

THE FINAL PUSH
towards
ELIMINATION OF LEPROSY

Strategic Plan
2000-2005



WORLD HEALTH ORGANIZATION

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Preface

One of the important developments in public health in recent years has been the tremendous progress made in conquering leprosy through the widespread implementation of multidrug therapy (MDT) to cure all patients and to reduce the disease burden in leprosy-endemic countries. This progress is essentially the result of a resolution of the World Health Assembly in 1991 that committed all leprosy-endemic countries to a global target of reducing the prevalence of leprosy to less than one case per 10 000 population. This effort was described as the elimination of leprosy as a public health problem, setting a target date for the year 2000. These targets were extremely useful in generating political commitment to push ahead and achieve the results that would otherwise not have been possible. This is well demonstrated by the fact that, since 1985, the prevalence of leprosy has been reduced globally by 85% by curing nearly 10 million leprosy patients. A large part of the credit for this should go to the determination and commitment of leprosy-endemic countries to eliminate leprosy under the overall leadership of WHO, the consistent efficacy of MDT in curing leprosy, and the all-round support provided by various partner agencies, in particular international donor nongovernmental organizations (NGOs). The epidemiological situation in leprosy was also very favourable in many countries, especially in Africa. The progress made so far is more than just in numbers and statistics alone. Advancements made in relation to reduced physical, psychological and social suffering, as well as an improved health image for countries, are truly immeasurable.

As we approach the end of the millennium leprosy is no longer the dreaded disease that it used to be and leprosy patients face a far better future than ever before. This does not mean that all leprosy problems have been resolved, nor does it mean that we can afford to slacken our efforts towards the elimination of the disease as a public health problem. In spite of the fact that the profile of the disease is much milder, and that disability among new patients is quite low, the social image of leprosy has not changed greatly in many parts of the world. This is all-too-well reflected in the attitude of the community, particularly towards individuals disabled or disfigured owing to the disease.

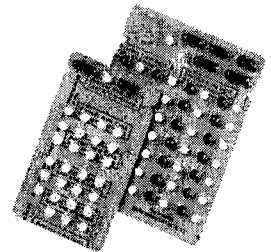
Today we can be confident that elimination -- the reduction in prevalence to less than one case per 10 000 population at the national level -- is within reach in all countries by the end of 2005. There must be no complacency, for there are still countries where very special efforts will be needed to reach that goal. And there are even more areas within countries where, long after the country has attained elimination at the national level, sustained efforts will be required to reach the target at provincial and district level.

1. Introduction and Overview

Leprosy is considered to be a special public health problem, owing to the permanent disabilities it causes as well as its social consequences such as discrimination and stigma. It currently affects over 1 million people in Africa, Asia, South America and the Pacific, and WHO estimates that between 2 and 3 million individuals are permanently disabled as a result of it. Although all the registered cases are on treatment, it is estimated that during the period 2000-2005, about 2.5 million people affected by leprosy need to be detected and treated.

Multidrug therapy (MDT) is the cornerstone of the leprosy elimination strategy as it cures patients, reduces the reservoir of infection and thereby interrupts its transmission. MDT also prevents disabilities through early cure. The 1991 World Health Assembly resolution to eliminate leprosy as a public health problem by the year 2000 (defined as a prevalence rate of less than one case per 10 000 population) gave substantial impetus to global leprosy control efforts.

Significant progress has been made towards this goal: over the past 15 years 9.8 million leprosy patients have been cured, the prevalence rate has dropped by 85%, and the number of countries where leprosy is a public health problem has dropped from 122 to 24. However, according to WHO estimates, about 10 countries -- representing 92% of the global leprosy burden (820 000 cases) -- will not reach the target on time, even at national level. Every year about 700 000 new cases are detected. But there is a risk that these significant achievements will be undermined unless efforts are intensified to eliminate leprosy in the remaining endemic countries.



Overall strategy

The strategy for the elimination of leprosy as a public health problem is quite clear in having a definite target that is not only aspirational but also managerial. The strategy focuses on:

- MDT, which together with early case-finding, is the best way of dealing with the problem of leprosy and its consequences;
- reducing the disease burden in terms of prevalence to very low levels, and the reduction of disease prevalence, will lead in the course of time to a reduction in transmission of infection and reduction of disease incidence;
- preventing the occurrence of disabilities by early diagnosis and treatment and improved management of cases;
- changing the negative image of leprosy;
- working closely with governments and every agency interested in leprosy elimination in a spirit of true partnership.

