The following three technical papers are presented as background information for the participants attending the Technical Discussions to be held during the eighth session of the Regional Committee for the Western Pacific. These papers were submitted at the invitation of the Regional Director on topics intended to focus attention on the important aspects of the theme for this year's Technical Discussions: LEPROSY CONTROL.

The ideas expressed in these papers are those of the authors themselves and are not to be considered as official statements of the Organization.

It is hoped that these working papers will be useful to the representatives in preparing for the Technical Discussions. Comments regarding these documents are invited and should be directed to the Regional Director.
A MODERN PROGRAMME OF LEPROSY CONTROL

by

José N. Rodriguez, M.D.* and H.W. Wade, M.D.**

1 INTRODUCTION AND SUMMARY

A review of leprosy control, past and present, shows that the modern trends are: abandonment of total compulsory segregation, i.e. indiscriminate segregation of all known cases; adoption of selective, or discriminate, segregation for such "open" or "infectious" cases as require it; chemotherapy on an out-patient or domiciliary basis for the remainder; increased health education leading to greater understanding of the disease and to voluntary attendance of patients for treatment; and changes in legislation to facilitate the new approach.

2 OUTLINE OF A PROGRAMME

The introduction of diaminodiphenylsulfone (DDS) in treatment permits important modifications in the methods of leprosy control because of its relative effectiveness. Its low cost places this treatment within the resources of even under-developed countries, although the widespread anemia in the Western Pacific Region due to an iron-deficient diet, and the existence of hookworm and other parasitic infestations, may require the concomitant administration of ferrous sulfate, thereby increasing somewhat the per capita cost.

The basic principle is to treat the patients whenever they may be found. Important corollaries are (a) that early voluntary presentation of the cases must be aimed at, so that this treatment can be given early, and (b) that it be adequately supervised in order to maintain an effective blood-level of the drug until the patients become non-contagious and the danger of relapses has been lessened. Early treatment is important because it is more effective, needing less time and medication to effect a cure in a larger proportion of cases, and disabilities and deformities in most cases will be prevented.

In planning an adequate leprosy control programme, advantage should be taken of the existing social structure of the population and customs of the people. Naturally, the amount of funds likely to be available must be taken into consideration; it is obviously useless to consider a programme which is...

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beyond the financial reach of the particular country involved. Also, some idea of the epidemiology of the disease in the country must be available beforehand. The necessary information may be secured in various ways, namely, by undertaking a special census, by requiring all health officers to report the cases in their districts, by means of sample surveys and by a study of references to the disease in the past annual reports of the Health Department. This information is necessary because the distribution of leprosy in most countries is focal and the progress of its spread in the different foci is variable. A clear idea of the situation will determine to a great extent the nature and extent of the control measures to be undertaken and indicate the places which should be dealt with first.

Although, as already indicated, the treatment with DDS is becoming more and more the mainstay of the control measures, it should be borne in mind that the danger of relapses among improved cases has not been eliminated.

A balanced control programme with clearly defined objectives should be established. Furthermore, it should be realized at the outset that a leprosy control programme necessarily has to be a long-range one and that it should be carefully integrated into the framework of the general public-health organization of the country.

Bearing in mind that treatment is the fundamental basis of modern control measures, the units or components of a balanced leprosy control programme consist of the following:

2.1 Stationary diagnostic and treatment centres

These centres may be set up separately or they may preferably be attached to existing dispensaries or hospitals located in highly endemic areas. Such centres should treat not only leprosy cases but also skin diseases as well, and it is advantageous to have them under the charge of a trained dermatologist. They should endeavour to acquire a reputation for establishing the diagnosis and for securing good therapeutic results in difficult cases of skin diseases, including leprosy. They are most successful if located in larger towns or cities, with a leprosy prevalence rate of 5 per 1000 or more. They should also serve as centres of education and propaganda with regard to leprosy.

