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ORGANISATION MONDIALE DE LA SANTÉ

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BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

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DISCUSSION GROUP REPORTS ON LEPROSY

Monday, 9 September at 2.30 p.m.

CONTENTS

ORIGINAL: FRENCH

REPORT OF GROUP I

The members of this group are -

Dr. Le van Khai (Viet Nam) Chairman
Dr. Ber Keng Hean (Cambodia)
Dr. Phav Sany (Cambodia)
Medecin-Colonel H.Demange (France) Rapporteur
Dr. Thongphet Phetsiriseng (Laos)
Dr. Phony Phoutthasak (Laos)
Dr. G.M.Thomson (UK)
Dr. Tran van Bang (Viet Nam)
Dr. Nguyen Tang Nguyen (Viet Nam)
Miss C. del Rosario (IUHEP)
Dr. Thos. C. Lonie (SPC)
Sir Alexander MacFarquhar (TAB)
Dr. Harmen (Hong Kong)
Dr. M. Giaquinto (WHO)
Mr. L. Keyes (WHO)

The members of Group I explained how the control of leprosy in their respective countries was envisaged and implemented. Following this discussion the items mentioned below emerged as starting points for leprosy control measures:-

1 Treatment

(a) An overall epidemiological survey leading to early case finding.

(b) Quick implementation of chemotherapy.

(c) Mass treatment at a dispensary or at the homes of non-isolated cases.

2 Preventive Treatment

(a) Temporary and selective isolation

(b) Health education of the public

3 Rehabilitation Programme

(a) Development of measures facilitating the physical and social rehabilitation of the leper.

(b) Revision of leprosy legislation

4 The members of the Group wish to make the following suggestions to the Regional Committee -

(a) WHO should intervene with the UNO to draw its attention to the importance of the social problems arising from leprosy control and the advantage of tackling them at the same time as campaigns sponsored by international assistance.

(b) WHO should provide information on mass treatment on the basis of observations already made and proceed with research in order to determine the highest possible degree of sulfonaemia for quick recovery.

(c) Help should be provided for Member States on the training of specialized staff for leprosy control and physical rehabilitation of lepers.

ORIGINAL: ENGLISH

REPORT OF GROUP II

Th members of this group are:-

Dr. W. Glyn Evans (UK) Chairman
Dr. Y. Danvoye (Cambodia)
Dr. Y.T. Kuo (China)
Mr. A. Saita (Japan)
Mr. Yu Sun Yun (Korea)
Dr. Jesus A. Nolasco. (Philippines)
Dr. P.W. Dill-Russell (UK)
Dr. Leroy Burney (USA) Rapporteur
Dr. G.C. Dansey-Browning (IAPB)
Dr. Neil D. Fraser (ILA)
Dr. Tsang Fuk Cho (WFUNA)
Dr. T.C. Lau (WFUNA)
Dr. C.Y. Shu (WHO)
Dr. H. Shega (WHO)

The members of Group II highly commended the Leprosy Control Programme of Hong Kong and the institutional programme of Hay Ling Chau, where an ef- f ctive rapport and co-ordination is demonstrated between the control activities of a governmental agency and an institutional service subsidized both by government and voluntary funds. It is apparent this effective relationship is a result, largely, of the stimulating and dedicated leadership of Dr. G. Graham-Cumming and Dr. N.D. Fraser.

1 Objective

The members determined that their objective was to present general principles of leprosy control for the guidance of governments and their staffs.

In the discussions, it was apparent that each country had certain problems and needs peculiar to each, but the comments and recommendations resulting from the discussion present broad administrative guidelines with which all could agree.

2 Control Measures

It was decided to comment upon the following control measures:

2.1 Case finding

2.2 Organization of treatment

(a) Out - patient

(b) In - patient

2.3 Rehabilitation of patients

(a) During treatment

(b) In his community

2.4 Health Education

(a) Patient

(b) Professional

(c) Public

2.5 Training Needs

2.1 Case finding

Members discussed the services in their countries regarding cas finding. Korea mentioned the value of medical clinics. In the Philippines, mobil clinics are used in areas of high incidence, especially for visiting towns and schools.

Many members mentioned the importance of follow-up of contacts of known cases.

Recommendations:

The following procedures were recommended, in order of priority, as having the greatest effectiveness in case finding:

(a) Follow-up of contacts of known cases;

(b) as an adjunct to regular services, such as B.C.G. and venereal diseas ;

and (c) the use of clinic visits for other purposes as a method of screening and case finding.

2.2 Organization of treatment

(a) The sulphones have made it possible to conduct treatment of milder or controllable cases on an out-patient basis. This keeps the patient in his community and decreases rehabilitation problems.

(b) Institutional care, in most of the world, is the exception rather than the rule. However, economic factors rather than available treatment most often determine type of care given.

It was generally agreed that correct thinking demands an open door to non-institutional, yet controlled, treatment, as a natural constructive development.

It was suggested that -

(i) Compulsory segregation hides cases.

(ii) Leprosy should be part of communicable disease regulations giving local health authorities power to act in individual cases.

2.3 Rehabilitation of Patients

This includes physical, mental and vocational aspects, which begin in the institution and is continued upon return to the community.

The question of acceptance upon return home is an important problem. The longer the stay in hospital, the more difficult is rehabilitation.

Centres for the physically handicapped were suggested where the leprosy patient could be treated together with other disabled persons so as to minimize the stigma.

