REPORT ON THIRD MEETING OF THE
WHO TECHNICAL ADVISORY GROUP ON
ELIMINATION OF LEPROSY

Brasilia, 1 and 2 February 2002

World Health Organization
Leprosy Elimination Group

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1. REPORT ON THIRD MEETING OF WHO TECHNICAL ADVISORY GROUP ON ELIMINATION OF LEPROSY (TAG)

1.1 Introduction

On behalf of Dr Maria P. Neira, Director, Department of Control, Prevention and Eradication, WHO/HQ, Dr D. Daumerie welcomed all participants. In her message, Dr Neira expressed her appreciation of the contribution made to leprosy elimination by the Group during the past two years and also her confidence that the outcome of this meeting would result in the best possible advice being given to countries on implementing The Final Push strategy to eliminate leprosy as soon as possible.

Dr Daumerie then reported on recommendations of the 2nd Meeting of the Global Alliance for Elimination of Leprosy (GAEL), which had recently been held in Brasilia. GAEL participants urged that:

- Greater efforts should be made to implement the strategy at local level in the 15 remaining countries over the next few years in order to reach the target of elimination by 2005.
- Accompanied MDT (AMDT) should be widely implemented in order to increase accessibility of all patients, especially those living in remote areas and amongst underserved populations.
- Rehabilitation of persons disabled because of leprosy should be integrated into established community-based programmes for the disabled.
- Monitoring and surveillance should be further simplified and should reflect the progress being achieved towards reaching elimination.

Dr M. D. Gupte, outgoing Chairman, presented the Group’s terms of reference and summaries of its recommendations, as well as those of its subgroups. The four key components of the elimination strategy are: reducing the reservoir of infection by early case detection and treatment with MDT; preventing suffering and disability through early cure; technical support; and integration of the programme into general health services. The timeframe outlined to implement The Final Push strategy included: advocacy and preparatory work in 2000, intensive implementation of the elimination strategy in 2000-2002, phasing out and validation in 2003, and detailed validation in 2005.

Dr Marijke Becx-Bleumink was unanimously elected as TAG’s new Chairperson. Both members and secretariat expressed appreciation to Dr Gupte of his contribution during the past two years and gave their assurance that the same support would be provided to Dr Becx.

Dr Becx presented an overview of the current efforts to integrate leprosy control into general health services and summarized the main issues lying ahead in the future. Experience has clearly demonstrated that specialised programmes result in limited geographic coverage and maintains the negative image of leprosy in the community. The major challenge will therefore be to aim for decentralization and complete integration of leprosy services into general health services. This will also be the main prerequisite for leprosy elimination and for sustainability of the service thereafter. It is important that all health care units and community health workers are involved, that the service is available on a daily basis, and that leprosy training is included in curricula of paramedical and medical students.
An overview of the general direction and framework within the new structure of UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) was presented by Dr H. Engers. Coordination between the research community and control community will be essential if technical challenges that arise in the future are to be addressed appropriately. TDR's current focus on the result-oriented approach and implementation research will be enhanced by the new structural and functional framework.

Dr D. Daumerie presented an overview of the global situation of leprosy elimination. The goal of leprosy elimination as a public health problem, defined as a prevalence rate of less than one case per 10,000 population, had been attained at the global level by the end of year 2000, in line with the resolution adopted by the World Health Assembly in 1991. The Final Push strategy is now zooming in on national and subnational levels in order to achieve the goal of elimination at national level in all remaining countries. The focus now rests on six major endemic countries: Brazil, India, Madagascar, Mozambique, Myanmar and Nepal. Registered prevalence has been steadily declining since 1985 and had been reduced by 90% at the end of 2000. The detection trend during the past seven years shows a peak in 1998, reflecting intensified elimination activities worldwide, and a steady decrease since then. Reported data shows that in 2001, the proportion of single skin lesions among new cases was 9% and the proportion of new cases with grade 2 disabilities was 4%, which has also been decreasing over the past years. At the global level, to accelerate the integration process, elimination kits for local adaptation have been developed. These include simplified technical guidelines, improved MDT supply logistics, toolbox for information, education and communications (IEC) and a set of essential indicators for monitoring progress towards elimination.