Other measures required in a balanced programme are the rehabilitation of the patients and the protection of their children from the disease.

2.2 Travelling skin clinics

The ambulatory clinics are the main agency for case-finding and may be utilized also to supervise the follow-up of treatment. The latter may be done by the ambulatory clinics themselves although it is preferable to have it done by the ordinary local health units of the national and/or provincial health agencies.

The number of travelling skin clinics required to cover the country depends on the number of important foci present and the funds available. The qualification of personnel depends on the availability of physicians, nurses and para-medical personnel; in many countries, well-trained non-medical personnel have been found satisfactory.

/In drawing up ...
In drawing up the schedule of the mobile clinics, knowledge of the epidemiological distribution of the disease is useful so that preferential attention may be given to the important foci of the disease, at least in the beginning. It is helpful to employ a sort of screening process by limiting the detailed examination to those portions of the population which are likely to produce the most cases.

The administration of sustained treatment necessary to maintain an effective concentration of the drug in the blood over a prolonged period needs a carefully checked follow-up. The administration of at least 70% of the expected number of treatments must be insisted upon if any real results are to be obtained. The necessary follow-up makes domiciliary treatment more difficult and perhaps more expensive to maintain that most people seem to expect. Yearly clinical and bacteriological re-examination of the patients is necessary to check results, at least until their organization has been perfected.

The success of a travelling clinic programme therefore should not be judged merely by the number of cases found and registered; the true criterion of its achievement is the proportion of the cases that continue the treatment until they have become bacteriologically negative and non-contagious.

2.3 Leprosaria

The role of the leprosaria has changed, as they are no longer considered merely as places of isolation; other added functions include the following:

2.3.1 Treatment of moderately advanced to advanced lepromatous cases. In spite of cautious initial doses and gradual increase, over 85% of advanced cases develop an erythema nodosum type of reaction over a treatment period of two years. Many of the resulting acute reactions need general nursing and medical care which cannot be given in individual homes.

2.3.2 Lepromatous cases which do not improve after a reasonable period under domiciliary care generally require individual treatment that can be given only in leprosaria.

2.3.3 The physical and socio-economic rehabilitation is best undertaken in sanitarium.

2.4 Rehabilitation

Since rehabilitation is the subject of a separate working paper, it is only mentioned here for the sake of completeness.

2.5 Protection of infants

The ideal way of protecting the infants of leprosy patients is to isolate them at birth and raise them in nurseries, not necessarily special ones, away from all contact with the disease. The main difficulties are the heavy expense and the fact that many children, after being brought up in an institution, find it difficult later to adapt themselves to the world outside. It seems probable - but not yet certain - that BCG vaccination may increase resistance and shorten the period of isolation where that is carried out, and lessen the danger of infection where it is not.

/The evidence suggesting ...
The evidence suggesting the BCG vaccination may have this effect will not be reviewed in this short paper. It is enough to state that it leads to an expectation that such vaccination may afford, by a cross-immunity effect, a material degree of protection against leprosy infection. This measure has been applied on a wide scale in only a few places as yet, notably in parts of Brazil and in the Loyalty Islands, and further research experience will be necessary before its effects can be evaluated.

If this effect is finally confirmed, it may be possible to protect the infants without isolation. It has been observed that when infants of leprosy patients living with their contagious parents develop lepotic lesions of leprosy below the age of two years, such lesions are of the tuberculoid type, which indicates some resistance to the disease. At any rate, if BCG vaccination is instituted soon after birth, or if repeated lepromin testings are made, the children will develop strong lepromin reactions presumably with corresponding reinforcement of their resistance. If the parents and other patients at the same time receive active treatment thereby diminishing their contagiousness, the lepromin positive infants will be given adequate protection during their most susceptible age period and at least should not acquire the lepromatous type of the disease.

