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TECHNICAL PAPER:

ELIMINATION OF LEPROSY

CONTENTS

ELIMINATION OF LEPROSY

Executive Summary

Leprosy continues to be a significant public health problem in some countries of the Eastern Mediterranean Region, in spite of the considerable decrease in the total number of leprosy cases registered for treatment.

Following the adoption of the Regional Committee resolution (EM/RC37/R.7) and the World Health Assembly resolution (WHA44.9) on the elimination of leprosy as a public health problem, Member States of the Eastern Mediterranean Region have strengthened their commitment towards controlling leprosy. All endemic countries in the Region prepared national plans for the elimination of leprosy, and elaborated time-bound frameworks to suit individual countries.

The main strategies for the elimination of leprosy as a public health problem are based on target-oriented deployment of multi-drug therapy (MDT), with the maximum efforts and resources being allocated to areas with the highest endemicity, as well as to the provision of training for medical personnel; health education at different levels; strengthening of cooperation between national programmes, WHO and NGOs in planning, implementation, monitoring and evaluation of control activities; and the promotion of community involvement, particularly in the rehabilitation of leprosy patients.

It is essential that national authorities in countries where leprosy is still an important public health problem ensure that they:

1. continue their commitment to achieve the target of eliminating leprosy by the year 2000, by giving priority to leprosy in the national health plans;

2. allocate adequate resources for surveillance, treatment and rehabilitation of leprosy patients;

3. maintain 100% coverage of leprosy patients with MDT;

4. support health education activities for patients as well as for the general community, with the aim of fighting the stigma attached to this disease;

5. strengthen the training of the medical and paramedical personnel in case-finding, treatment with MDT and prevention of disabilities;

6. ensure proper coordination of the support provided by international organizations, donor agencies and national and international non-governmental organizations, to achieve the goal of elimination of leprosy.

ELIMINATION OF LEPROSY
(Agenda item 8d)

1. Introduction

Following the adoption of resolution EM/RC37/R.7 by the Regional Committee on the leprosy situation in the Region in 1990, the Member States have strengthened their commitment to leprosy control through early case detection, wide use of multidrug therapy (MDT), training of personnel and health education. This has been instrumental in the significant improvement of the epidemiologic situation of leprosy in the Region.

The adoption, in May 1991, of the World Health Assembly Resolution WHA44.9 to eliminate leprosy as a public health problem further strengthened ongoing regional efforts. National plans for the elimination of leprosy have been prepared for all endemic countries in the Region; these included the elaboration of time-bound plans to suit individual countries.

The strategies recommended in the World Health Assembly Resolution for attaining elimination are based on target-oriented deployment of MDT, with the maximum efforts and resources being allocated to areas with the highest endemicity, provision of training for medical personnel, health education at individual, family and community levels, strengthening of cooperation between national programmes, WHO and NGOs in planning, implementation, monitoring and evaluation of control activities and the promotion of health systems research.

The International Conference on the Elimination of Leprosy, held in Hanoi, Viet Nam in 1994, recommended the implementation of the Global Plan of Action for the Elimination of Leprosy as a Public Health Problem by the Year 2000 and called for a close partnership between governments and non-governmental agencies working towards achievement of this goal.

2. Epidemiological situation of leprosy in the Region

Leprosy continues to be a significant public health problem in some countries of the Eastern Mediterranean Region, although the total number of leprosy cases registered for treatment has decreased steadily over the last few years. It has decreased from almost 100 000 cases registered in 1989 to 24 000 in 1993 which means a reduction in prevalence from 2.6 per 10 000 population in 1989 to 0.53 per 10 000 population in 1993. Improvements in the registration and treatment of leprosy cases have been the main reasons for this reduction.

It is estimated that there are around 50 000 leprosy cases in the Eastern Mediterranean Region (1994) out of a global total estimated number of 2.4 million. It is also estimated that 10 to 25% of leprosy patients suffer from various forms of disability.

The number of new leprosy cases detected in the Region during the last few years has increased from 3923 in 1990 to 5543 in 1993. New cases

represented 10.12% of the total number of registered cases in 1990, whereas the total increased to 23.12% in 1993. This shows the recent improvement in case-finding and treatment activities. The proportion of new leprosy cases accompanied by disability coming in for treatment ranges between 15% and 30% in the Region. Thus, cases are still being detected at a rather late stage.

