



Fédération Internationale des Associations contre la Lèpre
International Federation of Anti-Leprosy Associations

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ILEP Technical Forum

Wednesday, 24th March 2010

London

REPORT

In the Chair: Professor Cairns Smith, Chair, ILEP Technical Commission
Present: See Appendix 1
Secretary: Mr Douglas Soutar, ILEP General Secretary and Secretary to the ILEP Technical Commission

MORNING SESSION

1. Introduction of Participants

The General Secretary welcomed delegates to this Technical Forum, which offered the opportunity for the members of the ILEP Technical Commission (ITC) to interact with ILEP Members and to update their programme of work at the mid-term of their time in office. Dr Saunderson's apologies were noted.

2. New Evidence from Leprosy Research

2.i Introduction: Professor Cairns Smith

The Technical Forum of 2008 had helped set the programme of work for the current ILEP Technical Commission for their term up to the end of 2011 in the following areas: monitoring, implementation, research and development, stigma, and liaison with ILEP Members. The 2010 Technical Forum was being held primarily to present research findings to the Members and to discuss with them potential implications of the evidence for programmes in the field. Professor Smith explained that the ITC members would make presentations on seven areas: prevention, diagnosis, chemotherapy, reactions, prevention of disability, stigma and rehabilitation.

2.ii Prevention

Three systematic reviews and four primary research studies were appraised. Research supported the continuing use of BCG (Bacille Calmette Guerin) in preventing leprosy. BCG is widely used as a vaccine and new studies have confirmed that it has a protective effect against leprosy. Therefore, leprosy programmes should continue to support the use of BCG in infants. Revaccination with BCG does not always provide any additional protection. Research is recommended into the effect of combined BCG and chemoprophylaxis. Some protection was shown in a randomised controlled trial of *Mycobacterium w* (*Mw*) in India. *Mw* can provide reasonable protection in contacts.

Discussions around Prevention

Professor Lockwood wondered if there could potentially be a problem with new tuberculosis vaccines and BCG going out of use. Professor Smith replied that the evidence from these new TB vaccines would need to be examined before coming to any definite conclusions.

Dr Diefenhardt asked for clarification of the recommendation to explore the use of chemoprophylaxis as a tool to prevent new cases of leprosy in household contacts in the Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy 2011-2015. Professor Smith explained that this is currently at a stage before becoming routine. Feasibility trials and pilot studies are now required before being adopted for routine use. Dr Htoon described three groups that could be considered: household contacts, neighbours and social contacts. He stressed that each country would have to decide on the categories of contacts to whom they would consider administering chemoprophylaxis.

The General Secretary noted earlier interesting studies looking at the role of other environmental bacteria affecting the effectiveness of BCG.

It was recommended that studies should look at larger numbers as this could help detect cases of leprosy early.

2.iii Early Diagnosis: Professor Cairns Smith

Early diagnosis is important as it can help reduce the number of individuals who develop disabilities and impairments. However, there are as yet no tools that can be used routinely by programmes to identify those who are at greater risk of developing leprosy.

One review indicated that individual counselling of new cases can help in identifying other new cases. Generally there is little documentation about reducing delays in diagnoses of leprosy and no studies focussed on women.

It is recommended that much more work be done around the management of contacts; that immunological markers for *M lepræ* infection and early disease be developed and assessed; and that health education activities be developed and evaluated. Professor

Smith considered there were huge opportunities for research into early diagnosis.

Discussions around Early Diagnosis

Under vertical programmes household contacts had been examined, but this had become non-routine over time and the individual with leprosy had been relied on to recognise symptoms of leprosy in their circle of contacts. Today it should be possible to re-focus on the contacts of people who have been diagnosed with leprosy, since the case load is lower than previously.

A number of participants noted the positive effects of the recent expansion of contact examination in countries such as Brazil. Consideration also needed to be given to the frequency of contact examinations particularly given the long incubation period of *M lepræ*.