2.6 Health education

One of the main difficulties in controlling leprosy is the lack of understanding of the public about the nature and spread of the disease and the best means of prevention; hence, a programme of education and propaganda is important. The facts to be emphasized are: (a) the contagiousness of the disease, although its spread in the community is usually slow; (b) that childhood is the most susceptible age; (c) that the most important preventive measure is to avoid direct contact with lepromatous cases in this age group; and, finally, (d) that early diagnosis and treatment of cases is vital.

Any approach to the people should be based on thorough knowledge of their ideas about the cause, transmission and results of the disease.

All medical students and nurses should be taught the essentials of leprosy. Much can be done by co-operating with educational authorities and, in endemic countries, elementary teaching about leprosy should form a part of instruction in schools.

2.7 Legislation

In order to implement such a programme, laws providing for the compulsory segregation of all leprosy cases should be amended. They should provide for voluntary segregation of lepromatous cases in leprosaria, but should also permit compulsory isolation of such cases when necessary. Leprosy patients should also be prohibited from engaging in certain occupations so long as they are bacteriologically positive.

/3. CONCLUSION

1 Careful intensive field studies have shown that the average annual attack rate among house contacts to the lepromatous type is four times that for the total population, but that exposure to the non-lepromatous type is not followed by a measurable increase in the risk of contracting leprosy.
3 CONCLUSION

The modern control of leprosy is based on the sulfone treatment which may be administered wherever the patients may be found, whether in leprosaria or in their homes, provided that the treatment is effectively administered especially during the period of infectivity of patients suffering from the lepromatous type of the disease.

4 ACKNOWLEDGEMENT

The authors would like to express their appreciation for the help rendered by Dr. L. O. Roberts of WHO in the preparation of this paper.
It is customary to start a discussion of the problem of rehabilitation of leprosy patients with the prejudices of society and the need to educate it, so that it adopts a more balanced attitude towards a leprosy patient. I acknowledge the need to educate society in this matter but I differ about the meaning of education as I do not believe that the views held by society are prejudices in the same sense as other prejudices are. I think it will be more useful to find out why society holds to these views, rather than to dismiss them as mere prejudices. It is only through such understanding that we can find out how best to educate society and how best to tackle the problem of rehabilitation.

1 BASIS FOR SOCIETY'S ATTITUDE

Prejudices generally originate either out of accident and coincidence or out of some personal untested opinion of somebody in authority and so they vary from country to country. A careful perusal of mass psychology and the conditions which have led society to form particular views on leprosy will, however, show that there are some pertinent factors which are too important to be ignored. These are given below:

1.1 The attitude of society towards a leprosy patient is almost similar amongst peoples of all countries. Even in India, with a few exceptions, the leprosy patients are shunned as anywhere else in the world.

1.2 Our observations in India show that this stigma is associated more with the content than with the word. In different parts of India, leprosy is known under different names, but the stigma is the same everywhere.

1.3 This wide-spread similarity in views does not appear to be merely coincidental nor does it appear to have originated simply from untested opinion. For thousands of years people have been observing that leprosy is associated with three particular features: The first is that the persons known to the community as leprosy patients have always shown gross deformities and disfigurements; second, that in many instances two or more cases are seen in the same house; third, that leprosy is seen in certain families in successive generations. In the past, when scientific methods had not developed, these characteristics of leprosy were sufficient for society to conclude that leprosy is a devastating, hereditary and infectious disease.

1.4 Of all the chronic infectious diseases (with the exception of yaws) leprosy is the only one which gives rise to such unsightly deformities. It is, therefore, natural to conclude that the prejudice and stigma associated with leprosy are primarily ...
leprosy are primarily due to the gross deformities leprosy leads to. Cases of yaws are also shunned like leprosy patients but yaws, being restricted to certain regions and certain communities, may be omitted from our discussion here.

1.5 Even with modern scientific methods and all the finer instruments of observation available to us, we have not proved that the views held by society are completely wrong, for we believe in the partially infectious nature of leprosy and in the tissue susceptibility.