The elimination strategy based on MDT has proved to be effective and is working well even in countries facing political and economic challenges. However, in preparing for the future, particularly where the leprosy elimination goal has been achieved, there is a risk that political commitment may start to decline. Several challenges need to be overcome to ensure that leprosy services are fully integrated and sustained. These include to:

- further simplify and shorten the current MDT regimen;
- abolish classification for treatment purposes;
- identify areas and communities not yet covered by leprosy services;
- actively change the negative image of leprosy to be more positive;
- focus more on analysis of detection trends than on prevalence; and
- develop an integrated community-based strategy for rehabilitation.

1.2 Leprosy elimination campaigns (LEC)

A presentation on LEC experiences in Nepal was made by Dr J. P. Baral. LEC is a time-bound activity for intensifying leprosy activities, particularly in areas in which the disease burden is high and where the routine programme is relatively weak. Major LEC objectives are improving community awareness and participation, capacity building of general health staff and community volunteers, detecting undetected cases and curing them with MDT. Advantages of LEC include increasing political commitment and community involvement, promoting integration, extending services nearer to patients, and changing the image of leprosy. Potential disadvantages, however, include setbacks of routine services, higher number of defaulters, and over-diagnosis and recycling of patients. In Nepal, LEC was conducted in 27 high endemic districts in 1999 and was
repeated in 2001. Detection was reduced from 11 698 to 9 060, the proportion of MB cases among new cases from 64% to 32% and the proportion of grade-2 disabilities from 9% to 4%. A continuous information, education and communication (IEC) campaign was conducted through radio and television for three months together with distribution of posters, community rallies and wall paintings. Electronic media proved to be very useful in Nepal in conveying messages to the public.

**Discussion:**

LEC is a useful tool for promoting integration, changing the negative image of leprosy, training/motivating health staff, enlisting political commitment and promoting participation of communities and local NGOs in the elimination activities. The problem of setbacks to routine services can be significantly minimised by encouraging self-reporting instead of active survey. New case detection rates become reduced when LEC is repeated in the same area. Therefore, though LEC is needed in some countries, it should be focused on selected areas and carefully identified LEC components. It can also serve as a tool to reach marginalized or underserved population groups and reduce the gender imbalance, which is often seen in routine programmes. Other LEC components, such as increasing community awareness through media campaigns and capacity building, should not be restricted to selected areas but should cover all areas.

### 1.3 Uniform MDT regimen

**Presentation**

A presentation on the need and justification to consider a uniform MDT regimen to treat all types of leprosy, irrespective of clinical classification was made by Dr M. D. Gupte. Over the last 20 years, MDT has been widely implemented in all endemic countries, curing more than 12 million patients, with very low relapse rates and complete absence of emergence of *M. leprae* strains resistant to MDT. Further shortening and simplification of MDT drug regimen by introducing an uniform regimen will promote easier logistics support, simpler information system, reduced training needs and thus better sustainability through integration. The proposal is to carefully study in a large-scale field trial, MB/MDT regimen for 6 months as the uniform regimen for both MB and PB patients. A protocol will be developed in which clinical response, with the requirement of not more than 5% failure rate and a relapse rate of not more than 5% during a period of 5 years of follow-up were identified as endpoints.

**Discussions**

The advantages and disadvantages of implementing six-month MB regimen for all leprosy patients at this stage were discussed among TAG members. Uniform regimen is a simple approach, which is very much needed in the light of integration. MDT has proved to be robust in terms of treatment efficacy and safety. Relapse rate has proved to be very low, and relapse cases can still be cured by another course of same MDT. Some of the members were sufficiently comfortable with the proposal and suggested its implementation. On the other hand, reservation was expressed about implementation without evidence to support it, where there was no urgent need to do so. All the arguments that were raised supported conducting field trials, as an essential prerequisite for the implementation. The cost-effectiveness of adding clofazimine for PB patients and the issue of informed consent were also discussed.

Taking all these points into account, it was agreed that TAG recommends implementation of a uniform six-months MB/MDT regimen for all patients. The outcome will be closely and
rigorously monitored through a large-scale field study. WHO/LEP in close collaboration with TDR will provide support to ensure close monitoring of the patients recruited in this study in different parts of the world. The protocol for follow up will be developed and shared by TAG members and other experts before June 2002. The intake of patients for this study is planned to begin in September 2002 and will continue for the next two years. The TAG will continuously monitor the progress and interim results.

