the implementation of leprosy elimination activities within general health services.

The Conclusions and Recommendations were as follows:

Because the goal of eliminating leprosy as a public health problem is a feasible one and because MDT (in blister packs) is a robust technology capable of being applied by minimally trained health personnel, the Consultation concluded and recommended that:

1 MDT should be available in all health facilities in endemic areas after appropriate preparation, and the general health service personnel should also participate in case detection and treatment activities. They should be supported by referral services at district and regional levels. Technical supervision from upper levels has to be ensured to support health staff. General health supervisors should be involved in technical supervision.
2 Technical procedures for diagnosis, classification, treatment delivery, case-holding, recording and reporting have to be simplified. Similarly, monitoring of leprosy elimination activities has to be simplified using only crucial indicators.
3 Community demand and pressure should be created and sustained through professional approaches, (e.g., social marketing) and local strategies in order to achieve leprosy-free communities. The patients and general health workers who are also members of the community should be involved in the community action.
4 For leprosy elimination to be achieved, the utmost emphasis should be placed on full participation of the general health services. There is, therefore, no need for exclusive vertical or combined vertical (e.g., TB/LEP) programmes.
5 The training of general health workers should be brief and task-oriented to ensure acquisition of the specific skills required. On-the-job training by technical supervisors to enhance performance should be emphasized. Training should be supplemented by simple manuals and other education materials.

Document number: WHO/LEP/96.1. For further information write to: Action Programme for the Elimination of Leprosy, WHO 1211-Geneva, Switzerland.

Further decline in leprosy prevalence, *LEPNews*, WHO, June 1996

The following is taken from the opening page of *LEPNews*, Vol. 5, No. 2:

The number of registered leprosy cases in the world has fallen below one million for the first time since global statistics on the disease began to be collected. This suggests convincingly that WHO's strategy for eliminating leprosy as a public health problem is well on track. WHO's Action Programme for the Elimination of Leprosy (LEP) gives the figure for registered cases as 926,259, to make a global prevalence of 1·67 cases per 10,000 population.

In fact, the overall prevalence of leprosy, which declined by 27% between 1994 and 1995, has fallen by a further 28% between 1995 and this year. Over the past ten years, the world's leprosy burden has been reduced by 83%.

Moreover, 91% of the cases now have access to multidrug therapy (MDT), a figure which compares with only 55% of cases in 1994. The cumulative total of leprosy cases so far cured by MDT stands at around eight million. The increased coverage can mainly be attributed to the efficacy and acceptability to patients of this treatment, which is now fully standardized and of fixed duration. The number of

treatment failures or relapses remains very low, and drug resistance to MDT has never been reported. The supply of adequate quantities of drugs at the peripheral level, together with treatment free of charge, can also be credited for the high level of compliance. Better coverage with MDT has in turn led to improved case detection, and the large backlog of leprosy patients waiting for appropriate treatment has been significantly reduced.

Detailed figures for the estimated cases, registered cases and MDT coverage region by region, as well as details for the top 16 endemic countries and for other countries with more than 100 registered cases, were given in WHO's *Weekly Epidemiological Record* (Vol. 71, No. 20) dated 17 May 1996.

Against these encouraging figures must be set the fact that, in a few high-endemic countries, substantial numbers of patients still do not have easy access to diagnosis and treatment. Many live in such remote areas that they may not even be aware that leprosy is a curable disease. This could hamper the attainment of WHO's goal of eliminating leprosy as a public health problem by the end of the year 2000.

Once the prevalence has fallen below 1 case per 10,000 population at a national level, WHO and its partners working in this field will direct their attention to reducing the number of cases at sub-national levels.

Over half a million new cases are being detected each year, and these detection rates are particularly high in some countries or in areas within countries. WHO says that the extent to which this reflects a high level of disease transmission is not clear, but those countries or areas will clearly have difficulty in reaching the elimination target on time and will need special attention.

Leprosy remains a public health problem in 60 countries or areas, but 16 countries contribute to about 90% of the leprosy problem in the world. India heads the list with 560,000 registered cases, far ahead of Brazil with 95,564. Then follow Indonesia, Myanmar, Nigeria, Nepal, Bangladesh, Philippines, Mozambique, Ethiopia, Zaire, Madagascar, Sudan, Tanzania, Guinea and Cambodia.

WHO concludes that the elimination strategy has already had a significant impact in terms of a dramatic and constant reduction in morbidity, increased priority accorded to leprosy control activities in more endemic countries, free supply of MDT drugs through WHO to the countries in need, and focused attention on difficult-to-reach populations. But all these direct benefits of the strategy should not obscure the fact that considerable challenges remain, and continuing resources—both human and financial—are still needed, if the goal is to be attained by the end of the century.

For further information write to: WHO Action Programme for the Elimination of Leprosy, CH-1211 Geneva, Switzerland. Fax 41 22 791 4850.

Strategy for the elimination of leprosy from Maharashtra, India by the year 2000, June 1996

We thank Mr S. S. Naik for supply the following the report:

A seminar on 'Strategy for the elimination of leprosy from Maharashtra by 2000 AD' was organized by Acworth Leprosy Hospital, Society for Research, Rehabilitation and Education in Leprosy and held on 10 June, 1996.