1.6 "Scientific method is in some degree unnatural to man"¹ and Bertrand Russell has aptly described how even a man of science, when tackled on subjects other than his own, will be heard "expressing wholly untested opinions with a dogmatism which he would never display in regard to the well-founded results of his laboratory experiments."¹ This shows how people, including the scientists, form their opinions regarding common subjects.

1.7 The three particular features which were observed in the past are observable even today and as no man is very scientific in his daily life, what he sees with his own eyes is more convincing to him than the contrary facts emerging from scientific epidemiological studies.

1.8 Everyone is concerned with matters that touch his self-preserving instinct, and leprosy is far more personal a problem than, say, the theory of relativity or the solar system. A man, therefore, may not mind changing his views quickly about the latter but certainly must be adamant about leprosy - at least he cannot change till he is convinced that leprosy is curable and that it does not always lead to deformity.

2 NEW APPROACH NECESSARY

The above analysis shows that the most important factor responsible for stigma and prejudice about leprosy is the deformity that leprosy leads to and so long as we are not able to show and convince the people that leprosy is not always associated with deformities, we cannot do much either in removing the stigma or in rehabilitating a leprosy patient in his own home. In matters connected with leprosy, people have ample opportunities to observe for themselves and draw their own conclusions; and as we cannot prevent them from doing this, we have to change the very set of conditions on which people base their observations.

It is my firm belief that ex-patients with gross deformities will not be absorbed in society for many more years even if we continue to preach that these cases are non-infectious and harmless to society. I have, therefore, come to the conclusion that unless we adopt methods to prevent deformities we will not be able to solve the problem of rehabilitation to the satisfaction of the patients. With modern drugs it is now possible for us to achieve this and, along with usual campaign to educate society to adopt a more balanced outlook, we have also to emphasize the importance of early detection and curability of the disease in its early stages - stages when the nerves which give rise to the usual deformities are not yet involved. In future "education of society" should have this comprehensive meaning.

¹Russell, Bertrand
Scientific outlook
Glencoe, Ill., Free Press, 1948, 277
3 RECENT ADVANCES

Of all the recent advances in our knowledge of leprosy, only three are briefed below:

3.1 Modern drugs

In spite of the limitations of these drugs, they are of great use in checking the disease in all stages and in reducing the infectivity of cases.

3.2 Physiotherapy

Recent work has shown that special exercise, splints, baths, electrical stimulation and special shoes go a long way to prevent progress of deformities, in increasing usefulness of hands and in making them fit for surgery. But this branch is yet so young that an adequate number of trained personnel is not available. This work, however, should become a routine in every clinic.

3.3 Reconstructive surgery

A number of operations have now been standardized while some are still in the experimental stage. But the fact that very few surgeons are trained in this type of surgery puts a limitation on its large scale use.

4 REHABILITATION PROGRAMME

A rehabilitation programme, being linked up with the anti-leprosy campaign depends on the extent of leprosy and the available finances in each country. But as it is not possible here to discuss the rehabilitation programme of each country separately, the countries are grouped in three different categories and the problem of each category is discussed separately:

4.1 Category I - Countries with a small problem

In countries of this category, leprosy is usually-endemic only in certain areas and sometimes more common in certain communities. But cases being very few and doctors not being leprosy-conscious, they are likely to be missed. The problem should be dealt with as follows:

4.1.1 Start a campaign amongst medical practitioners to make them leprosy conscious.

4.1.2 Start a few field units for case-finding work in endemic areas.

4.1.3 Segregate all infectious cases either in sanatoria or in homes.

4.1.4 Start an educational campaign for the public and rehabilitate as many patients as possible in society.

4.1.5 Start rehabilitation centres\(^1\) for those who are not absorbed in their homes.

\(^1\)A place for the permanent settlement for ex-patients, i.e. arrested cases of leprosy.
4.2 Category II - Countries with a moderate problem

This is a category intermediate between Categories I and III in extent of the problem and in financial resources. In dealing with the problem in these countries, more emphasis will have to be laid on early diagnosis and treatment and more rehabilitation centres will have to be started.