The elimination strategy is a highly relevant and sound approach to deal effectively with the leprosy problem. The key elements of the strategy require further innovative approaches, better adaptation to local realities, and greater attention to the implementation process itself.

It is expected that a global coalition will sustain enthusiasm for leprosy elimination at all levels in countries as well as respond to demands for guidance, support, MDT drugs and materials in a timely and effective manner. In particular this will mean improved logistics, data collection and analysis, developing a network of focal points at national and subnational levels, constant communication and check-backs with national task forces, and rapid response for providing promotional material and drugs.

Scope for the future

- Implementation of the intensified strategy has already renewed the interest for leprosy elimination.
- WHO and other partners are fully committed and will continue to sustain the political commitment, especially in countries that will require additional efforts.
- New opportunities have been created to advocate globally and locally the elimination of leprosy. This should help in creating a new image for leprosy and promote its elimination.
- Broader partnership will help in mobilizing new expertise and additional resources for implementing innovative strategies at local level. Leprosy programme managers, at all levels, will be further motivated by being part of a global initiative and will share experiences with other public health managers. This will be particularly important for activities related to logistics, programme management and disease surveillance.
- Clear approaches will be worked out to ensure the true integration of leprosy control activities. Phasing out of specialized programmes, including giving new opportunities both to specialized and general health workers, will be built into the intensified strategy.
- Ownership of leprosy elimination will be actively given to national programmes, essentially at the local level.

1.1 Leprosy: a disease that can be eliminated

Over the last 15 years there have been significant advances in reducing leprosy prevalence, thereby reducing the grossly disfiguring consequences, pain and suffering, and social stigma it causes.

The programme to eliminate leprosy will help in:

- alleviating and preventing the suffering of the affected individuals;
- reducing the transmission of the disease;
- supporting and strengthening activities of local health services;
- reducing the social stigma and ultimately changing the image of leprosy.

1.2 Leprosy: a disease of poverty

Leprosy is a leading cause of permanent disability in the world. Although leprosy is not fatal, the chronic symptoms often afflict individuals in their most productive stage of life and therefore impose a significant social and economic burden on society.

In addition to its economic impact, leprosy imposes a heavy social burden upon affected individuals and their families. Patients are often shunned and become isolated within their communities. Mocking and social stigmatization are frequent behaviours toward affected

individuals. Because persons with chronic manifestations of the disease are often unable to work or to marry, they become dependent for care and financial support leading to further insecurity, shame, isolation and consequent economic loss.

1.3 The goal

Elimination of leprosy as a public health problem in all countries by the year 2005¹.

1.4 Rationale and Approach

Technology and strategic development

First put into widespread use in the mid-1980s, achievements with MDT implementation during the first 10 years were so impressive that it became possible to envisage eliminating leprosy as a public health problem. It was felt that a strategy based on MDT could reduce the prevalence to such a level that transmission of infection would be interrupted; that level was set at less than one case per 10 000 population. This apparent breakthrough emboldened the Forty-fourth World Health Assembly, in May 1991, to adopt resolution WHA44.9 which committed Member States to promote the use of all control measures, including multidrug therapy together with case-finding, in order to attain the global elimination of leprosy as a public health problem by the year 2000.

Achievements

The strategy based on MDT and its intensive implementation has so far resulted in the following achievements:

- by the beginning of 1999 about 10 million cases had been cured;
- currently almost all of registered cases are receiving MDT;
- the number of relapses remain low, at about 0.1% per year;
- drug resistance following MDT has not been reported;
- the number of countries showing prevalence rates above 1 per 10 000 population has been reduced from 122, in 1991, to 24 at the beginning of 1999.

The reduction in prevalence will lead in the course of time to a reduction in the transmission of infection and of disease incidence. The implementation of MDT by itself has helped in updating registers and improving case management in such a way that the impressive reduction in prevalence has been achieved in all leprosy-endemic countries. The fact that detection of leprosy is on the increase in a number of endemic countries is largely due to the wider implementation of MDT services, greater emphasis on early case detection and increased involvement of the affected communities in the elimination activities.

¹ In this document, elimination of leprosy as a public health problem is defined as reduction of the leprosy prevalence at a given point in time to a level below one per 10 000 population at the national level.