2. iv Chemotherapy: Dr Etienne Declercq

Dr Declercq argued that there is not much that can be implemented at the current time as regards chemotherapy due to a lack of sound evidence. At its Third Meeting the World Health Organization (WHO) Technical Advisory Group (TAG) recommended beginning trials on Uniform Multi-Drug Therapy (U-MDT) for all leprosy patients, whether multibacillary (MB) or paucibacillary (PB) for six months only. 2,094 PB and 1,302 MB patients were enrolled for control trials in India and Brazil. The study will not end until 2015 since the follow-up period has been extended by eight years. A randomised control trial in Secunderabad, India, revealed that six-months' U-MDT is too short a regimen to treat MB leprosy effectively.

It was noted that it is not possible to draw firm conclusions from trials of single dose ROM for those with only one to three skin lesions since they were on small numbers and follow-up was carried out for six months only.

Dr Declercq explained that there had been studies into the effectiveness of fluoroquinolones against *M lepræ*, which have shown that they may have a role to play in the future as part of more potent multi-drug regimens.

In conclusion, Dr Declercq recommended the collection of more information about the ongoing U-MDT trials. He also recommended research into new drugs or new regimens in case of basic intolerance of Rifampicin; trials of new and shorter MDT regimens with highly bactericidal drugs and further research into the risk of relapse after twelve months' of Multi-Drug Therapy (MDT) for MB leprosy.

Discussions around Chemotherapy

Dr Htoon noted that new MDT regimens would take at least another twelve years of trials before any such new treatment could be safely used. Instead he said he would like ILEP to take some action and use its existing networks to further test those regimens that are currently

being investigated.

Discussion also focused on Rifampicin resistance, the under-appreciated risk of side-effects of Dapsone and the reluctance of donors to put money into research.

2.v Reactions: Professor Diana Lockwood

Professor Lockwood noted that type one reactions and neuritis affected around 30% of MB patients. Reactions are of concern because they can cause disabilities, but are difficult to diagnose. They present a challenge for training and their management as they are not easy to treat and can recur.

Steroids are the first line of treatment. Professor Lockwood referred to two reviews of the effect of corticosteroid treatment on nerve damage and type one reactions. Neither of these provided adequate evidence of the long-term benefit of steroid treatment. There are also difficulties in measuring the effectiveness of steroids for treating type one reactions and it is hard to make comparisons between studies done in this area.

Recurrence often occurs when the steroid dose is reduced. The current evidence seems to suggest that longer doses of steroids are better than shorter ones, as the recurrence rates after twelve weeks are high.

Professor Lockwood recommended the following types of research into Erythema Nodosum Leprosum (ENL):

1. Developing scales for international use.
2. A trial to compare prednisolone and thalidomide in leprosy out-patients.
3. After the completion of the above comparison, the development of treatment guidelines.
4. The development of second line drugs – azathioprine, cyclosporine.
5. The identification of patients at risk of ENL.
6. The development of safe and effective alternatives to steroids and thalidomide.

In conclusion, Professor Lockwood noted that new studies were needed to provide more evidence on: the doses and duration of steroid treatment; the role for steroids and thalidomide in ENL needs evidence; second-line treatments in both type one reactions and ENL are needed; and that there should be studies conducted in Africa, Asia and Brazil.

Discussions around Reactions

Since there is a high relapse rate in steroids, Dr Diefenhardt wondered if WHO should be asked to amend its recommendations in this respect. It was noted however that WHO had changed its recommendations in Aberdeen in 2006 from 12 weeks to 20 weeks. If

better studies existed it might be possible to make stronger recommendations. The current evidence seems to suggest that 12 weeks is too short a period.

Dr Htoon also spoke of the lack of availability of Prednisolone in some health centres and said measures should be taken to rectify this weakness. Others talked about difficulties of obtaining Clofazimine more widely. The wider use of thalidomide was also discussed with stress laid on ensuring better safeguards.

Professor Lockwood suggested that a consortium approach might be useful in developing a set of scales for classifying types of reaction using a standardised approach.

2.vi Prevention of Disability: Dr Hugh Cross

The review of literature on this topic had concentrated on research undertaken since the Consensus Development Conference (CDC) held in Cebu, the Philippines, in September 2006, and its recommendations for best practice in the prevention of disability and its conclusion that self-care is a key strategy in the prevention of disabilities.

