

**Report of the Eighth Meeting of the WHO
Technical Advisory Group on Leprosy
Control**

Aberdeen, Scotland 21st April 2006

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1. Introduction

The Eighth meeting of the WHO Technical Advisory Group (TAG) on Leprosy Control was held in Aberdeen, Scotland, on 21st April 2006. The meeting was chaired by Professor W.C.S. Smith and attended by national programme managers from 10 endemic countries namely, Brazil, Democratic Republic of Congo, Ethiopia, India, Myanmar, Nepal, Philippines, Sudan, United Republic of Tanzania and Viet Nam. In addition, members of the Technical Commission of the International Federation of Anti-Leprosy Associations (ILEP) and president of the International Leprosy Association (ILA) also attended the meeting.

The meeting was held immediately after the three-day meeting of the Global Forum on Leprosy Control which was held at the same venue from 18th to 20th April 2006. The Global Forum included all participants of the TAG and four invited experts. The objective of the Global Forum was to finalize the Operational Guidelines for the implementation of WHO's Global Strategy.

The main objective of the meeting was to review the global leprosy situation, discuss key technical issues including progress and results of on-going drug trials. The most important agenda item was to approve the Operational Guidelines for implementing the Global Strategy for Further Reducing the Disease Burden and Sustaining Leprosy Control Services.

2. Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region

In his message, Dr Samlee expressed his appreciation to experts from WHO and ILEP for working together to discuss technical and operational issues related to leprosy control programmes, along with national programme managers from several leprosy-endemic countries.

The Global Strategy 2006-2010 focuses on sustaining the gains made so far and to reduce the disease burden further in all endemic communities. At the same time, particular attention should be given to ensure that quality of services is not compromised. Every person affected by leprosy should have easy access to diagnosis

and free treatment. He stressed the need to ensure that sustainable and high quality services are provided within integrated health care services. This included establishment of an effective referral network, so that leprosy related complications can be managed effectively.

Dr Samlee urged the participants to find best approaches to ensure prevention of disabilities and to facilitate rehabilitation. This area was often considered as difficult and outside the scope of disease control programmes. But in a disease like leprosy, this was an important issue.

3. Report of the seventh meeting of the TAG

The report of the Seventh TAG meeting held in Geneva on 4th and 5th April 2005 was approved in principle.

4. Global leprosy situation

The reported global registered prevalence of leprosy at the beginning of 2006 was 219 826 cases. The number of new cases reported during 2005 was 296 499. The new case detection globally continues to show a sharp decline, as the number of new cases reported has decreases by over 110 000 cases (27%) during 2005 compared to 2004.

Table 1: Leprosy situation by WHO region at the beginning of 2006 (excluding European Region)

WHO Region ^a	Registered Prevalence ^b at beginning of 2006	New cases reported ^c during the year 2005
African	40 830 (0.56)	42 814 (5.92)
Americas	32 904 (0.39)	41 780 (4.98)
South-East Asia	133 422 (0.81)	201 635 (12.17)
East Mediterranean	4 024 (0.09)	3 133 (0.67)
Western Pacific	8 646 (0.05)	7 137 (0.41)
Total	219 826	296 499

a Population data for 2005 from the United Nations Population Division (Reference: 2004 Revision, POP.DB.WPP.Rev.2004.2.F1. www.un.org/popin)

b Prevalence rate is shown in parenthesis as the number of cases per 10 000 population.

c Case detection rate is shown in parenthesis as the number of cases per 100 000 population.

As seen in Table 2, the global annual detection is showing a declining trend since 2001. The African (8.7%), American (20.1%), South-East Asia (32.5%) and Eastern Mediterranean (7.6%) Regions have reported a decline in the new case detection during 2005 compared to 2004. The Western Pacific Region, however, reported a 14.8% increase in new cases during the same period.

Table 2: New case detection trend during the years 2001 - 2005 by WHO Region (excluding European Region)

WHO Region	Number of new cases detected during the year				
	2001	2002	2003	2004	2005
African	39 612	48 248	47 006	46 918	42 814
Americas	42 830	39 939	52 435	52 662	41 780
South-East Asia	668 658	520 632	405 147	298 603	201 635
East Mediterranean	4 758	4 665	3 940	3 392	3 133
Western Pacific	7 404	7 154	6 190	6 216	7 137
Total	763 262	620 638	514 718	407 791	296 499

The leprosy situation in the six major endemic countries where the goal of elimination has yet to be achieved is shown in Table 3. These six countries are: Brazil, the Democratic Republic of the Congo, Madagascar, Mozambique, Nepal and the United Republic of Tanzania. Together, these countries represent about 23% of the new cases detected during 2005, and 24% of registered cases at the beginning of 2006.