1.4 Updating leprosy registers (ULR) and accompanied MDT (AMDT)

Presentation:

A presentation on updating leprosy registers was made by Dr N. S. Dharmshaktu. There were indications that patients are kept on treatment registers longer than necessary and it was emphasized that the following patients should be removed from registers: patients who had completed a standard course of MDT; patients wrongly diagnosed as a case of leprosy; defaulters; died and patients transferred to other health centres or migrated to other areas.

An overview of Accompanied MDT (AMDT) was presented by Dr A. O. Awe. He stated that MDT has proved to be effective and safe and that there was a growing feeling that monthly supervision is not really necessary any longer as it hampers integration and is not user-friendly to mobile populations, patients living in remote areas and/or areas affected by civil strife. Providing patients with a full course of treatment on their first visit is both patient- and staff-friendly and will improve compliance, help directly in removing stigma and promote the participation of families and communities. The patient and the accompanying person should be fully informed about leprosy and its treatment, and be advised to come back to the health centre when the treatment is completed and/or any time they feel concerned. The 2nd Meeting of the Global Alliance for Elimination of Leprosy (GAEL) recommended that there is a need for a more flexible, patient-friendly delivery system of MDT and that each country should adopt guidelines according to the situation.

Discussion:

As it is known that the number of viable \textit{M. leprae} decreases dramatically after the first dose of MDT, there is theoretically no problem in implementing AMDT. Monthly supervision has an advantage of close follow-up of patients, which may be given up by AMDT. This can be overcome by encouraging them to come back to the health centre any time if they have a problem or need to consult with the health staff. They should be fully informed about the disease, its treatment and potential complications. It was also stressed that patients should feel responsible for their own health. Various points on practical aspects were raised but answers may differ from one country to another. Guidelines should therefore be adapted by the national programme according to the situation in each country. It was agreed that in the field most patients will benefit from AMDT and only a small proportion of patients who may develop complications would require more frequent visits to the health facility.
1.5 Integration

**Presentation:**

The process of integrating leprosy control into the general health services in Brazil was presented by Dr G. Pereira. The leprosy programme in Brazil started in 1920 with compulsory segregation policy. The programme was restructured in 1986 with the introduction of MDT, and a unified health system was created in 1988. The implementation of decentralisation started in 1999 with the creation of a National Task Force. Experience so far shows that decentralisation and integration reduces defaulters, increases new case detection with increased service coverage, improves cure rate and decreases the proportion of grade-2 disabilities among new cases. Through training, and by increasing human resources and coverage, it is hoped that all basic health staff will be able to diagnose and treat patients.

**Discussion:**

The perceived reluctance of general health staff to be involved in leprosy services is already changing after having seen patients’ positive reactions. Timing of integration is important as it is better that integration takes place as soon as possible, even if the prevalence is high, rather than to wait for elimination. Leprosy surveillance should also be integrated within the integrated disease surveillance system. The priority will be to focus on functional integration, for which responsibility should be given to all health staff irrespective of the structure. It is important that communities are informed of the change of location and/or function of the nearest health centres after integration.

1.6 Simplified and integrated information systems

**Presentation:**

A presentation on the integrated information system was made by Dr M. Kawano. Information from some of the countries where leprosy had been eliminated over 10 years ago shows examples of two systems: either leprosy is a notifiable disease and relatively detailed information is collected or no information is collected at all. In countries that had achieved elimination recently, there is a tendency that the less endemic leprosy becomes, the less information becomes available. In India, on the other hand, the information system was much more detailed than that collected by WHO, which is now being simplified. What is going to happen when leprosy is eliminated and becomes less of a priority? Is the current information system simple enough in view of sustainability in the future?

**Discussion:**

In order to integrate the leprosy information system into the general information system, it should be simplified and the number of indicators kept to a minimum. The integration process of information systems can take a long time and the integrated information system often provides insufficient data for national programme managers in countries where leprosy is still a public health problem. Under such circumstances, a parallel system is needed to collect additional information for planning and management purposes. This topic should be further discussed in the subgroup meeting on monitoring and evaluation.
1.7 Information, education and communication (IEC)

Presentation:

A review of the existing strategy was presented by Dr Khin Than Oo. The objectives of IEC for leprosy elimination are to motivate patients to seek treatment, remove stigma from the community and patients themselves, and to actively involve local health services and communities in elimination activities. The expected behavioural change of each target audience should be clearly defined before the campaign approach – including mass media advertising, community mobilisation events and advocacy – is decided. Peer education programmes, advocacy, also be important.