Recent studies had widely reported the positive effects of self-care on ulcer healing and prevention. Social support channelled through self-care facilitators has also been found to be crucial. It was noted that though self-care is known to be effective, there are still many challenges to implementing such measures through many national programmes, particularly in low income countries. Middle-income countries have been in a better position to implement some relevant measures. It will be imperative that such interventions are cost-effective and since these do not already exist, these should be undertaken to determine the nature of adequate resources and how they should be used for optimal effect. Dr Cross recommended that further research is needed to assess coverage and access to self-care.

The report of the International Leprosy Association Technical Forum of 2002 had identified the routine use of appropriate footwear as "one of the most important prevention of disability (POD) interventions in leprosy". Dr Cross reported that developments in modern footwear technology have made access to contemporary insole materials relatively inexpensive and that footwear is now being produced that is likely to be appropriate for people with impaired sole sensitivity. However, it is becoming more and more difficult to identify appropriate footwear that is useful in reducing pressure on the foot.

Dr Cross also reported on studies looking at the feasibility of governmental health workers being capable of conducting such monitoring as will be required for the implementation of the Enhanced Global Strategy. Operational factors can influence whether disability is recorded and reported adequately and appropriate research into the health systems should be conducted.

With regards to wound care Dr Cross reported on studies into the

effect of topical phenytoin. Optimal concentrations and best method of delivery have still to be established.

Dr Cross spoke about a review of the effectiveness of decompressive surgery for treating nerve damage in leprosy and reported that there was insufficient data for meta analysis and therefore insufficient evidence to draw robust conclusions. Randomised control trials were needed to establish optimal methods to restore nerve function and should also consider costs and quality of life.

Dr Cross had also reviewed studies concerning bone density including the use of risedronate in preventing further disability in elderly male leprosy patients with osteoporosis.

Discussions around Prevention of Disability

Dr van Brakel felt there needed to be stronger advocacy in favour of self-care since there is a lack of hard evidence on its efficacy.

Dr Cross considered that self-care has been shown to work as an intervention, but agreed that the evidence is not as robust as scientists would wish and that it is very hard to carry out controls. He added that we should look at more than just wound care within the realms of what is possible within self-care.

In response to questions about a possible recommendation on the use of risedronate, Dr Cross said that more needs to be discovered about optimal concentration and how best to apply and use it.

2.vii Stigma: Dr Wim van Brakel

Dr Wim van Brakel began with a currently accepted definition of stigma, which emphasises the dynamic and experiential aspects of stigma, devised by Weiss and Ramakrishna: "Stigma is a social process, experienced or anticipated, characterised by exclusion, rejection, blame or devaluation, that results from experience, perception, or reasonable anticipation of an adverse social judgement about a person or a group".

The literature review had focussed mainly on measuring stigma and interventions to reduce stigma. It was reported that whilst measures have been undertaken to reduce stigma, very little has been done so far to assess their effectiveness. Levels at which stigma intervention strategies should be implemented are at the: intrapersonal, interpersonal, organisational/institutional, community and governmental/structural levels. A multi-pronged approach is needed, in addition to legislation and advocacy to eliminate stigma and stigmatisation.

The Stigma Elimination Project (STEP) used the Participation Scale (P-scale) of the International Classification of Functioning, Disability and Health to evaluate the impact of their three-year project in Eastern Nepal. This project had trained people affected by leprosy as change agents in their own communities and as a result perceived social

participation among people affected by leprosy within the area of the project was better than could be expected in the general population.

Dr van Brakel concluded that future stigma-related research should be based on multiple perspectives for this very complex issue. Approaches should be emancipatory and include persons affected by leprosy. A comparison should be made of tools to measure stigma and the optimal ones selected for assessing levels of stigma and stigma reduction. Further studies are also needed on the effectiveness of stigma interventions and these should be graded according to recognised scientific standards.

Discussions around Stigma

Dr van Brakel noted that most studies to date have concentrated on analysing the determinants of stigma arising from one condition and that one needs to bear in mind that stigma in various conditions comes from different sources.

Discussions also touched on the importance of linking stigma research to anthropological and psychological studies, since stigma does always not lend itself to a rational approach.