The distribution of leprosy cases in the Region is not uniform between countries and even within regions in the same country. The epidemiological data available from endemic countries of the Region are based essentially on self-reported cases. A substantial proportion of cases, particularly those in the early stages of the disease, are believed to be missed due to under-reporting of patients to the public health services. The data are still incomplete in spite of the considerable efforts made by countries to improve the recording and reporting systems. Unfortunately, some of the areas most affected by leprosy are affected by wars and political unrest resulting in the destruction of public health infrastructures, including reporting systems. As a consequence, information from those areas is either missing or only partially provided.

The available data (**Table** 1) indicate that there is a significant difference between countries in the Region as to the registered prevalence of the disease. Based on this criterion, countries of the Region can be divided into three groups:

1. Countries with a prevalence of 0.4 per 10 000 population and below

This group of countries includes Bahrain, Cyprus, Djibouti, Iraq, the Islamic Republic of Iran, Jordan, Kuwait, Lebanon, the Libyan Arab Jamahiriya, Morocco, Oman, Qatar, Pakistan, Saudi Arabia, the Syrian Arab Republic, Tunisia and the United Arab Emirates. The distribution of leprosy in these countries is limited and the disease is no longer considered a public health problem. However, in Pakistan there are some foci of higher prevalence. In the countries of the Arabian Peninsula, the majority of registered cases belongs to the expatriate group of the population.

Although statistical data from Afghanistan are not available, according to previous reports Afghanistan can also be included in this group.

2. Countries with a prevalence of 0.5 to 0.9 per 10 000 population

This group comprises Egypt and the Republic of Yemen. The distribution of leprosy cases in these countries has a focal character and the prevalence in some areas is higher than one per 10 000 of population.

3. Countries with a prevalence of more than one per 10 000 population

This group includes Sudan and possibly Somalia. Leprosy is a public health problem in many provinces of Sudan. The distribution has a cluster character with a high prevalence in some foci. Recent information from Somalia is not available. However, on the basis of previous data, leprosy in Somalia is a major public health problem.

Table 1. Registered prevalence of leprosy, detection and coverage with multidrug therapy (MDT) in countries of the Region

Category/ country	Source & year	Reg. cases	Reg. prev: per 10 000	New cases	MDT cov(%)
Prevalence 0.4 and below					
Bahrain	CR(93)	26	0.48	1	100.0
Pakistan	CR(93)	6104	0.46	1227	59.7
Morocco	CR(93)	1105	0.41	113	63.47
Iran, Islamic Republic of	CR(93)	2346	0.38	147	100.0
Djibouti	CR(93)	16	0.33	7	100.0
Islamic State of Afghanistan	WER(94)	641	0.31	20	61.93
Oman	CR(93)	43	0.25	38	100.0
Tunisia	EMR(90)	181	0.21	-	100.0
Libyan Arab Jamahiriya	CR(93)	205	0.20	18	100.0
Lebanon	WER(94)	47	0.16	16	-
Syrian Arab Republic	CR(93)	224	0.16	3	100.0
United Arab Emirates	EMR(89)	22	0.13	-	100.0
Saudi Arabia	CR(93)	96	0.06	75	100.0
Jordan	CR(93)	20	0.05	0	100.0
Kuwait	CR(93)	5	0.03	16	100.0
Qatar	WER(94)	1	0.02	-	100.0
Iraq	CR(93)	16	0.01	11	100.0
Cyprus	CR(93)	0	0.0	0	100.0
Prevalence 0.5-0.9					
Yemen, Republic of	CR(94)	877	0.72	309	100.0
Egypt	CR(93)	3947	0.63	846	100.0
Prevalence 1 & above					
Sudan	CR(94)	4554	1.82	1935	92.0
Somalia	WER(94)	1084	1.41	150	59.0

CR = country report
EMR = Eastern Mediterranean Report
WER = Weekly epidemiological report
(-) indicates data not available
cov:= coverage

3. Follow-up on the recommendations of the Regional Committee at its Thirty-seventh Session on leprosy control in the Region

3.1 Recommendations to Member States

Recommendation 1: *Provide the necessary support and commitment to leprosy control through the development or implementation of national plans with emphasis on implementation of multidrug therapy.*

National plans for the elimination of leprosy have been prepared with WHO assistance in all major leprosy endemic countries of the Region. These plans emphasized the importance of coordinating activities with the National Leprosy Control Programme and local and international nongovernmental organizations regarding country strategy on leprosy control.