Dr M. D. Gupte presented a brief summary of the evaluation of IEC in India. Among the community members interviewed 52% in Madhya Pradesh and 73% in West Bengal answered that they had seen the TV spot. Regarding facts about leprosy, 40% to 86% of those interviewed answered correctly. In general, males and people living in urban areas are better informed, probably because of better access to information.

Discussion:

Active efforts towards changing the image of leprosy should be continued even after the elimination target has been reached. The campaign approach is useful and should be repeated where necessary. Community approaches and close collaboration with media personnel, who are clear about how to frame attractive and positive messages to the public, is important. Messages should be carefully selected so that they reflect the reality; otherwise they will cause confusion. Electronic media proved to be effective in some countries. IEC plans, including the selection of appropriate media, should be developed within the cultural, social and economic context of the country. Global advocacy would enhance these activities at the national level. Special and innovative approaches will be needed to conduct IEC campaigns for marginalised and underserved populations. To be sustainable and cost-effective, an integrated approach with other important communicable diseases and social issues should be explored.

1.8 Research

Presentation:

An overview of leprosy research was presented by Dr Euzenir Sarno. Over the past years, research expertise has been declining from endemic countries and many highly qualified scientists have moved from leprosy research to other more attractive fields. Research on transmission and incidence, as well as tests for infection and improved methods for case-detection, will contribute to early case detection whereas research on rifampicin resistance, prevention and management of nerve damage and pathogenesis of reaction will contribute to improved case-management, including chemotherapy. PCR can serve as a tool for diagnosis of PB, relapse and pure neural cases, or evaluation of infection and transmission. First and second generation skin tests will be useful in evaluating the disease as well as infection. Genome will be useful for identifying new antigens, drug targets, drug resistance, neurotropism and persistence and could lead to third generation skin test as well as an effective antileprosy vaccine.

An overview of the research needs in order to achieve elimination by 2005 was presented by Dr Becx. The priority today is for operational research in order to improve implementation of the
elimination strategy, particularly integration, reaching the isolated, marginalized or urban population groups, removing stigma, changing the negative image of leprosy, and for assessing the minimum requirements for monitoring and surveillance.

**Discussion:**

Making leprosy attractive as a research field is a challenge. There are more and more examples of multidisciplinary approaches in research. Collaboration at an early stage between the product development side and the control programme will lead to a more promising research outcome. Basic research and implementation research should be balanced. A study of which the result will only be published in five years from now will not help elimination efforts.

Research topics, such as measuring the progress towards elimination and the impact of interventions, quality of patient care in the system, monitoring for drug resistance and relapses under the universal drug regimen were discussed. It was agreed that research priorities noted in the report of the first TAG meeting are still valid.

1.9 Prevention of disabilities (POD) and rehabilitation

**Presentation:**

Discussions and recommendations of the 2nd Meeting of the Global Alliance for Elimination of Leprosy were reported to the group. Rehabilitation of leprosy patients should include socioeconomic aspects, be community based and be integrated within other available social services. The participation of patients, as well as their families and communities, should be encouraged. Equity of access to these services, including access to health care, education, employment, housing, transport and amenities, is important and should not be leprosy specific.

**Discussion:**

Prevention of disabilities should be considered at the same time as diagnosis and treatment. Rehabilitation includes social services that go beyond activities provided by the health sector. It should be community based, and should involve social welfare departments and NGOs specialised in providing rehabilitation services. Health centres can be an entry point for people affected by leprosy to these services, but cannot be the major players. Having a special plan for rehabilitation of people affected by leprosy will support isolation and stigma rather than integration of people affected by leprosy into the community. Equity of access to all existing services must be advocated for all those who need them.

1.10 Conclusions and recommendations

- The global leprosy elimination strategy based on community awareness, early detection and flexible MDT treatment has proven to be effective and should continue to be implemented. Special efforts should be made to increase accessibility of MDT in countries that have not yet reached the target.