Dr Diefenhardt drew attention to the possibility that evaluations of stigma can themselves contribute towards or perpetuate stigma, by the way such evaluations are structured.

2.viii Rehabilitation: Dr Sunil Deepak

Dr Deepak noted that rehabilitation comprises many aspects beyond the medical, such as socio-economic rehabilitation (SER), education, autonomy, participation and equal opportunities among others. A lot was done at the field level, but much less at the Federation level. He also noted that the literature he had reviewed was not qualitative. He had found it to be very limited, mostly restricted to leprosy, with no cross-over into broader social science concerns. The community approach has been shown to be effective, and there is scope for ILEP Members to learn from each others' substantial expertise in CBR and to find ways to extend it beyond its narrow leprosy orientation.

Dr Deepak stressed the importance of strengthening support for human rights through rehabilitation services. He believes there is much to be gained from linking with groups affected by disabilities as a result of other conditions than leprosy and noted that disabled peoples' organisations (DPOs), other professionals and researchers are collaborating more than in the past. 83 countries had now signed the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). However, he made the observation that persons affected by leprosy are hardly ever involved in the drafting of new legislation by states to ensure that their rights enshrined in this Convention are upheld.

Dr Deepak concluded that there is a huge gap in research about different aspects of rehabilitation. Systematic research is lacking and a

greater multi-disciplinary approach should be adopted for research into rehabilitation.

Discussions around Rehabilitation

Professor Porter noted that with major donors such as the Department for International Development (DFID) in the UK, rehabilitation is a current priority issue. There are real opportunities for leprosy organisations to tap into this, linking into human rights issues, health systems development and the integration of leprosy into primary health care. He noted that there is also a big push being made around disabilities as a result of chronic disease. In addition, he was struck by the multi-disciplinary aspects of rehabilitation and the need to be much more proactive and to radically re-think research into rehabilitation.

The General Secretary said that compared to what needs to be done in this area, work is currently only scratching the surface. Many challenges remained in working towards a more holistic approach.

Dr Diefenhardt asked if the review had revealed any practical implications for the field and whether the ITC had any recommendations to put forward about rehabilitation. Dr Deepak indicated that the WHO/ILEP Technical Guide on CBR and Leprosy already contains practical advice as will the new WHO CBR Guidelines that are due out in October of this year. Dr Cross remarked that the ITC are constrained by the need to provide gold-standard evidence, therefore it will be necessary to look as well at other non leprosy-related CBR models.

2.ix General Discussion

Professor Smith rounded up the discussions and concluded that the literature review of leprosy research had been useful and had forced the ITC members to look more widely at the literature. It had presented challenges where, for example, they had discovered that often there is no watertight evidence despite multiple research projects. They had also realised that different paradigms for methodologies are needed, noting for example that randomised trials are less suitable for conducting research into stigma and rehabilitation.

The next steps to be taken in compiling a report of this review would be considered by the ITC in its meeting the following day.

AFTERNOON SESSION

At the start of the afternoon session, Professor Smith noted how much the Forum was missing the presence and insight of both Professor Ji Baohong and Dr Augustin Guédénon, who had both died early in 2010. Professor Ji was missed for his extensive knowledge of chemotherapy and Dr Guédénon for his experience of field programmes in Africa.

3. Update on WHO/ILEP Meeting of 11th November 2009 on Training and Capacity Development Strategy

Dr Eggens, Consultant to Netherlands Leprosy Relief (NLR) from the Royal Tropical Institute (KIT) explained he was part of a small group put together by the Global Leprosy Programme (GLP) to develop a set of guidelines for a Capacity Development Strategy in Leprosy Control. The group includes Charles Phaff, NLR Representative in Mozambique and Jos Brand, an independent consultant. The aim is to ensure that there will be a sufficient number of leprosy professionals, who know about leprosy control and care. He noted that countries would need to manage and develop their own human resources, organisations and institutions to this effect. He suggested that provision of training could be more effective if an analysis of needs is conducted every three years, including an assessment of political commitment, supervisory requirements, career development, staff turnover and transfer, and other long-term influences such as the quality and quantity of leprosy control. Consideration should be given to the most suitable method of learning depending on a country's needs and could be face-to-face, on the job, or by distance learning.