1.5 Critical operational issues

- Improving community participation in early detection and drug treatment.
- Improving access to high quality MDT drugs.
- Implementation of best practice for case management, including prevention and management of disabilities.
- Mechanisms of surveillance and monitoring of interventions at the local level.

Such issues can be addressed only by implementing programme activities together with monitoring mechanisms and the modification of strategies adapted to local realities.

1.6 Partnerships

Success will depend on strong public-private coalitions built on wide ownership, equality of stakeholders, transparency of governance, shared credit, and recognition of respective roles and responsibilities.

2. The plan

Each of the sub-sections below represents one of the four major spheres of activity in the leprosy elimination programme: (i) reducing the reservoir of infection by improving access to MDT services; (ii) curing patients and preventing suffering and disabilities; (iii) essential technical support; and (iv) phasing out.

2.1 Reducing the reservoir of infection by improving access to MDT services

2.1.1 The principles underlying the strategy

The global strategy is based on detecting patients as soon as possible and curing them with the MDT regimens recommended by WHO. Over the years, the leprosy elimination strategy has been working extremely well, as evidenced by the fact that about 10 million patients have been cured by MDT with a very low relapse rate. The main elements of the current strategy are: (a) capacity building within integrated programmes, including simplified procedures for diagnosis and treatment; (b) free-of-charge MDT treatment; (c) reaching neglected population groups; and (d) monitoring progress towards elimination.

2.1.2 Country planning, preparation and activities

The first step in developing a programme to accelerate leprosy elimination is to adapt the national plan of action with the Ministry of Health (and other ministries) and to provide support in terms of advice, supervision and assistance to run the national programme. This should be done by joining the appropriate national task force (or equivalent where necessary) to develop and implement tailor-made solutions adapted to local realities. The national plan of action records the background, objectives, strategy, administration, management and proposed budget for the national programme. It will also serve as a descriptive document for presentation to potential donors interested in becoming partners in the programme.

Based on the national plan of action, applications with detailed implementation plans will be prepared by the Ministry of Health for free-of-charge supplies of donated MDT (for

all national programmes and NGOs). These applications, which should include detailed proposals for implementation, are reviewed for programme feasibility, integrity and sustainability by independent groups charged with these responsibilities. Review groups will encourage the earliest and widest possible initiation of revised national plans of action.

2.1.2.1 Status (country activities) 1999

- By mid-1999, 24 countries in all the Regions of WHO except Europe had not reached the elimination target. These are: in Africa (Angola, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Gabon, Gambia, Guinea, Guinea Bissau, Madagascar, Mali, Mozambique, Niger and Sierra Leone), in the Americas (Brazil and Paraguay), in South-East Asia (India, Indonesia, Myanmar and Nepal), and in the Western Pacific (Papua New Guinea).
- By mid-1999, 80 countries had submitted requests for the MDT donated to WHO.

2.1.2.2 Targets (country activities)

By the end of 1999:

- Detailed review of the situation in the 24 remaining endemic countries.
- Development of workplans for implementing intensified activities in 12 major endemic countries.

By 2000:

- Elimination at national level will be achieved in all but about 10 of the remaining countries.
- Intensified activities will be implemented in all major endemic countries.
- National task forces will be operating in all major endemic countries.

2.1.2.3 Activities

For planning purpose, and based on existing information, countries may be classified as follows²:

- *Countries that need special efforts to intensify elimination strategy.* In these countries, epidemiological trends over the last 10 to 15 years show high and often increasing detection rates, and geographic coverage with MDT is not complete or has been completed only recently. Some of these countries are close to the elimination level nationally. However, lack of information does not allow trend analysis and it is felt that intensive activities should be sustained to ensure that the geographic coverage is optimal.
- *Countries where the elimination strategy should be accelerated.* These countries are close to the elimination level nationally and are likely to reach the target by the end of 2000.

² Grouping of countries is subject to changes.

- *Countries where the elimination strategy should be sustained.* These countries have a long history of high endemicity and it is important to make sure that leprosy control activities are fully integrated and that epidemiological surveillance is maintained for a number of years.

Group 1: Countries that need special efforts to intensify the elimination strategy

Angola, Brazil, Central African Republic, Democratic Republic of Congo, Guinea, India, Indonesia, Madagascar, Mozambique, Myanmar, Nepal, and Niger.