Table 3: Countries yet to reach the elimination target

Country	Registered prevalence ^a			Number of new cases detected ^b		
	At the beginning of 2004	At the beginning of 2005	At the beginning of 2006	During 2003	During 2004	During 2005
Brazil	79 908 (4.6)	30 693 (1.7)	27 313 (1.5)	49 206 (28.6)	49 384 (26.9)	38 410 (20.6)
Democratic Republic of the Congo	6 891 (1.3)	10 530 (1.9)	9 785 (1.7)	7 165 (13.5)	11 781 (21.1)	10 737 (18.7)
Madagascar	5 514 (3.4)	4 610 (2.5)	2 094 (1.1)	5 104 (31.1)	3 710 (20.5)	2 709 (14.6)
Mozambique	6 810 (3.4)	4 692 (2.4)	4 889 (2.5)	5 907 (29.4)	4 266 (22.0)	5 371 (27.1)

Nepal ^c	7 549 (3.1)	4 699 (1.8)	4 921 (1.8)	8 046 (32.9)	6 958 (26.2)	6 150 (22.7)
Tanzania	5 420 (1.6)	4 777 (1.3)	4 190 (1.1)	5 279 (15.4)	5 190 (13.8)	4 237 (11.1)
Total	112 092	60 001	53 192	80 707	81 289	67 614

a Prevalence rates are shown in parenthesis: the number of cases per 10 000 population.

b Case detection rates are shown in parenthesis: the number of cases per 100 000 population.

c Detection reported for mid-November 2004 to mid-November 2005

As seen in Table 4, there are 17 countries in which 1 000 or more new cases were reported during 2005. These 17 countries contribute 94% of the global new case detection. Case detection has increased since 2002 in the Democratic Republic of Congo, Indonesia and Philippines.

Table 4: New case detection in top 17 countries reporting 1 000 and more new cases during 2005 in comparison to 1993, 2002, 2003 and 2004

No.	Country	Number of new cases detected				
		1993	2002	2003	2004	2005
1	Angola	339	4 272	2 933	2 109	1 877
2	Bangladesh	6 943	9 844	8 712	8 242	7 882
3	Brazil	34 235	38 365	49 206	49 384	38 410
4	China	3 755	1 646	1 404	1 499	1 658
5	DR Congo	3 927	5 037	7 165	11 781	10 737
6	Egypt	1 042	1 318	1 412	1 216	1 134
7	Ethiopia	4 090	4 632	5 193	4 787	4 698
8	India	456 000	473 658	367 143	260 063	161 457
9	Indonesia	12 638	12 377	14 641	16 549	19 695
10	Madagascar	740	5 482	5 104	3 710	2 709
11	Mozambique	1 930	5 830	5 907	4 266	5 371
12	Myanmar	12 018	7 386	3 808	3 748	3 571
13	Nepal	6 152	13 830	8 046	6 958	6 150
14	Nigeria	4 381	5 078	4 799	5 276	5 024
15	Philippines	3 442	2 479	2 397	2 254	3 130
16	Sri Lanka	944	2 214	1 925	1 995	1 924
17	United Republic of Tanzania	2 731	6 497	5 279	5 190	4 237
	Total (%)	555 307 (94%)	599 945 (97%)	495 074 (96%)	389 027 (95%)	279 664 (94%)
	Total Global	590 933	620 638	514 718	407 791	296 499

The profile of newly detected cases observed in the various countries in each of the WHO Regions is shown in Table 5: Countries in all regions are reporting a wide range of MB proportion among the newly detected cases. In the African Region,

it ranges from 23% in Comoros to 92% in Kenya and in the American Region from 36% in Bolivia to 83% in Cuba. The Eastern Mediterranean Region has a range of 58% in Yemen to 92% in Sudan. The South-East Asia Region is reporting 38% in Bangladesh to 79% in Indonesia and the Western Pacific Region is reporting 30% in the Federated States of Micronesia to 94% in the Philippines. It is recognized that these statistics reflect changes in criteria, and can not be compared with past data.

The female proportion among the newly detected cases in the African Region ranges from 21% in Chad to 60% in the Central African Republic. In the American Region it ranges from 34% in Venezuela to 50% in the Dominican Republic, in the South-East Asia Region, from 21% in Timor-Leste to 42% in Bangladesh, in the Eastern Mediterranean Region, from 28% in Sudan to 39% in Pakistan and in the Western Pacific Region, from 28% in Cambodia to 36% in the Federated States of Micronesia. The extent to which this reflects differences in case ascertainment is unclear.