4.3 Category III - Countries with a colossal problem

In countries of this category, the financial position puts a limitation on all activities. In my opinion these countries cannot and should not start rehabilitation centres, neither should they depend much on institutional segregation. Their mainstay of leprosy work should be detection of cases in the early stages and mass treatment in out-patient departments. As regards rehabilitation of patients, these countries cannot do much except to adopt preventive measures.

In dealing with the question of rehabilitation, it will be convenient to classify the patients into different groups and deal separately with each.

4.3.1 Group I - Early cases still in their own homes

In this group are included cases who have few lesions with only minor deformities or without deformities and who may or may not be known to society as leprosy patients. The important feature of this group is that the patients still have their jobs and are still in their own homes. There are thousands of cases in this group but they usually do not seek medical advice. It is therefore necessary to launch the following programme to get these cases:

(i) In endemic areas, launch intensive and extensive educational and case-finding campaigns; provide sufficient facilities for treatment. This will save thousands from developing deformities and being ousted from jobs.

(ii) As far as possible, do not remove a patient from home for purpose of segregation.

4.3.2 Group II - Patients on the verge of begging

In this group are included cases who have developed deformities, lost their jobs and become burdens in their own homes. They still live at home with the hope of securing some job.

The patients in this group should be saved from being thrown on the streets and though it will not be possible to save every individual, the following programme will save quite a large number:

(i) Patients who are completely crippled should be given some financial aid so that their relatives may be able to maintain them.

(ii) Those who, inspite of deformities, can do some work, should be trained in a suitable craft in special training centres.

/(iii) Agencies should ...
(iii) Agencies should be started to provide work and market the products prepared by ex-patients.

(iv) Employment bureaus managed by voluntary social workers should be started to find out suitable service jobs for ex-patients.

4.3.3 Group III - Non-infectious cases to be discharged from sanatoria

A sanatorium is really a place for segregation of infectious cases but in every sanatorium there are a number of non-infectious cases who cannot be sent away because they are not admitted into their own homes. This problem has become still more acute after the advent of sulphone therapy. As it is, the institutional accommodation is very limited and if the beds are going to be occupied every year by the increasing number of non-infectious cases, there will soon come a time when all sanatoria will be virtually blocked with non-infectious cases.

My proposals to deal with this situation are given below:

(i) The present batch of all non-infectious cases in the sanatoria should be removed to a separate rehabilitation centre.

(ii) In future admit only such cases to the sanatorium as are highly infectious and whose relatives give an assurance that they will re-admit them into their homes.

(iii) Try to discharge the cases as early as possible and, if necessary, even when they are mildly infectious.

(iv) Appoint a leprosy social worker in each sanatorium to act as a liaison officer between the patients and their relatives during the period of segregation so that a constant contact is maintained with the patient's home.

4.3.4 Group IV - Beggar leprosy patients

This group is too unwieldy to be dealt with at the present stage.

5 SUMMARY

5.1 In expecting society to change its attitude towards leprosy patients, we seem to ignore human nature and the fact that a man's opinions on leprosy, were (and are even now) based on actual observations.

5.2 For thousands of years, people have been observing that leprosy leads to deformities and runs in families. On the basis of these observations a person naturally concludes that leprosy is a devastating, hereditary and infectious disease.

"Scientific method is in some degree unnatural to man" (Bertrand Russell) and therefore in all matters which are likely to endanger life or /limb an average ...
limb, an average person cannot ignore what he sees with his own eyes, just because science says that what he sees is not true. In the case of leprosy, which not only gives rise to deformities but is also apparently infectious, he will prefer "to err on the safe side" and avoid contact with all known cases of leprosy - particularly those who have gross deformities - even if experts say these are non-infectious.