The following activities will be intensively implemented:

- enabling all health facilities in endemic districts to diagnose and treat leprosy;
- ensuring easy and uninterrupted access to free MDT drugs;
- ensuring high cure rates through flexible and patient-friendly drug delivery systems;
- promotion of case-finding by informing the public about the disease and encouraging individuals with suspicious skin lesions to come forward for treatment;
- sustaining high geographic coverage with MDT services over 3-5 years;
- sustaining interventions for the prevention and management of disabilities;
- closely monitoring progress towards elimination at the district level;
- changing the community image of leprosy through information, education and advocacy.

Group 2: Countries where the elimination strategy should be accelerated

Cameroon, Chad, Congo, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Guinea Bissau, Mali, Papua New Guinea, Paraguay, and Sierra Leone.

The following activities are to be accelerated to ensure elimination is achieved as planned:

- ensuring easy and uninterrupted access to free MDT drugs;
- ensuring high cure rates through flexible and patient-friendly drug delivery systems;
- sustaining high geographic coverage with MDT services;
- sustaining interventions for the prevention and management of disabilities;
- closely monitoring progress towards elimination at the district level.

Group 3: Countries where the elimination strategy should be sustained

Argentina, Bangladesh, Benin, Burkina Faso, Cambodia, Colombia, Cuba, Egypt, Ghana, Haiti, Laos, Liberia, Maldives, Malaysia, Nigeria, Pakistan, Philippines, Senegal, Sri Lanka, Sudan, Tanzania, Thailand, Uganda, Venezuela, Viet Nam and Yemen.

The following activities should be implemented:

- providing simplified guidelines and materials for diagnosing and treating leprosy at the health centre level;
- providing easy access to MDT by supplying adequate stocks of MDT free of charge;
- identifying geographical areas where the disease is more prevalent and to implement the core activities of the intensified strategy;
- sustaining interventions for the prevention and management of disabilities;
- putting into place simple and integrated surveillance system as well as referral systems.

2.2 Curing patients and preventing suffering and disability

2.2.1 MDT in all health facilities

2.2.1.1 Principles

While treating all registered patients with MDT is a dramatic achievement in the fight against leprosy, it has to be recognized that the geographic coverage of health facilities capable of providing MDT services is far from satisfactory. This is mainly because leprosy has always been considered as an exceptional disease requiring special systems for dealing with it. As a result, procedures and norms for diagnosing and treating the disease have hitherto been seen as beyond the capabilities of the majority of general health services.

To overcome these difficulties and to accelerate progress towards elimination, WHO and its advisory bodies have simplified technical procedures for diagnosis, classification and treatment, including shortening treatment duration.

Ensuring that MDT is available and readily accessible to patients at the community level is one of the essential elements in the elimination strategy, without which all the efforts of case-finding, diagnosis, classification and drug supply are rendered meaningless. The strategy aims at focusing on the district level in major endemic countries. In each endemic district, core activities related to diagnosis and treatment of leprosy will be vigorously implemented in all existing health facilities.

2.2.1.2 Targets

By end of 1999:

- a list of endemic districts in all endemic countries;
- a list of all health facilities and their capability with regard to providing MDT services.

By 2000 and beyond:

- MDT services in all health facilities in endemic areas;
- close monitoring of MDT utilization;
- monitoring of the reduction of prevalence and detection at district level.

2.2.2 Leprosy elimination campaigns and special initiatives for reaching out

Leprosy elimination campaigns (LEC) aim at accelerating elimination activities in the major endemic countries through detecting and treating patients who for various reasons have not as yet been detected. This initiative is a combination of three elements, namely:

(i) promoting community awareness and participation in leprosy elimination activities; (ii) capacity building measures for local health workers to improve MDT services; and (iii) case finding and curing patients with MDT. LEC is designed as a campaign in that all the efforts are carried out within a relatively short period of time. They cover a fairly large population and involve the maximum possible number of health workers.

Special action projects for the elimination of leprosy (SAPEL) were introduced with the objective of reaching patients living in difficult-to-access areas or among neglected population groups, and thus to provide leprosy services, specifically MDT, to those patients who otherwise would never have received treatment. They include those who are geographically inaccessible, politically neglected groups, ethnic minorities and certain population groups like nomads and refugees.

The main elements of the special action projects are: (i) innovative actions, adapted to the local culture and resources to find cases and cure them; (ii) capacity building for local health workers or volunteers (i.e. local leaders, priests, imams, teachers, etc) with the aim of establishing sustainable MDT services; and (iii) promotion of community awareness and mobilization of their participation in case-finding and treatment activities.