Table 5. Profile of newly detected cases reported by countries (reporting 100 or more new cases) in the various WHO Regions

WHO Regions	MB Proportion range (%)	Female Proportion range (%)	Child Proportion range (%)	Grade 2 Disabilities Proportion range (%)
African	Comoros: 22.6 Kenya: 92.4	Chad: 21 CAR: 59.9	Kenya: 3.2 Comoros: 39.1	Comoros: 3 Benin: 21.7
Americas	Bolivia: 36.0 Cuba: 83.2	Venezuela: 34 Dom. Rep: 50.3	Argentina: 1 Dom. Rep: 16	Argentina: 1.7 Mexico: 11.1
South-East Asia	Bangladesh 38.3 Indonesia: 79.4	Timor-Leste: 21.2 Bangladesh: 42.1	Thailand: 5.0 Sri Lanka: 10.5	India: 1.9 Timor-Leste: 21.2
Eastern Mediterranean	Yemen: 58.5 Sudan: 92.1	Sudan: 28.1 Pakistan: 38.8	Sudan: 4.1 Yemen: 10.9	Egypt: 2.7 Pakistan: 20
Western Pacific	FSM: 29.6 Philippines: 94.3	Cambodia: 28.2 FSM: 36.2	China: 2.1 FSM: 32.3	FSM: 0.8 China: 21.3

CAR= Central African Republic; Dom. Rep= Dominican Republic; FSM= Federated States of Micronesia

A wide variation is seen regarding the child proportion among newly detected cases especially in the African, American and Western Pacific Regions. The child

proportion in the African Region ranges from 3% in Kenya to 39% in Comoros and in the American Region from 1% in Argentina to 16% in the Dominican Republic. In the Western Pacific Region it ranges from 2.1% in China to 32% in the Federated States of Micronesia. However, less variation was observed in the South-East Asia and Eastern Mediterranean Regions with Thailand reporting 5%, Sri Lanka 11%, Pakistan 4% and Yemen 11%.

Similarly, the grade 2 disabilities among the newly detected cases show a wide variation in all the Regions. In the African Region, it ranges from 3% in Comoros to 21% in Benin and in the American Region from 2% in Argentina to 11% in Mexico. In the South-East Asia Region, it varies from 2% in India to 21% in Timor Leste. In the Western Pacific Region, Federated States of Micronesia is reporting 1% grade 2 disabilities among new cases and China 21%.

TAG reviewed the figures based on data reported by countries to WHO. A number of issues were identified which need further analysis, particularly disparities between new case detection and registered prevalence, and large changes in the number of cases detected from year to year in some countries. The data were more likely to reflect operational factors rather than the underlying epidemiological situation. TAG recommended that a more detailed analysis of these data, along with any validation studies, should be presented and discussed at the next TAG meeting.

5. Uniform Multidrug Therapy (U-MDT) regimen for all types of leprosy patients: *Progress report*

A uniform MDT regimen multicentric study is being conducted to assess the effectiveness of 6-month MDT for multibacillary leprosy for all types of leprosy patients through the general health services. During follow-up, patients are closely monitored for clinical response and for any complications. The long-term follow-up for assessing the effectiveness of the U-MDT study is the cumulative relapse rate at the end of five years after completion of the treatment.

The total number of patients enrolled as of April 2006 was 2,507. Of these, 2,106 patients (84%) have completed the treatment phase. It is observed that patients opted and accepted U-MDT regimen in all the participating centres. There were no

difficulties with respect to pigmentation due to addition of clofazamine for paucibacillary (PB) patients. Baseline characteristics were analysed for all patients. MB proportion was 41% (n=1 017) and the proportion with WHO Grade-2 disabilities was 4% (n=92). In total, 111 (4%) patients reported special events. Status of skin lesions was assessed as “cured” in 418 (22%) of 1,879 patients who completed the U-MDT regimen and in 513 (54%) of 944 patients who had completed one-year follow-up after completion of U-MDT regimen. Encouraging results were observed regarding the effectiveness of U-MDT regimen even for MB patients.

At present the study is faced with challenges relating to funding, time-scale and in recruiting a sufficient number of patients to reach the required sample size. It is suggested that some of the current participating centres may increase intake of patients for the study. There is a possibility that centres from other endemic countries may join the study.