From time to time, revision of the national plans is needed to reflect the changing epidemiological situation in some Member States, as well as the operational targets currently achieved by the National Leprosy Control Programmes. Countries where the geographical coverage of MDT is still not at a satisfactory level will need to revise plans so as to be on target for their elimination goals.

Recommendation 2: *Strengthen their national capabilities for leprosy control through giving adequate priority to, and allocation of resources for, leprosy control within the framework of general health services based on the primary health care approach and support of specialized service within the integrated programmes.*

To achieve wide coverage of the population with diagnosis, treatment and rehabilitation, leprosy control activities in the majority of the countries have been partly integrated within the existing primary health care (PHC) system.

The present integration of leprosy control into the PHC system needs to be strengthened further through provision of on-the-job training of PHC staff and close technical supervision of leprosy control activities performed by the staff of the vertical leprosy control programmes. Allocation of resources for this activity has not been given priority by the basic health services or by the leprosy control programmes.

Recommendation 3: *Give priority to multidrug therapy in their national control programmes.*

Multidrug therapy (MDT) was introduced in most of the national leprosy control programmes starting in 1983, and at present all national programmes in the Region are using MDT as a major tool for leprosy control. However, some leprosy control programmes continued to provide monotherapy treatment with Dapsone for old leprosy cases, and even new leprosy cases in remote areas, where the supervision of intake of the MDT drugs is difficult.

Coverage with MDT has increased considerably over the last 10 years. In the middle of 1986, only 15% of the registered leprosy cases in the Region received treatment with MDT. At the beginning of the nineties, MDT coverage

reached 40% and at present 92.4% of registered cases in the Region are undergoing treatment with MDT.

MDT has proved to be operationally feasible in areas where there is an adequate primary health care infrastructure for the delivery of drugs. The geographical coverage of MDT in some Member States is still inadequate and this needs to be improved by speeding up the integration process of MDT delivery in primary health care services. The main constraints have been in developing efficient delivery systems for MDT in areas in certain regions of the country with a weak public health infrastructure. Innovative approaches to cover these areas must be developed, taking into account local situations and resources.

Drug requirements for MDT need to be well planned for the future in order to provide uninterrupted treatment for leprosy cases and to ensure that drugs do not run out, especially at a time when national programmes are expanding their coverage.

Recommendation 4: *Encourage the provision of health education to patients, health personnel and the community with a view to removing the stigma traditionally associated with the disease and to institute adequate legal guarantees protecting the rights of cured leprosy patients as full participants of society.*

Health education has been an important part of the leprosy control activities and it has been conducted at different levels utilizing a wide range of activities. Distribution of pamphlets for individual patients as well as posters and educational talks for the general public are being carried out by leprosy control personnel in the main endemic countries. The use of mass media such as newspapers and TV to reach a wider audience as well as talks on leprosy in schools, mosques and other public places have been practised in some countries.

WHO and local, international and nongovernmental organizations have supplied the national control programmes with publications, pamphlets and training materials. The observance of International Leprosy Day has been undertaken annually in main leprosy endemic countries with publication of articles in the press, broadcasts on local radio, TV coverage and talks for large public gatherings.

However, in the majority of Member States health educational activities have been carried out mainly by the staff of the vertical leprosy control programmes. Greater involvement of the general public health staff in such activities and support from voluntary organizations working at the community level are needed in order to increase the coverage of the educational messages as well as to reduce the stigma of leprosy. Admittedly, health education activities have not been undertaken in a sustained manner in most of the Member States, especially where the stigma of leprosy is still great.