5.3 Realizing the above facts, it is necessary to adopt measures to prevent deformities and thus change the set of conditions on which people base their observations.

5.4 Society, therefore, should be educated not only to absorb patients, but also to realize the importance of detection and treatment of cases in the early stages.

5.5 A rehabilitation programme, being an integral part of an anti-leprosy campaign, will depend on the financial position of each country. Rich countries should start sanatoria for infectious cases and rehabilitation centres for those non-infectious cases who are not absorbed in society, but poor countries can do neither and have to depend only on mass case-detecting and treatment campaigns.
LEPROSY BALANCE SHEET IN FRENCH WEST AFRICA - END FEBRUARY 1957

by
Dr. Richet

1 Population
Approximately 19 million Africans. (Over 20 million according to the figures of the latest census. These figures should be checked in Dakar. The population is still increasing as a result of the successful control of major endemic and communicable diseases, as well as the gradual improvement in living conditions.)

2 Number of Leprosy Cases at the end of February 1957 ..... 285,653 i.e. 1.5%
Leprosy cases treated by the end of February 1957 .... 121,177 i.e. 42.42% of all patients
Leprosy cases treated (without interruption) in February 1957 ......................... 73,243 i.e. 25.64% of all patients

So far, both treatment and case-finding activities have been carried out almost exclusively by the SGHMP². It is important that the AMA Service should play an increasingly active part in these activities with its staff and permanent teams.

3 Organization of the SGHMP in French West Africa: 42 bodies i.e.:
26 special sectors (with 4 groups) covering some ... 9,000,000 inhabitants
12 separate sectors
2 travelling teams covering some ...................... 3,000,000 inhabitants

The rest of the population (approximately 7,000,000 inhabitants) living mainly in the Sahel areas of Senegal, Sudan and the southern part of Dahomey, is not covered by the SGHMP and it is therefore among this group that case-finding and consequently the treatment of leprosy is least adequate.

Activities will, however, continue to expand owing to:

(a) the considerable increase of funds for the "FIDES - SGHMP" plan for the control of important endemic diseases.

For leprosy alone, the amounts at our disposal have increased from 20 million Frs CFA (FY 1956-1957) to 148 million (FY 1956-1957 and following).

(b) The implementation ...

1 Director of the "Service général d'Hygiène mobile et de Prophylaxie" in French West Africa
2 Service général d'Hygiène mobile et de Prophylaxie.
(b) The implementation, in the very near future, of international assistance on a large scale which will amount to $345,000 per annum (over a period of 2 years) and will be expressed in terms of:

- 90 pick-up Land Rovers to arrive in July 1957
- 200 bicycles
- 10 motorized bicycles (Dahomey)

(c) Sulfones to treat
- 300,000 leprosy cases in 1958
- 400,000 leprosy cases in 1959
- 500,000 leprosy cases, if necessary, in 1960.

In fact, it is believed that there are some 500,000 leprosy cases in French West Africa.

For several years, the SGEMP groups have done everything possible to control leprosy. Case-finding activities are carried on on every possible occasion by the whole staff of the Service:

- 23 medical officers of the Armed Forces
- 7 civilian medical officers (Europeans with contracts or from the AMA)
- 26 African medical officers graduated from the Dakar School
- 17 European health technicians, former NCO's of the Medical Corps
- 10 NCO's of the Medical Corps of the Colonial Troops
- 1668 African nurses of the SGEMP trained at the Jamot School (Bobo-Dioulasso)

In addition to the permanent nursing staff of the 73 leprosaria which can accommodate 4,405 patients, 325 of the 1,168 nurses of this service work in the field centres where they treat the leprosy patients at these centres and from the neighbourhood. Furthermore, nearly every day they carry out difficult trips on their bicycles to give sulfone treatment - weekly tablets and semi-monthly injections - in an effort to treat patients at home. The aim being to spare the patients too long trips and to treat a higher percentage of leprosy cases.