Discussions around Capacity Development Strategy in Leprosy Control

Dr Htoon explained that in the course of developing the Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy (Plan Period: 2011 – 2015), it had been clear that expertise in leprosy is declining at an alarming rate. Whilst it is up to countries to manage this situation, the Global Leprosy Programme is prepared to help support countries in assessing their training needs so as to sustain leprosy expertise. It will recommend that they look ahead ten years and estimate the future levels of political commitment in their country for leprosy control. This was why the GLP had put together a small group to examine this issue and to prepare a set of guidelines that could be of assistance. The next phase would involve sharing the Draft Capacity Development Strategy in Leprosy Control with a wider audience and seeking their advice on any improvements. The GLP is looking to ILEP Members to assist national leprosy programmes to analyse their training needs on the basis of the guidelines and to assist in any other way they can. There will be meetings of the various WHO regions throughout this year, at which the Capacity Development Strategy for Leprosy Control can be introduced ready for implementation from 2011.

A number of participants reflected on the importance of ensuring the involvement of people affected by leprosy in the process of developing this strategy. It was also argued that it would be good to bring to the fore the role of private doctors and dermatologists.

Dr Eggens mentioned that existing training organisations are facing difficulties in financing training courses. He suggested four-day training courses for national leprosy programme managers from low-endemic countries for leprosy.

It was suggested that leprosy training might be embedded into joint Tuberculosis-leprosy programmes and that issues such as advocacy, prevention of disability, rehabilitation and stigma, need to be included. Dr Htoon replied that it is up to national programmes to adopt training according to local needs.

Dr Htoon also remarked that obtaining political commitment is a real challenge. Often this boils down to resource allocation and it was suggested that a systematic approach should be adopted to help ensure that some resources can be allocated for leprosy training. Professor Porter confirmed that this approach had already worked in human immunodeficiency virus (HIV) and tuberculosis (TB) programmes.

The General Secretary stressed that ILEP is committed to capacity building and training and noted that the WHO recognises ILEP as a key player in this area. Ultimately, capacity building and training are integral to the EGS. Integrated thinking was needed around how much can be realistically provided. He also noted the need to see beyond the health worker to also include the social and welfare worker and highlighted the fact that the health worker will need to be able to refer cases to relevant specialists who can help.

Dr Eggens and Dr Htoon thanked everyone for their positive critical comments, which would be fed in to the further drafting of this strategy document. Dr Htoon stressed that where there were felt to be gaps he would consult experts and ask them to help expand relevant sections.

4. Update on WHO Informal Consultation on Monitoring Grade-Two Disability Rate and Applicability of Chemoprophylaxis in Leprosy Control, 12th – 13th November 2010

Dr Htoon said that the need for this Informal Consultation arose from the Enhanced Global Strategy meeting held in New Delhi in April 2010. He reiterated the conclusions and recommendations of this two-day meeting:

1. All new cases should be assessed for grade-two disabilities and the findings recorded and reported in standard forms.
2. WHO grade-two disability grading should be used for collecting data for the population-based indicator as described in the Updated Operational Guidelines for the Enhanced Global Strategy to ensure uniformity.
3. Training by national programmes is important to ensure validity and reliability of grade-two disability assessment, recording and reporting. Validation of data on a sample basis where possible is recommended.
4. Pilot projects on implementing chemoprophylaxis under routine programme conditions and using standard definition of “contacts” are recommended to better understand the operational issues. Pilot projects could be conducted in areas where contact examinations are being done successfully with current staff in order for it to be cost effective. Such pilot projects should use robust, standard measures to assess acceptability, cost effectiveness, feasibility and ethical issues.

Discussions around monitoring grade-two disability

Professor Smith explained the intention behind the new indicator: to improve quality and help ensure records are more accurate and complete. Detecting cases early, will help reduce the numbers of cases with grade-two disability. The intention is to be able to see the trend over the five-year period of the Enhanced Global Strategy. It had also been important, according to Dr Htoon,

to have an index that could be determined from the data that is currently reported to WHO and recorded in the *Weekly Epidemiological Record* (WER).