Recommendation 5: *Strengthen training in leprosy control for medical and paramedical students, as well as to general and specialised health service personnel to ensure early case-finding, accurate diagnosis and treatment of leprosy.*

During the last few years, several training courses have been organized on the management of leprosy for national managers and district medical officers by using WHO training modules. These have been carried out at both Regional and country levels.

National training activities for different categories of health care personnel have been intensified in most endemic countries. The training topics have included diagnosis, treatment, follow-up of leprosy cases, health education and rehabilitation. Several technical publications on these subjects have been prepared in national languages and distributed among public health personnel in leprosy endemic countries of the Region. Manuals on leprosy for medical personnel have been published in Egypt, the Islamic Republic of Iran, Morocco, Pakistan, Sudan and the Republic of Yemen.

Training of medical and paramedical students in leprosy has improved in some countries by increasing the number of teaching hours and practical experience of the students in the field of leprosy control. Particularly, leprosy as a special subject was introduced into the curriculum of nursing schools in Sudan.

The inclusion of leprosy in the medical curriculum of medical schools and in the training of various categories of paramedical health workers must still be institutionalized and carried out in a uniform manner at all medical schools and paramedical health training centres.

Recommendation 6: *Secure effective coordination between the ministries of health, national and international nongovernmental organizations and agencies through the organization of national coordinating committees.*

Leprosy coordination committees have been formed in all leprosy endemic countries of the Region with members representing various government agencies, and local as well as international NGOs.

Unfortunately, in some Member States these committees are not functioning as anticipated, especially in the planning and monitoring of coordinated leprosy control activities, follow-up of earlier approved decisions and recommendations, and providing support to national control programmes in the mobilization of resources. The role of the ministries of health in these committees should be increased in order to provide leadership and to solicit support from voluntary organizations in the implementation of control activities.

3.2 Recommendations to WHO

Since the adoption of the Thirty-seventh Regional Committee resolution on "Leprosy in the Eastern Mediterranean Region" in October 1990 several activities have been carried out. They are presented below under each item of the RC resolution requesting action by EMRO.

Recommendation 1: *Continue to support the strengthening of national leprosy control programmes, including the development of appropriate information systems, essential laboratory services, training, implementation, monitoring and evaluation of the programmes.*

WHO has continued its support for the strengthening of national leprosy control programmes through joint projects in major leprosy endemic countries.

WHO consultants were assigned to Afghanistan, Egypt, the Islamic Republic of Iran, Pakistan, Saudi Arabia, Sudan and the Republic of Yemen to assist in the preparation of a plan of action for leprosy control and elimination.

Several WHO consultants were also assigned to support the training activities carried out by the national leprosy control programmes in major endemic countries on the management of leprosy and the implementation of MDT.

WHO consultants were provided to two countries with moderate prevalence (Egypt and the Republic of Yemen) to establish a computerized system for recording and reporting of leprosy cases. Both countries have been supplied with computers and software for this purpose.

Two regional workshops for training of trainers to conduct training courses on the management of leprosy using WHO training modules were organized by WHO in 1991 and 1992. These were followed by national training courses on managing leprosy control in Egypt, the Islamic Republic of Iran, Pakistan and Sudan.

WHO assisted in the preparation and production of the national manuals on leprosy in Morocco, Oman and the Republic of Yemen. WHO documents and publications on chemotherapy and the elimination of leprosy have been distributed among the Member States where leprosy continues to be a public health problem.

In order to monitor the implementation process of leprosy control at the national and Regional levels and to provide a forum for the exchange of information and experience between national staff, the Regional Seminar on Leprosy Control was held in Cairo, Egypt in 1991 to review the leprosy situation at country and Regional levels. The seminar was meant to assess the progress achieved in the implementation of MDT, to discuss training and research needs and to discuss methods of coordination with nongovernmental organizations. Representatives from 12 countries attended.

A Regional Workshop on Leprosy Elimination was held in Karachi, Pakistan in January 1994 and was attended by national programme managers from the Islamic Republic of Iran, Pakistan, Sudan and the Republic of Yemen. At this workshop the progress of the elimination of leprosy was reviewed along with a review of guidelines and training modules on leprosy control. Preparations for drawing up national plans of action for 1994-1995 were also made. A regional plan for elimination of leprosy was adopted by the participants (**Annex**).