6. Clinical trials for treatment of PB leprosy patients with single dose of rifampicin, ofloxacin and minocycline (ROM)

Final report

These WHO-sponsored trials address two issues: (i) Effectiveness of single dose ROM in paucibacillary leprosy patients with two to five skin lesions carried out in India as a randomized double-blind trial, and (ii) Relapse rates in single-lesion paucibacillary leprosy cases treated with single dose ROM.

(i) Effectiveness of single dose ROM in paucibacillary leprosy patients with 2-5 skin lesions

The study was carried out in India to evaluate the effectiveness of single-dose ROM compared to standard, six-monthly doses of MDT regimen for PB leprosy patients with two to five skin lesions, under programme conditions. PB leprosy cases that were smear-negative presenting with two to five lesions were included in the study. These patients were recruited from five centres in India. All patients were treated for six months, with appropriate pre-coded drugs and identical looking placebo. The

primary outcome was complete clearance of skin lesions. The initial plan was for six months each for intake and treatment phase followed by periodic post-treatment assessments for 36 months. The post-treatment follow-up period was extended for another 12 months in two centres that recruited the majority of the patients in this study. Data were analysed for these two centres with multivariate longitudinal regression analysis using Generalized Estimating Equations (GEE).

A total of 1,082 paucibacillary (PB) cases were randomly allocated to ROM (n= 539) or WHO PB-MDT (n= 543). Baseline characteristics were similar at intake. The total number of patients at the final follow-up was 468 (87%) in the ROM group and 477 (88%) in the WHO PB-MDT group. Complete clearance was observed in 71% (332 out of 468) in the ROM group and 75% of (358 out of 477) in the WHO PB-MDT group. Relapse rate was more than two times higher among patients treated with ROM as compared to WHO PB-MDT (Rate ratio: 2.31; 95% Confidence Interval 1.00-5.35). GEE analysis indicated that patients' age and time of follow-up were statistically significant after adjustment for factors included in the model. The clinical score was not statistically significant between the two treatment groups (Model coefficient: -0.045; 95% CI: -0.27-0.17)

(ii) Relapse rates in single-lesion paucibacillary leprosy cases treated with single-dose ROM

The objective of the study was to evaluate the effectiveness of ROM for the treatment of skin smear negative single-lesion PB leprosy patients and to determine the occurrence of relapses over a period of 54 months.

Four leprosy control units in the Chittoor and Cuddapah districts of Andhra Pradesh were selected for this trial. PB leprosy patients with only a single lesion who were untreated were enrolled for this study. Patients were examined at the time of intake, and then every six months from the date of inclusion. The rate of relapse was calculated using survival analysis.

A total of 1,262 patients were enrolled for this study out of which 35% (n=440) were children and 49% (n=619) were males. The study observed 126 special events. These were suspected relapse patients (n=19), confirmed relapse patients (n=7), migrations (n=84), deaths unrelated to leprosy (n=22) and misclassification (n=1). At the end of 54 months, 88% (n=988) patients had complete clearance of skin lesions. The improvement and deterioration scores of patients show that 0.1% had deterioration compared to their clinical status at intake, 2% had static clinical condition and the rest showed varying degrees of improvement. The incidence rate of suspected relapse was 3 per 1000 person- years.

7. Review of the Operational Guidelines

The Global Strategy for further reducing the leprosy burden and sustaining leprosy control activities (2006 – 2010) has been widely welcomed and endorsed. The overall goal is to provide access to quality leprosy services for all affected communities following the principles of equity and social justice. The purpose of the Operational Guidelines is to help managers of national health services to implement the new Global Strategy in their own countries. This will be done as they develop detailed policies applicable to their own situation, and revise their National Manual for Leprosy Control.

Leprosy services are being integrated into the general health services throughout the world; a new emphasis is given here to the need for an effective referral system, as part of an integrated programme. Good communication between all involved in the management of a person with leprosy or leprosy-related complications is essential. These Guidelines should help managers to choose which activities can be carried out at the primary health care level and for which aspects of care patients will have to be referred. This will depend on the nature of the complication and the capacity of the health workers to provide appropriate care at different levels of the health system.

The promotion of self-reporting is now crucial to case detection, as case-finding campaigns become less and less cost-effective. It is important to identify and remove barriers that may prevent new cases from seeking treatment. The procedures for establishing the diagnosis of leprosy remain firmly linked to the cardinal signs of the

disease, but the accuracy of diagnosis must be monitored. The Guidelines call for a greater emphasis on the assessment of disability at diagnosis, so that those at particular risk can be recognized and managed appropriately.