Dr Declercq said that he hoped this indicator will encourage nations to put an emphasis on early detection. The target should also assist them in assessing and analysing the results and provide a motivation to keep leprosy on the agenda. He was aware of the limitations of this indicator, but suggested that countries can still compare their results according to the other indicators also.

Discussions around chemoprophylaxis

The General Secretary stressed that the Enhanced Global Strategy had only suggested exploring the use of chemoprophylaxis as a tool to prevent the occurrence of new leprosy cases among household contacts. It was noted that although the evidence for its effectiveness exists, it is a matter of setting parameters for health services to meet in order to be able to implement. Dr van Brakel suggested that ILEP could ask the ITC to make suggestions. Dr Both wondered whether there could be a standard protocol for evaluating the validity of research findings.

5. Update on the Infolep Information Portal Project

Dr Lenka Körner-Nahodilova explained the development and rationale of this project which recognises and anticipates the need for a networked on-line global database of information, which can be accessed by all with an interest in leprosy. Since it is about creating a pathway to links, it will not be duplicative. Key target users will be ILEP Members, policy-makers, public health officials, programme managers, health care practitioners, teachers and providers of services, academics and researchers.

ILEP will host this information portal through its website, whilst Infolep is playing the lead role in the development of the portal. They have identified a free United Nations Educational Scientific and Cultural Organization (UNESCO) software that is suitable for the creation of the database. Technical experts in the Royal Tropical Institute (KIT) will assist with the technical management of this project.

Contacts have been established with virtual libraries e.g. in Brazil that wish to link into this portal. Mr Verstappen said that this project would officially start in June 2010 and take three years to complete. Initially, it will be in English and Portuguese. It may be extended to other languages at a later stage.

In discussions, Dr van Brakel stressed the importance of linking different resources to this portal and making use of local resources. The General Secretary suggested this portal will have the potential to be a training resource in the future.

6. Open Session for Issues Raised by ILEP Members Including Any Additional Topics on Which Members Would Like ITC Advice and Guidance

6.i German Leprosy and Tuberculosis Relief Association (GLRA) Requests

- **An evaluation of the joint WHO/NLR/GLRA training courses of the last two to three years.** (As they feel that it could shed some light for the Capacity Development Strategy in Leprosy Control that is currently being prepared).
- **ITC to make recommendations on strategic issues** such as: the use of chemoprophylaxis and BCG or not; the need to maintain referral centres and centres of excellence now that leprosy is perceived as being a lesser problem.
- **The endorsement of the WHO/ILEP Technical Guide on CBR and Leprosy**

6.ii The Leprosy Mission International (TLMI) Requests

- **ILEP/ITC to monitor the available knowledge and skills about leprosy in countries where ILEP Members are active and make it internationally available.** (This could be facilitated by reports from ILEP Representatives).
- **ILEP/ITC to keep a list of experts/specialists in leprosy.**
- **Recommendations concerning alternative regimens/combinations to MDT.**

6.iii Sasakawa Memorial Health Foundation (SMHF) Requests

- **Advice/guidance on critical interventions that would involve persons affected by leprosy in the WHO EGS.** (Dr Htoon explained that there had been a first meeting of the Task Force set up to examine the involvement of persons affected by leprosy and they had identified thirteen areas in which they could be involved. The group comprising Dr Myo Htoon, Dr PK Gopal, Dr P Krishnamurthy, Dr Wim van Brakel, Mrs Kay Yamaguchi et al would develop their proposals which are to be sent to experts and all interested parties for comment prior to the next meeting of this Task Force which is to take place in Manila 9th – 10th June 2010. Prof. Smith suggested it was best to leave this matter in the hands of this Task Force.)
- **Advice on social enterprise of protective footwear** (Hugh Cross advised it would be best to continue purchasing shoes for people affected by leprosy through general manufacturing routes).
- **Heritage advocacy as a tool to sustain interest in leprosy** Several participants spoke of the important role that museums etc can play in informing people about leprosy. It was also noted that issues of stigma and social communication are of interest to young people. It was mentioned that there are countless negative mentions of leprosy in social media and that the word "leper" is frequently used. The General Secretary said that it is up to ILEP Members and other advocates to make sure that what is on the Internet is appropriate and

accurate.