The Seminar was Chaired by Dr J. A. Ponniah, NLEP Consultant, State of Maharashtra and the resource persons included Dr R. Ganapati, Member, Maharashtra State Leprosy Council, and Dr J. T. Kale, JT Director of Health Services Leprosy, State of Maharashtra.

About 45–50 delegates representing State Government, NGOs in leprosy, staff and students from the medical colleges participated in the seminar.

After extensive scientific deliberations the following points were recommended:

1 As the operational experiment in the hilly terrain of Panvel was highly successful, it was recommended that similar strategies may be developed and worth emulating in other parts of the districts of Maharashtra that are difficult to access.

2 It was also recommended that in some of these districts certain community volunteers may be identified and trained in diagnosing leprosy.

3 It was recommended that in urban areas, smear facility provision be started for the city of Greater Bombay with the active assistance of staff from ADHS, to the practising dermatologists. It was decided to set up a pilot scheme in one suburb of Greater Bombay, after identifying a group of practising dermatologists.
4 On involvement of associations like the Indian Medical Association, it was recommended to avail the assistance of the leprosy wing (to be started) of the Indian Medical Association for case detection, referral of cases for research etc.
5 It was recommended to have a separate strategy for certain tribal population of Maharashtra, namely advance dispensing of blister-calendar packs to the patients.

Acworth Leprosy Hospital Society, 25th Anniversary

This 52-page report shows the wide range of activities undertaken in research, rehabilitation and education in leprosy undertaken by the Society from 1970–1995. Copies are available from: Dr S. S. Naik, Acworth Leprosy Hospital, Wadala, Bombay 400 031, India.

Tropical Medical Resource, The Wellcome Centre, London

The August 1996 issue of *Focus*, a bulletin from Tropical Medicine Resource (TMR), describes the development of material on leprosy:

Few diseases have evoked more fear (by its more mention) or despair (by its cruel disfigurement and social rejection) than leprosy. Today, as the worldwide prevalence of this disease declines, 75% of an estimated total of 1·8 million people afflicted with leprosy are benefiting from multidrug therapy. Although many questions about leprosy remain, it provides a good epidemiological model for the elimination of a disease. Indeed, the World Health Organization (WHO) aims to 'eliminate' leprosy as a public health problem by the year 2000 ('elimination' is defined as a prevalence of less than 1 case per 10,000 of the population). However, leprosy will continue to cause significant global concern long after the millennium. Relapse and residual disability are just two considerations.

The TMR Leprosy Information/Training Resource will help maintain professional and public awareness of the disease to assist the elimination process. The Project, with Dr Simon Cathcart as task editor/cataloguer, will offer a comprehensive collection of catalogued images and related interactive tutorials.

The WHO will help appraise the completed materials (estimated production time, 12–18 months). The Project will reflect international interest and collaboration between TMR and specialists working in the UK (including several from the London School of Hygiene and Tropical Medicine) and overseas, for example:

THE NETHERLANDS

Ms Helga Dietrich (Nederlands Leprosy Relief Association) and Dr Peter Lever (Dutch Tropical Institute) viewed the TMR leprosy images and CD-ROM in London last October. Simon is collaborating with Dr Lever, to catalogue images gathered by the late Professor Dick Leiker. Appropriate examples will be included, with due credit, in the TMR leprosy archive.

INDIA

In January, Simon diverted from a holiday in India to visit the Schiefflin Leprosy Research and Training Centre at Karigiri. The centre—under its Director, Dr P. S. S. Sunder Rao—combines a 200-bed hospital with rehabilitation, research and training facilities. Mr Timothy ffytche (Consultant

Ophthalmic Surgeon) is helping TMR with the leprosy project training courses at Karigiri. The Centre's video unit, managed by Mr Michael Joseph, produces excellent audiovisual materials for a wide range of local and overseas leprosy training programmes.

The WHO is funding new leprosy treatment trials around Karigiri. However, the local population has a poor understanding of both the recognition and transmission of leprosy and of basic healthcare. Dr Kumar Jesudasan (Head of the Department of Epidemiology at the Centre) expressed interest in using TMR materials to help local medical officers and health workers develop community health education/ public health programmes. The leprosy project is thus providing opportunities to develop valuable professional networks and address fundamental issues in public health.

For further information write to: Dr Simon Cathcart, TMR, 210 Euston Road, London NW11 2BE, UK. Fax 44 171 611 8270.

XV International Leprosy Congress, Beijing, China, September 1998

Basic concept and framework:

The XV International Leprosy Congress in Beijing, to be held in September 1998, may be termed a '*Centennial Congress*,' signifying the end of the first century of modern leprosy control. This century was initiated by the first Congress in Berlin in 1897 and, hopefully, will achieve the 'Elimination of leprosy as a public health problem.' This achievement will signal the start of the second century of our modern fight against the disease which should culminate in the total eradication of the disease and its consequences. Eradication means elimination of not only the disease itself but, also, of all the adverse effects of the disease, including the social problems faced by 'people affected by leprosy.'