The treatment of leprosy with MDT has been a continuing success; neither relapse nor drug-resistance are significant problems and the regimens are well-tolerated. Clear procedures are given for managing irregular treatment with MDT. Leprosy reactions are a serious complication affecting some patients. The Guidelines address this topic, with additional references under Further Reading. A key decision for programme managers is to determine how and at which level of the health system leprosy reactions are to be managed. Different countries must develop their own detailed guidelines on this issue.

Prevention of disability (POD) is also described in some detail as there is a need for much greater coverage with basic POD activities. This is an important component of 'quality leprosy services' emphasized in the Global Strategy. Items mentioned under Further Reading will be essential for programmes planning to build capacity and increase their service provision in this area.

Rehabilitation may include a medical component (such as reconstructive surgery) but its scope is much broader. It is likely that some people affected by leprosy would benefit from socio-economic rehabilitation (for example, vocational training or a small loan). Staff in the health services need to be familiar with what is being done in the locality, and know how and where to refer people who need these services.

Recording and reporting are essential to maintain quality in any programme. The indicators selected in the Global Strategy are useful for monitoring and evaluation, and they determine which data must be recorded. The data needed to monitor POD activities have not been collected routinely in the past, so this represents a significant change – national managers must therefore decide for themselves which indicators will be used to ensure quality as these will vary from country to country.

Programme management is a broad subject; the topics covered in this Section are those that are central to the running of integrated leprosy control services, including supervision, supply of MDT, partnerships, training and programme evaluation.

8. Areas of collaboration and joint activities with WHO and ILEP

Endorsement of the Operational Guidelines

The Chair of ILEP's Technical Commission commented that he had found the Global Forum discussions on the Operational Guidelines constructive and positive. The Commission appreciated that all the recommendations included in the Guidelines were evidence-based. It was understood that the Guidelines represented a consensus document and that some members of the ILEP's Technical Commission might have prepared them in a different way. It was also emphasised that the Guidelines are not to be considered a textbook, but a tool for programme managers to implement the Global Strategy 2006 - 2010, and that it is important that both ILEP and WHO proactively support the Guidelines.

Coordination of data collection

It was agreed that ILEP and WHO will coordinate their data collection in the future and that programme managers will not be required to provide separate data for WHO and ILEP. However, in special situations, individual ILEP members may still request such data for their own purposes.

South-East Asia Regional Inter-Country Meeting, Bangkok, Thailand

The General Secretary of ILEP reported that their delegation will attend the meeting and promote the Global Strategy and Operational Guidelines. ILEP members active in the Region will be encouraged to send delegates.

WHO AFRO Meeting, Maputo, Mozambique

ILEP agreed to support the meeting on a collaborative and participatory basis and suggested that the new Operational Guidelines should be a major focus of the meeting. It is expected that several ILEP members working in the African Region will participate in this meeting.

9. Rifampicin-resistant leprosy: A challenge that should not be ignored

The MDT regimens for both PB and MB leprosy contain rifampicin. Compared with other components of MDT, i.e. dapson and clofazimine, rifampicin being far more bactericidal against *M. leprae*, is the backbone of the MDT regimens. Emergence of rifampicin resistance strain and its dissemination would pose a serious threat to leprosy control efforts.

Currently, in addition to the standard mouse footpad technique, new PCR-based DNA sequence analysis of the *rpoB* gene represents a rapid and reliable tool to identify rifampicin resistant *M. leprae*.

Although there are no reports of rifampicin resistant leprosy among patients treated with MDT, there is a potential risk that emergence of resistance may not be detected if appropriate protocols and procedures for surveillance are not established. Therefore, it is important that a global surveillance network be established for early detection of any possible emergence of rifampicin-resistant leprosy. At the same time, research on new chemotherapeutic agents should be promoted to manage leprosy patients who cannot be treated with rifampicin containing MDT regimens.

10. Verification of elimination of leprosy as a public health problem at the national level

The conclusions and recommendations of previous TAG meetings in 2001, 2002, and 2003 were reviewed including the sub-group on monitoring and elimination of leprosy. TAG members discussed the issue of verification of elimination during the meeting and concluded that it was not advisable to undertake such an exercise in endemic countries. Verification of elimination of leprosy as a public health problem at a point in time is not justified as the outcome of this exercise will not lead to a change in the basic strategy as in the case of verification of disease eradication. Current epidemiological trends show that new cases will continue to be detected for several years though the trend may be declining in some countries. The TAG recommended that all endemic countries should now focus on sustaining quality leprosy control services.