These projects serve an important role in bringing services to neglected population groups and to those patients who would not otherwise be reached. Linkages with other partners in the planning and implementation of activities should be sought with a view to expanding to more underserved populations.

2.2.3 Prevention of disabilities and rehabilitation

The current situation with regard to leprosy and people with leprosy-related disabilities warrants a clearly-focused strategy in order to reach all those in need. It has been estimated that, at present, there may be between 2 and 3 million persons with leprosy-related impairments and disabilities in the world. The strategy should be elaborated at country level with full participation of the health sector, as well as other sectors, nongovernmental organizations and community leaders. Rehabilitation of disabled people is only one aspect of the more general issue of communities sharing the responsibility of providing a meaningful life to all its members. Access to all the existing programmes for disabled, social and economic welfare, including community-based rehabilitation, should be made available to leprosy-affected persons.

2.3 Essential technical support

2.3.1 Community ownership and information

The participation of the community in leprosy elimination activities needs to be increased, especially in order to change the negative image of leprosy and the stigma attached to the disease towards a positive end. This will require identifying obstacles to community participation and developing strategies for promoting community action. The main difficulties are the lack of political will, and ignorance about the symptoms and signs of the disease. The elimination strategy cannot depend on the health services alone and therefore the involvement of other sectors in the community is crucial to achieving the goal.

The local community and its leaders should play a key role in improving public awareness of the disease and the availability of free and effective treatment. They may also be crucial in supporting MDT services, case-finding, and ensuring that patients complete their treatment, particularly in areas where routine general health services either are not available or do not function properly. Indeed, they may be the only possibility for delivering MDT drugs, supervising the monthly drug administration and retrieving defaulters.

There is an important need to improve communication and collaboration for advocacy between the elimination programme and the media on how to make leprosy elimination attractive to the public and on how to generate support for the activities. As a disease affecting mainly underserved people and generating intense emotions linked with the age-old stigma attached to those affected by it, leprosy has always had certain very special features. As a result, the fight against leprosy has traditionally been undertaken by a relatively small group of people, highly dedicated but often reluctant to share the responsibility for the disease and its control with a wider audience. This explains to some extent why the tremendous achievements in leprosy control during the last half of the 20th century are not well known or are even under-played. Today we know leprosy is curable, but making it interesting to the public, the scientific community, decision-makers and politicians is not easy. The major approaches to creating awareness and support in the community are through information, education and communication. The mass media can be very helpful in improving community awareness but may also have a negative impact through biased stories.

2.3.2 Capacity building at local level

The key to intensifying and sustaining elimination activities at local level is to build the capacity of general health workers and community health volunteers in suspecting and diagnosing the disease, in counselling patients and in providing appropriate MDT services. WHO and its advisory bodies have already simplified the technology for these activities, including providing standard blister calendar packing for easy delivery of drugs and adequate training and teaching materials. The clinical signs of early leprosy are easily visible and the cardinal diagnostic sign, i.e. loss of sensation in the affected skin, is unique to the disease. All health workers can be educated in simple procedures for diagnosis and prescribing the appropriate MDT blister pack.. Similarly, community volunteers can be motivated to inform the community to report to the nearest health centre and can assist patients in getting their treatment.

Capacity building for undertaking elimination activities will be done through simple, task-oriented, self-learning and user-friendly materials made available at the local level. National training centres, educational institutions and local NGOs will play a key role in disseminating appropriate information on leprosy elimination.

2.3.3 Drug supply and logistics

While the supply of high quality MDT remains the cornerstone of the intensified elimination strategy, greater emphasis needs to be given to ensuring that all communities have free and unfettered access to treatment, even in the most peripheral areas. Endemic countries naturally exhibit regional differences in terms of the prevalence of the disease and the capacity to effectively manage the control programme. There are many reasons for this,

including the availability of trained health staff, difficult terrain or poor security, lack of storage capacity for MDT drugs, and shortage of vehicles with which to distribute the drugs.

For similar reasons, there can also be wide disparities *within* individual regions of endemic countries. In order to fully interpret and manage both these inter-regional and intra-regional disparities, countries where leprosy is still endemic and their partners should strengthen management at a more micro-level than is generally done at present.