- Although it is recommended that the first dose of MDT be supervised by health staff, supervision of subsequent monthly doses is no longer essential. Large-scale implementation of accompanied MDT (AMDT), as described in WHO’s *Guide to Eliminate Leprosy as a Public
Health Problem is therefore recommended. This will give better access to MDT for all patients and facilitate integration of leprosy treatment into general health services. Countries implementing AMDT should adapt their national guidelines accordingly. Patients treated with AMDT should be fully informed about the disease and treatment. A full course of treatment can be given to patients and they should be encouraged to consult health services at any time, and at the end of the treatment.

- Leprosy surveillance should be integrated into national disease surveillance systems. In countries where leprosy has not been eliminated, additional information should continue to be collected in order to monitor the progress towards elimination.

- Transforming the negative image of leprosy is important and should be a continuous activity. An appropriate mix of several media is necessary for this rather than being dependent on any single media. Messages should match the reality. Where resources are limited, appropriate media should be selected. Inter-personal communication is important and should involve health staff, educational staff, NGOs and others. Global advocacy for leprosy elimination and changing the image of leprosy will enhance the credibility of national programmes.

- TAG recommends the implementation of six-months MB MDT regimen for all leprosy patients (PB and MB) on the condition that the outcome will be closely and rigorously monitored through standardized procedures. A uniform regimen based on six MDT blister packs\(^1\) will be of great benefit to patients and health services. This will facilitate integration and demystify the disease. MDT has been shown to be robust in terms of treatment efficacy and safety. Relapse rates are very low (less than one per cent), resistance to MDT is virtually non-existent, and relapse cases can still be cured by MDT.

- WHO will assist countries willing to implement this strategy in informing and training relevant staff, in supplying necessary drugs and in monitoring implementation and results regularly.

- Leprosy elimination campaigns (LEC) are still a useful approach to accelerate leprosy elimination in some specific areas in endemic countries. Case detection activities should aim at focusing on areas where elimination is not yet achieved, unreached communities, marginalized groups, including gender imbalance. Capacity building of general health services and improving community awareness is important components of LEC. Planning and implementation of LEC should be done at the local level and ownership should be with the local communities.

- Research priorities as outlined in the first TAG report are still valid. New avenues opened by \textit{M. leprae} genome decoding are promising. There is a need to improve the dialogue between national elimination programmes and the multidisciplinary research community. This will help in better identifying research priorities and enhance research capacity. TDR should be more proactive in accomplishing these objectives.

- It is imperative that individuals disabled because of leprosy have the same access to all existing rehabilitation and social services as any other individual. WHO and its Member States

\(^1\) Adult: RMP 600 mg CLO 300 mg and DDS 100 mg once monthly; CLO 50 mg and DDS 100 mg daily
Child (10-14): RMP 450 mg CLO 150 mg and DDS 50 mg once monthly; CLO 50 mg every other day and DDS 50 mg daily
should take the lead in advocating and promoting integration of rehabilitation of persons disabled because of leprosy. This integration should include the activities and services of existing international and national organizations (both governmental and nongovernmental) with responsibilities for medical and socioeconomic rehabilitation.

2. REPORT OF TAG SUBGROUP ON MONITORING AND EVALUATION

2.1 Background

In 1991, WHO and its Member States committed themselves to eliminate leprosy as a public health problem by the year 2000, elimination being defined as prevalence rate below one case per 10 000 population. At the end of the year 2000, the prevalence rate at the global level was below one per 10 000, and the number of countries where leprosy is still a public health problem (prevalence rate one or above one per 10 000 and population above one million) was reduced from 122 in 1985 to 15 in 2000. These are countries mainly situated in Africa, Asia and Latin America: Angola, Brazil, Central African Republic, Congo, Côte d’Ivoire, Guinea, India, Liberia, Niger, Madagascar, Mozambique, Myanmar, Nepal, Paraguay and Tanzania.

During the first meeting of the Subgroup on Monitoring and Evaluation of Leprosy Elimination (New Delhi, 3 February 2001), it was recommended that Leprosy Elimination Monitoring (LEM) could be used in monitoring progress towards leprosy elimination, and that it should be conducted on an annual basis in Group 1 countries and on a selected basis in Group 2 and 3 countries. At the same time, it was agreed that pilot studies using Lot Quality Assurance Sampling (LQAS) should be conducted to assess their value.

2.2 Presentations

An overview of the key issues in leprosy monitoring was presented by Dr D. Daumerie. The main points are essential indicators, methodologies and implementation of leprosy elimination monitoring (LEM), updating leprosy registers (ULR), implications of uniform regimen on leprosy information system, simplified and integrated information system and validation of elimination.