Recommendation 2: *Continue to support the introduction and wider implementation of multidrug therapy regimens in national control programmes.*

WHO continued to support national control programmes with training of personnel and the provision of drugs and training and learning materials on the implementation of MDT.

Following the Hanoi International Conference on Elimination of Leprosy and its Declaration, WHO set up a Leprosy Elimination Drug Fund from an extrabudgetary contribution from the Japan Shipbuilding Industry Foundation (JSIF). The fund is meant exclusively for the supply of MDT drugs by WHO to national programmes in need of the drugs. In future, several countries of the Region will be provided with MDT drugs from this fund. All requests from Member States interested in receiving drugs from the Leprosy Elimination Drug Fund should be sent to WHO.

Recommendation 3: *Continue to mobilize resources from the regular budget and extrabudgetary sources for leprosy control activities.*

WHO has supported National Leprosy Control Programmes through funds allocated in the regular budget as well as through extrabudgetary funds.

A total of US$180 900 was spent in the regular budget during 1990-91, US$182 100 during 1992-1993 and US$167 800 has been earmarked for the 1994-95 biennium. Funds secured from extrabudgetary sources amounted to US$63 700 during 1990-1991. US$185 600 during 1992-1993 and US$272 600 has been earmarked for 1994-1995.

The leprosy control activities implemented by the national programmes in Afghanistan, Egypt, the Islamic Republic of Iran, Morocco, Pakistan, Sudan and the Republic of Yemen were supported by the WHO Regular Budget. At the same time assistance in the form of voluntary funds was provided to the national programmes in Afghanistan, Pakistan, Saudi Arabia, Somalia, Sudan and the Republic of Yemen. Extrabudgetary funds were used for the provision of a nine-month consultancy to Sudan during 1992-1993 and an 11-month service consultancy in Egypt, the Islamic Republic of Iran, Pakistan, Sudan and the Republic of Yemen during 1994-1995. Extrabudgetary funds have also been used to support the organization of a national conference on leprosy control in 1992 in Egypt, the organization of Regional and national training courses on managing leprosy control and to support disability prevention.

During 1994 a new WHO initiative called Special Action Projects Towards Elimination of Leprosy (SAPEL) was introduced with support from donor agencies. The aim of this initiative is to support the national programmes in identifying situations and areas within the country requiring rapid action toward leprosy elimination and in developing projects with operational and technical solutions for implementation in these special circumstances. Four countries, namely the Islamic Republic of Iran, Pakistan, Sudan and the Republic of Yemen submitted proposals. Support for a project amounting to US$28 000 to be carried out in Rashad Province of Sudan during 1995 was approved.

4. Future projections and priorities

Greater and more sustained political commitment and coordination by the Member States are essential in achieving the goal of the elimination of leprosy in the Region. With the continued application of MDT in the Member States, the registered case-load of leprosy will continue to decline in the coming years. With the exception of Sudan and possibly Somalia, all leprosy

endemic countries have a registered prevalence of below one per 10 000 population at the national level, but new cases will still occur in all Member States since the transmission of leprosy has not stopped totally. Also, the incubation period of leprosy is very long. In some Member States such as Egypt, the Islamic Republic of Iran, Pakistan and the Republic of Yemen there will still be pockets in areas where prevalence is above one per 10 000 population. In the coming years, leprosy control activities must be given priority in these areas so that the elimination goal is achieved (sub-nationally) by the year 2000.

National leprosy control programmes in endemic countries will still require resources from both internal and external sources so as to ensure that the present MDT coverage is maintained and the existing control measures do not slacken.

Maintaining a core group of expertise for leprosy control activities in each Member State will be needed, especially when the prevalence is declining. Health personnel at the central as well as intermediate levels need to be provided with managerial as well as technical skills for leprosy control.

With the high level of MDT coverage already achieved in the Region, it is necessary to strengthen case-finding activities so that the remaining undetected cases existing in the community are treated with MDT. Improved methods of passive case-finding using intensified health education and community participation should be applied more extensively, even in Member States which presently have a prevalence rate of below one per 10 000.