Governments of countries, WHO and its partners will be directly involved in logistics planning by:

- estimating MDT requirements at district level, and planning and coordinating delivery schedules of MDT from central stores;
- monitoring MDT flow at state/province, district and sub-district levels to ensure that it is adequate, and that remote or isolated communities are not missed out of the delivery network;
- empowering communities by raising awareness of the disease and its treatment, and ensuring that drugs are available at the local level;
- applying a simplified information and reporting system in the field, wherever possible computerized, and using existing geographic information systems to identify areas of high endemicity that require special attention or additional targeted resources.

2.3.4 Surveillance and programme monitoring

Most endemic countries are currently using well-standardized leprosy information systems. The essential indicators used for monitoring progress towards the elimination of leprosy are prevalence, case detection, coverage with MDT, patients cured with MDT, relapses and newly-detected cases with grade 2 disabilities and impairments. These indicators should be analysed at the district level through the development of a district-level database. Geographical information systems can be a valuable management tool in strengthening the district-level capacities for surveillance and monitoring. The internal validity of the indicators should be continuously assessed by independent monitors in collaboration with the national programme. The main objective of such monitoring will be to collect indicators that reflect the performance of MDT services, especially the availability of drugs and the quality of patient care at the district level.

2.4 Phasing out

2.4.1 Validation of leprosy elimination

A weak spot in many countries is the collection and analysis of information on leprosy. Several attempts have been made to standardize definitions and reporting systems, but in general these are still too complex and have had limited acceptance. There is an urgent need to identify, through independent (and rapid) assessment, geographic areas where the transmission of leprosy is high. On the other hand, very sophisticated routine information collection on leprosy at health centre level should be stopped. In a significant number of endemic countries, it is still virtually impossible to get a clear picture of what the situation is, what has been achieved, and what remains to be done.

Certification or validation is linked with the concept of elimination, and it is therefore likely that an increasing number of countries and donor agencies will ask for it in the near future. However, there are no tools at the moment to carry out such an exercise, and existing epidemiological surveillance systems are not yet sufficiently effective. The only alternative to certification would be to strengthen and maintain surveillance systems with a high degree of coverage over a number of years, and this is feasible only if adequate resources are made available.

2.4.2 Handing over

To achieve elimination, it is important that MDT services should be available and accessible at the most peripheral level so that patients can get treatment at their nearest health centre. The integration of MDT services within the general health services is regarded as the key to achieving elimination. The rationale behind this approach is that the general health services are relatively more widely distributed, and have close and frequent contact with the local community. Involving the general health services will also improve case-finding and case-holding activities. In addition, such integration will help to demystify the disease and increase awareness about the disease in the community.

The process of integration should be simple and practical. The tasks assigned to the workers from the general health services should be clear and in line with their daily routine activities, including the information systems. With integration, more health centres are expected to be providing treatment, and the caseload in each centre will be relatively low in comparison to the attendance at monthly or weekly leprosy clinics opened by the specialized/vertical programmes. Some countries with larger vertical programmes will require assistance in carrying out these structural adjustments.

Integration will help in maintaining MDT services at the peripheral level, especially in areas where prevalence is declining. Several national programmes, even in countries with very high prevalence, have integrated leprosy services, mainly because of the urgent need to expand MDT coverage. However, it is important to have an element of a specialized programme in all endemic countries, either at the central level or -- in some larger countries -- at intermediate level. This specialized element for leprosy will be needed for providing technical guidance, for monitoring and evaluating the progress of elimination, for training and for research purposes. Referral centres will also support the general health services in diagnosing difficult cases and in providing certain specialized care to patients with complications.

3. Timing

Year 2000 :

- Advocacy for leprosy elimination in all countries.
- Detailed review of the situation in the most endemic countries.
- Strategic development in collaboration with countries and partners.
- Development of materials for capacity building, advocacy, and public information.
- Creation of national task forces (or equivalent) (government, WHO and partners) in the most endemic countries.

Years 2000-2002:

Intensive implementation at the district level, including integration, together with close monitoring of the progress and adaptations at the local level.

Years 2003-2004:

Phasing out and validation of elimination at national and possibly subnational levels.

Year 2005:

Detailed validation of leprosy elimination.

And beyond:

Although the intensified and focused implementation of the strategy will reduce the leprosy burden to very low levels, and therefore liberate resources to address other health priorities in the community, new cases of leprosy will continue to occur after 2005. In addition, a significant number of individuals disabled because of past leprosy will need attention. The national programmes, in partnership with all relevant agencies working in the field, through integrated health systems at the most peripheral levels, will continue to provide the best possible care.

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