A presentation on the outline of LEM was made by Dr Awe. LEM is a joint exercise with the national programme manager and LEM monitors. It enables collecting indicators that are not collected through routine information system, validating reported data, physical observation of MDT drugs, assessment of level of integration and providing information to policy makers.

A detailed presentation on the global leprosy situation, current situation on the completeness of reporting, reports on LEM carried out during 2000 and 2001, and updating leprosy registers (ULR) was made by Dr M. Kawano. The prevalence rate at the global level by the end 2000 was below one per 10 000. However, in six major endemic countries, the prevalence rate was still at around 4 per 10 000. 120 countries reported to WHO in 2001 on leprosy data. LEM has proved to

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2 Angola, Brazil, Central African Republic, Democratic Republic of Congo, Guinea, India, Indonesia, Madagascar, Mozambique, Myanmar, Nepal, Niger
3 Cameroon, Chad, Congo, Côte d’Ivoire, Ethiopia, Gabon, Gambia, Guinea Bissau, Mali, Papua New Guinea, Paraguay, Sierra Leone
4 Argentina, Bangladesh, Benin, Burkina Faso, Cambodia, Colombia, Cuba, Egypt, Ghana, Haiti, Laos, Liberia, Malaysia, Maldives, Nigeria, Pakistan, Philippines, Senegal, Sri Lanka, Sudan, Tanzania, Thailand, Uganda, Venezuela, Viet Nam, Yemen
be a good tool to validate reported data by the exercise of applying standard definition and cohort studies on cure rate. ULR was also useful in assessing internal validity of reported data. The proportion of health facilities providing MDT among total number of health facilities and cure rate for MB are relatively low in many countries. Countries that are not classified as Group 1, 2 or 3 have a common challenge of dealing with outdated information system.

Dr M. D. Gupte reported to the group on the efforts made to validate the technique of lot quality assurance sampling (LQAS) to judge its utility in monitoring leprosy situation in certain defined areas. LQAS was recommended in an endemic region like the South Indian state of Tamil Nadu. However, it may need some modifications in moderately endemic regions, and it is not appropriate to be used in comparatively low endemic regions. Snowball sampling or some other techniques need to be explored for such areas.

Presentation on the discussions held during the meeting of the Global Alliance for Elimination of Leprosy (GAEL) was made by Dr M. D. Gupte. In integrated disease surveillance setting, it was very important that the objectives of surveillance are made clear. The number of indicators should be minimum and use of proxy data such as MDT blister packs used may be considered. Guidelines for data analysis would be useful for field workers.

Dr G. Pereira made a presentation on the integrated information system in Brazil. It was pointed out that changing an information system takes time and requires training of staff, which are currently the major challenges for constant and timely update of data.

2.3 Discussion

Experiences of LEM and of national programme managers showed that reported data is not updated on time, and could include patients wrongly diagnosed as cases of leprosy, recycled cases and patients not following fixed MDT regimen. Continuous updating of leprosy registers is urgently needed.

When the information system is changed from a vertical system into the integrated system, there will be a certain amount of confusion and it is likely to take time for the system to be fully functional. Under an integrated setting, non-priority diseases may not be given as much attention as priority diseases, and therefore it is essential that the data to be collected should be kept to the minimum.

The LQAS method is not suited for estimating prevalence of a given area but for deciding whether it is above or below a certain level. It is not supposed to be a one-time exercise but suited for estimating the milestones towards elimination. Low level of endemicity compared to other diseases and the clustering nature of leprosy are the major concerns in using LQAS methodology. It is important that the purpose of such an exercise is made clear before carrying it out.

Though elimination of leprosy as a public health problem has been achieved at the global level, a strong concern was expressed for the relatively stable detection over the last decades. Detection does not reflect the true incidence of leprosy, therefore there is a need to analyse already collected data. However, it was felt that the absolute number of cases detected during the year is suitable as the minimum indicator to be collected in the future, in light of the direction towards integrated information system and the implementation of uniform MDT regimen.
2.4 Conclusions and recommendations

- Analysis of the current global leprosy situation indicates that it is possible for all countries to achieve leprosy elimination at national level by the year 2005, if the current momentum and political commitment are maintained. However, it is likely that elimination will not be achieved at subnational level in some countries, and therefore intensified activities are required.