The improved MDT coverage will help reduce the proportion of disability among new leprosy cases but it will not have an impact on those leprosy patients who have been cured of leprosy but are suffering from various degrees of physical disability. It is estimated that there will be around 30 000 to 40 000 persons who are disabled as a consequence of leprosy in the Region and these individuals should be provided with care through community-based programmes for rehabilitation and prevention of disabilities.

5. Factors impeding progress in leprosy control in the Region

The main factors impeding progress in leprosy control in the Region are as follows:

- The continued presence of serious social stigma attached to leprosy has resulted in a reluctance of patients with early signs of leprosy to come forward for treatment. This has made the task of case-finding difficult and has resulted in a high proportion of newly detected cases suffering disabilities which could have been prevented if they have obtained treatment earlier during the disease process.

- The tendency, as leprosy prevalence goes down, to downgrade the priority given to the disease, in terms of manpower, materials and financial inputs when the present momentum of leprosy elimination activities needs to be sustained or enhanced. The

present declining trend of the disease cannot continue effectively so that the elimination goal can be attained.

- Ambulatory treatment is the most common method of drug delivery, but its organization in many countries needs improvement, especially as regards the supervision of activities.

6. Conclusions and recommendations

Although leprosy is still an important public health problem in some countries of the Region, the political commitment of all Member States and the technical and operational tools available to control leprosy indicate that the goal of the elimination of leprosy by the year 2000 is attainable.

Countries of the Region still need to solve some problems related to the organization of proper surveillance and information systems, early identification of leprosy patients, promotion of the integration of control activities within existing public health systems, organization of efficient monitoring and evaluation mechanisms, reduction of social stigma and promotion of community involvement in the process of rehabilitation of leprosy patients.

The national control programmes, nongovernmental and international organizations must make further efforts to ensure:

- continued updating of national plans and the implementation, monitoring and evaluation of leprosy control activities in different epidemiological situations;

- provision of adequate and uninterrupted supplies of drugs for MDT for the national programmes;

- strengthening of national capabilities for implementing MDT through training of public health personnel;

- systematic efforts towards health education to break down social prejudices against leprosy and;

- incorporation of disability prevention activities within leprosy control.

Accordingly, the following recommendations are submitted for consideration by the Regional Committee:

1. to reaffirm commitment to achieve the leprosy elimination target by the year 2000 by giving priority to leprosy in national health plans;

2. to strengthen the national leprosy control programmes through allocation of resources for surveillance, treatment and rehabilitation of leprosy patients;

3. Member States which have achieved 100% MDT coverage should maintain present coverage and those who have not should give top priority to increasing MDT coverage to reach the target;

4. to support health education activities for patients as well as the general community with the aim of removing the stigma attached to leprosy;

5. to strengthen the training of medical and paramedical personnel in the control of leprosy, particularly in case-finding, treatment with MDT and the prevention of disabilities;

6. to ensure proper coordination of activities with international bodies, donor agencies and national and international nongovernmental organizations working towards the achievement of the goal of elimination of leprosy.

Annex

Regional Plan for Elimination of Leprosy

A Regional plan for elimination of leprosy was developed in 1994 in consultation with the National Leprosy Control Programmes from the most endemic countries of the Region.

Implementation of the elimination strategy will require the increasing involvement of communities, general health services, governments and nongovernmental organizations traditionally involved in leprosy control.

Objective

The elimination of leprosy from all countries of the region by the year 2000. Elimination means reducing the prevalence of leprosy to below one case per 10 000 population.

Targets

The set targets relate to the identification of cases and ensuring that all patients are reached and provided with quality patient care, including MDT, disability prevention and adequate referral services. These targets have two stages:

Targets for 1997:

- at least 50% of the estimated number of leprosy patients will have been detected in the early stages in endemic countries;
- at least 95% MDT coverage (of all cases registered currently for treatment) will have been achieved in countries of the Region;
- 100% coverage of all new leprosy cases with MDT in situations where resources for the provision of MDT for all cases is not possible;
- all endemic countries will have trained personnel in the management of leprosy.

Targets for 2000:

- at least 75% of the estimated number of leprosy patients will have been detected in the early stages in endemic countries;
- a 100% MDT coverage (of all cases currently registered for treatment) will have been achieved in countries of the Region;
- every individual Member State of the Region will have achieved prevalence of less than one per 10 000 population;

- leprosy control activities will have been completely integrated into general health services.