Therefore, the Congress is being organized under the heading of '*Working Toward a World Without Leprosy*,' not just hoping but actually intending to achieve that final goal sometime during the next century.

The Congress will deal with leprosy and its problems from a holistic point of view, and try to come up with some practical, appropriate solutions in a closely-integrated manner.

The whole programme of the Congress, including keynote speeches, open panel discussions, workshops, question-and-answer sessions in plenary, oral presentations of individual papers in separate sessions as well as poster presentations and other exhibits, have been planned with this approach in mind.

The date of the Congress of six working days is currently fixed as from *Monday 7 September to Saturday 12 September 1998*. The venue will be the *Beijing International Convention Centre* with accommodation at the adjacent Continental Grand Hotel. Both are located well within the city on the 4th Ring Road of Beijing, less than half an hour from the airport by direct highway link, and about 20 minutes by car from Tian An Men Square, the centre of the city.

The Congress is being arranged quite differently from previous Congresses. Four main changes are proposed: 1, no more pre-Congress workshops; 2, much less time for oral presentations of individual papers; 3, much more provision for poster presentations; 4, much more time to be spent in plenary sessions. There will be short teaching sessions on 10–12 subjects on three or four evenings. The plan reflects the four main characteristics of the XVth Congress which are: '*Integrated*,' '*Action Oriented*,' '*Interactive*,' and '*Participant Friendly*.'

The *first official announcement of the Congress*, a one-page flier with dates, venue, and a broad outline, will be sent out *later this year* without details such as daily programmes, which will appear only in the *second/final announcement* scheduled to be published in *October 1997*.

In addition to the daily programmes, we have discussed some other relevant matters as follows: The expected number of *Participants*, 800–1000 overseas plus 300 Chinese. The *Registration fee*, US$250 or less. *Accommodation cost*, with more than 10% annual inflation, the cost of living is increasing rapidly, but we are hoping to settle on US$100 per twin bedroom for two persons per day. *Language*, English only with Chinese translation as required. *Schedule* of events related to the preparation of the

Congress: Joint consultation with Chinese Organizing Committee in September 1996. Second Organizing Committee meeting in April/May 1997 to decide the details of the programme, selection of people for key roles, such as keynote speakers, moderators and members of open panels and workshops, teachers for short-course sessions, etc. Closing of Abstract submission, end of March 1998. Third Congress Organizing Committee Meeting, June 1998.

Robert Cochrane Fund for Leprosy

The Fund, in memory of the great leprologist Robert Cochrane, is administered by the Royal Society of Tropical Medicine and Hygiene. It is to be used to finance up to three travel Fellowships each year, to a maximum value of £1000 each.

The Fund will support travel for:

Leprosy workers who need to obtain practical training in field work or in research.
Experienced leprologists to provide practical training in a developing country.

There is no restriction on the country of origin or destination providing the above requirements are fulfilled.

Application forms are available from the Society and completed forms must be received by the Society at least six months ahead of the proposed visit. All applications must be sponsored by a suitable representative of the applicant's employer or study centre, and agreed by the host organization. A two-page report on the travel/study should be submitted to the Society within one month of the recipient's return.

Apply: Robert Cochrane Fund for Leprosy, Manson House, 26 Portland Place, London W1N 4EY, UK. Tel: 44 171 580 2127; fax: 44 171 436 1389.

American Lung Association & American Thoracic Society Conference, May 1997, USA

The above Conference is to be held in San Francisco, USA, 16–21 May 1997. Vital information on the prevention, control and management of lung disease will be presented in a variety of symposia and workshops. For more information write to: 1997 International Conference, ALA/ATS, 1740 Broadway, New York, NY 10019-4374, USA.

Where are we in the fight of leprosy approaching 2000? April 1997, Turkey

The above Conference is to be held 27–30 April 1997 in Instanbul, Turkey. The guest speakers include: J. G. Andersen, J. W. Brandsma, T. ffytche, S. D. Gokhale, M. Kararcorlu, K. U. Kiran, A. C. McDougall, S. K. Noordeen, T. Ozkan, T. J. Ryan and T. Saylan.

All workers who have spent the last 20–30 years in the fight against leprosy and invited to discuss the past, present and the future of the struggle. If you wish to participate contact: Dr Tulay Cakiner, Istanbul Lepra Hastenesi, Bakirkoy, 34747 Istanbul, Turkey. Tel: 90 212 575 25 75; fax: 90 212 583 00 86.

Leprosy Review posters: Immunology

The A3 poster enclosed with this issue of *Leprosy Review* is the third in a series of four covering important areas of management and research in leprosy and is distributed free to subscribers to the Journal.

We hope subscribers will find these posters informative and useful. Displayed prominently in clinics, they should serve as a useful teaching resource and aide memoire for all those involved in the treatment of leprosy and its reactions and in prevention of disability work.

We would welcome feedback and comments (to the Editor please) on this series and suggestions for future topics. Additional copies of the poster in this issue and those in future issues will be available from LEPRA, Fairfax House, Causton Road, Colchester CO1 1PU, England.