- There is evidence that significant number of patients on treatment registers should be removed from registers. Regular updating of leprosy registers as indicated in guidelines is an important activity of elimination programme and is the responsibility of all programme managers at all levels.

- Leprosy elimination monitoring (LEM) continues to be a useful and valid method of independently assessing leprosy elimination activities to assist programme managers within individual countries.

- Case detection rates do not reflect the true incidence. Therefore, there is a need to assess true incidence rates and it is recommended that WHO provide assistance in analysing specific projects that have already collected detailed prospective data on incidence of new cases. (e.g. Brazil, India, Malawi, Myanmar)

- Assessment of leprosy prevalence is important for planning and for monitoring progress. The very low prevalence and its non-random distribution are methodologically challenging. Methods that can be used at high prevalence may not be reliable at low prevalence. Further study in designing new tools is required.

- The use of integrated health information system for collating data on leprosy is important for long-term, sustainable surveillance of leprosy. Efforts are required to improve the quality as well as coverage of the minimum data within such information systems. The minimum data required is absolute number of new cases detected.

- As global elimination has been achieved, WHO will collect and publish information on case detection only as reported by Member States. In addition, WHO will continue to collect and publish information on six essential indicators from countries that have not reached elimination. However, all countries are advised to collect additional information at the national and sub-national level for the purpose of programme management.
WHO TECHNICAL ADVISORY GROUP ON ELIMINATION OF LEPROSY (TAG)  
Brasilia, 1 and 2 February 2002

AGENDA

1 February 2002

09:00 – 10:30 Opening:
- Welcoming remarks and report on GAEL meeting (Dr Daumerie)
- Review of TAG reports (Dr Gupte)
- Leprosy in TDR (Dr Engers)
- Introduction to members, nomination of chairperson
- Remarks by chairperson

10:30 – 11:00 Report on activities: Status Report 2001 (Dr Daumerie)

11:30 - 13:00 Technical discussion on:
- Single MDT regimen (Dr Gupte)
- Special campaigns for case detection (Dr Baral)
- Updating of treatment registers (good registration practice) (Dr Dharmshaktu)

14:00 – 15:00 Technical discussion on:
- Accompanied MDT (Dr Awe)
- Integration and decentralization (Dr Gerson Pereria)

15:30 – 17:00 Technical discussion on:
- Simplification and integration of information systems (Dr Kawano)
- Innovative approaches to IEC (Dr Khin Than Oo)

2 February 2002

09:00 – 10:30 Discussion on:
- New horizons of research and implications for leprosy elimination (Dr Sarno)
- Research needs for elimination by 2005 (Dr Becx)

11:00 – 11:30 Conclusions and recommendations

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Annex 2

WHO TECHNICAL ADVISORY GROUP ON ELIMINATION OF LEPROSY (TAG)
Brasilia, 1 and 2 February 2002

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Annex 3

WHO TECHNICAL ADVISORY GROUP ON ELIMINATION OF LEPROSY (TAG)
SUBGROUP ON MONITORING AND EVALUATION OF LEPROSY
ELIMINATION AS A PUBLIC HEALTH PROBLEM
Brasilia, 2 and 3 February 2002

AGENDA

2 February 2002

14:00 - 14:30 Opening remarks (Dr Daumerie)
14:30 -15:00 Global leprosy situation 2001, leprosy elimination monitoring (LEM) and updating leprosy registers (ULR) (Dr Kawano)
15:00-15:30 Outline of leprosy elimination monitoring (LEM) (Dr Awe)
16:00 -17:30 Discussion (All participants)

3 February 2002

09:00 - 09:30 Report of pilot studies on lot quality assurance sampling (LQAS) and snowball sampling methods (Dr Gupte)
09:30 - 10:30 Discussion (All Participants)
11:00 -12: 00 Brainstorming session on integrated information systems
Example of SINAN in Brazil (Dr Pereira)
Discussion (All participants)
12:00 -12:30 Adoption of recommendations and any other issues (All participants)

* * *
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SUBGROUP ON MONITORING AND EVALUATION OF LEPROSY
ELIMINATION AS A PUBLIC HEALTH PROBLEM

Brasilia, 2 and 3 February 2002

LIST OF PARTICIPANTS

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