Approaches:

- promotion of, and support for the revision of national plans for leprosy control in affected countries with emphasis on target-oriented MDT and with work plans for specific high prevalence districts and provinces. This process is to be carried out in close collaboration with, and the participation of, the NGOs involved in leprosy control in the country concerned;

- encouraging the establishment of national coordination committees for mobilization of political and community support and resources and for monitoring programme progress;

- promotion of the development of an adequate system of assessment of the situation and of the recording and exchange of information on leprosy cases in the Region;

- case-finding and application of MDT is the main operational tool to achieve the elimination of leprosy. National programmes are encouraged to adopt a flexible approach in MDT implementation, particularly through better involvement of local communities in leprosy control;

- strengthening of management, supervision, monitoring and evaluation of programmes at the national level, through various means including the provision of technical support through consultants;

- organization of, and support for meetings, workshops and seminars for national, provincial and district officers on critical issues of management, monitoring and evaluation, using WHO guidelines;

- strengthening of laboratory services, especially at district and provincial levels, to ensure correct smear-taking and reading as necessary for the diagnosis;

- support for efforts to integrate the accepted national strategies for leprosy control into the curriculum of medical and paramedical institutions;

- promotion of training of medical and paramedical personnel;

- encouraging the production and wide dissemination of essential documents and literature on leprosy control in local languages. Support for the involvement of mass media in information, education and communication on leprosy to achieve community involvement in resource mobilization and in social acceptance of leprosy patients;

- promoting applied research to address important sociological and operational problems; and

- support for activities related to disability prevention and rehabilitation.

Implementation

The uneven distribution of leprosy among countries of the Region requires the adoption of flexible approaches in the control and elimination of leprosy at the country level. Stratification within the countries and the adoption of control plans according to the size and intensity of the problem, delivery of leprosy control services and resource allocation should have first priority for achieving the elimination targets.

The strategy adopted should take into account the gap between the number of estimated and registered cases, the rate of defaulters in MDT treatment, the proportion of newly recorded patients with disabilities as an indirect indicator of late reporting of patients and delayed diagnosis, the accessibility of health services for the patients and sociocultural factors which can affect the efficiency of control measures.

The implementation of strategy requires continued political commitment from the health authorities to support the elimination of leprosy as one of the priority tasks for the public health system. The mechanism of collaboration between national control programmes, WHO, local and international NGOs and other donor agencies should function in cooperative spirit even after achieving the goal of elimination of leprosy as a public health problem.

Assistance from WHO for the national control programmes is continuing in the form of technical expertise, training and supplies. Cooperation and coordination of WHO activities with the national programmes will be further strengthened, particularly in the epidemiological assessment and stratification by endemicity, planning, implementation and evaluation of control strategy, provision of training for national personnel, improvement of recording and reporting systems, organization of meetings with the national managers in order to exchange experience and to evaluate progress in the process of elimination.

REGIONAL COMMITTEE FOR THE
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TECHNICAL PAPER

ELIMINATION OF LEPROSY

Summary of Recommendations

It is recommended that Member States:

1. reaffirm commitment to achieve the leprosy elimination target by the year 2000 by giving priority to leprosy control measures in national health plans with emphasis on multidrug therapy (MDT);

2. strengthen the national leprosy control programmes within the framework of Primary Health Care (PHC) through allocation of resources for surveillance, treatment and rehabilitation of leprosy patients;

3. those countries which have achieved 100% MDT coverage should maintain present coverage; those which have not should give top priority to increasing MDT coverage to reach the target;

4. support health education activities for patients as well as the general community with the aim of overcoming the stigma attached to leprosy;

5. strengthen the training of medical and paramedical personnel in the control of leprosy, particularly in case-finding, treatment with MDT and the prevention of disabilities;

6. ensure proper coordination of activities with international bodies, donor agencies and national and international nongovernmental organizations working towards the achievement of the goal of elimination of leprosy;

7. those which have reached the elimination goal at the national level, should strive to reach the goal also at subnational levels including pockets of endemicity through vigorous and focused application of MDT.