However, the number of patients treated will only really increase when mobile services have been organized, thus enabling the UNICEF Land Rovers to be used.

At present, some of the 200 vehicles of the 42 sections of the SGEMP have already undertaken treatment visits. Among those vehicles are the six new Land Rovers generously donated by Mr. Follereau, which has enabled an average of 2,000 leprosy cases per vehicle to be treated. They have been assigned to the following districts which suffer particularly from leprosy:

- Sikasso (Sudan)
- Débogou (Haute-Volta)
- Diébgou (Pays Lobi Haute-Volta)
- Batié
- Ouagadougou
- Tenkodogo (Zabré)

/With the vehicles ...

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1 Distribution: Senegal 7, Sudan 22, Guinea 17, Ivory Coast 17, Haute-Volta 19, Dahomey 5, Niger 20.
2 Distribution: Senegal 18, Sudan 50, Guinea 40, Ivory Coast 20, Haute-Volta 17, Dahomey 35, Niger 20.
3 Distribution: Senegal 9, Sudan 8, Guinea 20, Ivory Coast 13, Haute-Volta 14, Dahomey 8, Niger 1.
With the vehicles provided by international assistance, approximately 100 mobile organizations will be functioning at the end of 1957.

Thus, 150,000 patients should receive regular treatment (average of 1,500 per vehicle) if the patients appreciate all these efforts and respond by attending regularly for treatment.

If consideration is given to the fact that such a vehicle covers an average of 2,000 kms. per month, i.e. 24,000 per annum, these hundred automobiles will cover every year at least 24 million kms, or 600 times the earth's circumference.

With the funds of the FIDES plan allotted for leprosy control to the SGHMP, at least 200 and, if necessary, perhaps 250 or even 300 local assistant nurses will be recruited and trained to distribute sulfone tablets to the patients during regular visits on bicycles.

Thus, the work of the 325 cyclist-nurses of the SGHMP will be extended and supplemented and their number will be raised to at least 525 or perhaps to 625.

Each of them can treat a minimum of 200-300 leprosy cases and sometimes many more.

Taking as an average 500 kms. per month and per nurse or 6,000 kms. per annum, one is amazed to note the number of kms. covered in one year - at least 3 million or 75 times the earth's circumference.

Thanks to the FIDES plan, many other means of transportation will be implemented for special duty trips:

- 10 metal boats with powerful motors
- Camels and horses in certain Sahelian areas where many more expenses will become necessary
- Complementary drugs and replacement drugs
- Daily medical assistance during the visits to leprosy patients
- Building maintenance or improving of clinics (leprosaria, asylums, etc.)
- Well-being and social reclassification of certain categories of patients within available means

In conclusion, it must be stressed that at a time when territorial governments are being established in accordance with the recent law, France leaves or puts at the disposal of the Government important material means:

All existing SGHMP staff and supplies
Annual funds of the FIDES plan which have increased enormously as from the present financial FY onwards
Considerable international assistance to be obtained for two years as from the second semester 1957 onwards and which is to be renewed according to the needs and results.

If the territories will make use of these enormous means according to the standards set by the Government and the international agencies, which have already been applied by the SGHMP in French West Africa, if they agree to follow exactly the instructions issued by this service and if all the African staff - both administrative and sanitary - agree to continue the efforts for case-finding and the treatment of all leprosy cases in French West Africa, there will undoubtedly be a spectacular decrease of all leprosy cases within a few years.

/Without taking into ...
Without taking into consideration the considerable means available, the contribution of France to the control of this disease is as follows:

The SGBMP of French West Africa (260 million) and the Staff and services of the AMA which will have to co-operate more and more in this over-all leprosy control campaign.

For 1958 and 1959, the amounts available are the following:

FIDES plan : 296 million Frs CFA
International assistance : $690 000

or a total of approximately 1 billion Frs.
GROUP DISCUSSION ASSIGNMENTS FOR REPRESENTATIVES AND OBSERVERS

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