- ***Advice on application of ethnological methods for study of stigma in leprosy***

Dr Wim van Brakel is going to look into this issue. He mentioned that he knew of one paper published in the Asia Pacific Disability and Rehabilitation Journal about people affected by leprosy in South Sulawesi, from which he had taken some quotes for his presentation earlier.

Discussions:

It was agreed that these requests would be considered by the ITC the following day.

Some discussion followed around the request for guidance relating to maintaining knowledge and referral centres and the need to link these. Professor Lockwood made the point that it is very important to have referral centres, but they have to be part of larger structures. Professor Porter mentioned the opportunities for leprosy to link in with broader chronic diseases, health systems and communicable diseases. Dr van Brakel agreed that this was a multi-sectoral and multi-disciplinary issue.

Document distribution:

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Acronyms used in this report:

BCG	Bacille Calmette Guerin
CBR	community-based rehabilitation
CDC	Consensus Development Conference
DFID	Department for International Development (UK)
DPO	disabled people's organisation
EGS	Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy (Plan period: 2011-2015)
ENL	Erythema Nodosum Leprosum
GLP	Global Leprosy Programme
GLRA	German Leprosy and Tuberculosis Relief Organisation
HIV	human immunodeficiency virus
ITC	ILEP Technical Commission
KIT	Royal Tropical Institute (The Netherlands)
MB	multibacillary
MDT	multi-drug therapy
Mw	mycobacterium w
NLR	Netherlands Leprosy Relief
PB	paucibacillary
POD	prevention of disability
P-scale	participation-scale
ROM	rifampicin ofloxacin and minocycline
SER	socio economic rehabilitation
SMHF	Sasakawa Memorial Health Foundation
STEP	Stigma Elimination Project
TAG	Technical Advisory Group
TB	tuberculosis
TLMI	The Leprosy Mission International
U-MDT	uniform multi-drug therapy
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNESCO	United Nations Educational Scientific and Cultural Organization
WER	<i>Weekly Epidemiological Record</i>
WHO	World Health Organization

Appendix 1: List of Participants

Both, Dr Piet	TLMI
Burgess, Mrs Maggie	Promise Nepal
Cross, Dr Hugh	*
Declercq, Dr Etienne	*
Deepak, Dr Sunil	*
Diefenhardt, Dr Adolf	GLRA
Eggens, Dr Henk	NLR
Htoon, Dr Myo Thet	* <i>WHO Global Leprosy Programme</i>
Jones, Ms Eliza	LEPRA
Kömm, Mr Burkhard	GLRA
Legault, Mrs Maryse	SLC
Lockwood, Professor Diana	*
Nash, Ms June	TLMI
Porter, Professor John	LEPRA
Smith, Professor Cairns	* <i>Chair, ILEP Technical Commission/ ILEP Technical Forum</i>
Torres, Dr Pedro	SF
Van Brakel, Dr Wim	*
Verstappen, Mr Rens	NLR

* *Member of the ILEP Technical Commission*

ILEP Secretariat:

Bonham, Ms Felicity	ILEP Secretariat
Clark, Mr Andrew	<i>Assistant General Secretary of ILEP</i>
Körner-Nahodilova, Dr Lenka	<i>Technical & Information Co-ordinator</i>
Soutar, Mr Douglas	<i>General Secretary of ILEP/ Secretary, ILEP Technical Commission/ILEP Technical Forum</i>
St Hill, Ms Beverley	ILEP Secretariat

Appendix 2: List of Presentations

All of the presentations listed below are available for download from the ILEP website: <http://www.ilep.org.uk/technical-advice/ilep-technical-forum/>

- *Introduction/Prevention and Early Diagnosis (Professor Cairns Smith)*
- *Chemotherapy (Dr Etienne Declercq)*
- *Reactions (Professor Diana Lockwood)*
- *Prevention of Disability (Dr Hugh Cross)*
- *Stigma (Dr Wim van Brakel)*
- *Rehabilitation (Dr Sunil Deepak)*
- *Capacity Development Strategy in Leprosy Control (Dr Henk Eggens)*