11. Conclusions and recommendations

1. TAG endorses the Operational Guidelines and appreciates the efforts of the national programme managers and various partners and experts in developing them.
2. TAG recognizes that the Operational Guidelines will be an additional tool for the national programme managers to facilitate operationalization of their own national strategies in the context of the Global Strategy. TAG emphasized the important role of the WHO Regional Offices and various partners in facilitating the wider dissemination of the guidelines and promoting their use.
3. TAG appreciates that while significant progress has been made in leprosy control in most countries, many still have a significant burden and even more face big challenges to ensure sustaining good quality care for all people affected by leprosy.
4. TAG acknowledges the progress made in strengthening collaboration between WHO and its partners in supporting national programmes.
5. TAG recognises the number of important research developments in leprosy. These developments should be reviewed at the next TAG meeting in order to consider their implications for the global programme.
6. TAG appreciates the potential threat posed to leprosy control by the emergence of rifampicin-resistant leprosy and the importance of keeping the subject on the agenda and continuing to sustain the search for appropriate solutions through research.
7. TAG acknowledges that the results from the single-dose ROM study for PB leprosy are very promising.
8. TAG considers the Uniform MDT study for all leprosy cases as highly relevant for integrated leprosy control programmes. However, constraints in terms of funding, time-scale and number of patients to be recruited for the

study remain. TAG encourages the participating centres to make efforts to increase the intake of subjects into the study so that the required sample size is obtained.

9. TAG reviewed the conclusions and recommendations of previous meetings and the sub-group on monitoring and elimination held in 2001, 2002, and 2003. The group concluded that the previous recommendations that certification of elimination at national level in leprosy was not relevant remained valid. Also, the very low prevalence and non-random distribution made it methodologically challenging. The additional resources required to undertake such exercises may not be cost effective.
10. TAG considers that although registered prevalence was a useful indicator to achieve the leprosy elimination milestone, it is not an adequate indicator to reflect changes in the epidemiological trend of leprosy. Therefore, the new case detection rate should be reported for monitoring leprosy trends.
11. TAG acknowledges that the completeness and the quality of statistics on leprosy collected on an annual basis need to be improved and maintained. A more detailed analysis of global data on leprosy is to be presented at the next TAG meeting.
12. TAG appreciates the contribution by the University of Aberdeen in organizing and hosting these meetings.

Annex 1**Terms of Reference of the WHO Technical Advisory Group on Leprosy Control**

The WHO Technical Advisory Group on Leprosy Control is composed of experts who are independent of WHO. Members are chosen for their expertise in leprosy and programme management with particular reference to public health, epidemiology, community mobilization and advocacy, operational research, and disability prevention. They form a strong team with a good technical balance and geographical representation.

The members of this advisory body are selected and appointed by WHO and meet at least once a year. The period of membership is two years, with the possibility of extension.

The Technical Advisory Group's deliberations are open to representatives of national and international partners as observers to encourage open debate.

In addition, the Group may invite, as necessary, representatives from selected leprosy endemic countries and other experts to its meetings.

The terms of reference are:

- To review and monitor the implementation of the Global Strategy to further reduce the leprosy burden and sustain leprosy control activities.
- To advise WHO on new strategies and approaches if necessary.
- To monitor progress in further reducing the leprosy burden.
- To give technical advice and guidance on sustaining leprosy control activities.
- To identify and facilitate implementation of a research agenda in order to improve the quality of leprosy control activities, including prevention of disabilities and rehabilitation.
- To support efforts related to reducing stigma and discrimination against individuals and families affected by leprosy.

- 12:00-12:30 Areas of collaboration and joint activities with ILEP and WHO
(Professor Smith & Dr Feenstra)
- 12:30-14:00 *Lunch break*
- 14:00-14:30 Rifampicin-resistant leprosy: A challenge that should not be
ignored *(Professor Baohong Ji)*
- 14:30-15:30 Uniform MDT regimen for all types of leprosy patients: Progress
report *(Professor M.D. Gupte)*
- Clinical trial on “Treatment of paucibacillary patients with single dose
of ROM” *(Professor M.D. Gupte)*
- 15:30-16:00 *Coffee break*
- 16:00-17:00 Discussion on issues relating to verifying elimination at the
national level *(Professor Smith & Prof Gupte)*
- 17:00-17:30 Conclusions and recommendations
- 17:30 Closing

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