Health officials were urged to use voluntary groups to assist in other problems and it was further agreed that governments should assume leadership in employment of leprous and other handicapped patients. The possibility of resettlement of lepers on the land was suggested, where they could contribute to their own welfare and remain productive.

2.4 Health Education

It was agreed that there is a need for all health personnel to be alert and knowledgeable, in order to assume their proper role of leadership.

2.5 Training Needs

Recommendations:

(a) Greater training for medical students in leprosy in those countries where the problem is serious.

(b) Public health schools should add training in leprosy to their curricula.

(c) Each country with a real problem of leprosy should provide training courses for physicians, public health nurses, midwives and other ancillary health personnel, preferably in conjunction with a medical school.

(d) WHO should establish at intervals a training course, where patients are readily available, for those health personnel concerned with the treatment and control of leprosy, including, but not limited to, such activities as occupational therapy and orthopaedic rehabilitation.

ORIGINAL :ENGLISH

REPORT OF GROUP III

The members of this group are:-

Dr. L.J. Clapham (UK) Chairman
Dr. H.E. Downes (Australia)
Dr. Wu Ching (China)
Dr. M. Yamaguchi (Japan)
Dr. Mohamed Din bin Ahmad (Malaya) Rapporteur
Dr. J. Paiva Martins (Portugal)
Dr. G. Graham-Cumming (UK)
Miss Mary Chow (ICW)
Mrs. D.C.C. Trench (LRCS)
Dr. Wong (Hay Ling Chau Leprosarium, Hong Kong)
Dr. E. Campbell (ICA)
Dr. L.O. Roberts (WHO)

This group, after deciding to limit the discussions to the public health angle and control of leprosy by health officers, spent some time in obtaining the views of the members as to the existing practice of leprosy control in their respective countries.

It immediately became apparent that greatly divergent opinions on the methods of control are now prevalent in this Region.

1 It was noted that:-

(a) Segregation.

This varied from the most rigid compulsory segregation to that of almost no segregation. In the former instances there seems little likelihood of any early relaxation of this policy. However, certain countries are preparing to revert to non-segregation in view of improved current treatment as well as reduction in costs.

(b) Notification of cases.

A marked variation was again a feature, ranging from compulsory

notification to none at all. Even where notification is compulsory by law it is not possible to enforce it.

(c) Case Finding.

(i) General individual practitioners contributed little.

(ii) Self-diagnosis by patients on themselves, relatives and friends was prominent.

(iii) Health visitors tracing contacts claimed some success.

(iv) Special survey teams had been utilised to look for leprosy.

(d) Leprosaria.

In general they appeared to work on similar lines to Hay Ling Chau Leprosarium. Whilst certain governments financially supported their own leprosaria, voluntary organizations assisted considerably in others.

(e) Prevention.

There has been insufficient experience as yet as to whether BCG is protective against leprosy and whether protective sulphetrone is of any value.

2 Furthermore -

(a) many members are of the opinion that ignorance and fear have formed a strong barrier against the control of leprosy;

(b) many believe, too, that there has been a marked fall in the incidence of leprosy in certain modern countries throughout the years, which could perhaps be attributed to better living conditions, improved sanitation and good nutrition. A contrary view is upheld by one or two members.

3 After some discussion this group agreed:-

(a) that the ideal public health measure would be to take the infective case out of the community without offence or fear;

(b) that more research would be required to determine when a case could be considered infective. (A case may be infectious even before any signs appear);

(c) that the control of leprosy should be centralized at the national level in a country;

(d) that it was satisfactory to treat non-infectious cases in out-patient departments and that in certain countries it was an economic necessity to do so;

(e) that there might be an advantage in the injection of sulphones as opposed to tablets by mouth for reasons of economy, blood levels and less frequent attendances;

(f) that the follow-up of cases should continue throughout the patient's life - less often in later years;

(g) that the education of the patient and the public, particularly school children, should be encouraged;

(h) that it was desirable to find an effective prophylactic because of the universally accepted desire to protect children.

4 The group noted, too, that some very interesting work on leprosy appeared to have been undertaken outside the Western Pacific Region and it was suggested that an inter-regional seminar, with particular emphasis on the public health aspects of leprosy, could be beneficial to all concerned.

ORIGINAL: ENGLISH

REPORT OF GROUP IV

The members of this group are:-

Dr. R.K.C. Lee (USA) Chairman
Dr. C.H. Yen (China)
Medecin-Colonel M. Demange (France)
Dr. J. Bierdrager (Netherlands)
Dr. Antonio Ejercito (PI)
Dr. M. Doraisingham (UK) Rapporteur
Dr. P.H. Teng (UK)
Dr. Walter C. Allwright (IDF)
Dr. Marie Hui-hsi Feng (MWIA)
Mr. Brian Jones (UNICEF)
Dr. Eugene Campbell (US-ICA)
Dr. H.P.L. Ozorio (WFSA)
Professor F.E. Stock (WMA)
Dr. J.N. Rodriguez (PI)
Dr. O.K. Skinsnes (HK University)

The grouping comprising 15 persons met under the chairmanship of Dr. R.K.C. Lee. Dr. M. Doraisingham was designated to be Rapporteur.

The group at the outset realized that demands and conditions must vary from one place to another by reason of the nature of the terrain, the availability or otherwise of adequate medical and social services and the differing social and cultural patterns. It agreed to concentrate on the theme of Control as opposed to eradication, or curative measures.

The main headings under which the problem was discussed were as follows:-

1 Case finding

Among the numerous measures possible, the group listed the following as the more important for this Region:-

(i) Examination of family contacts.

(ii) Examination of organized groups particularly school children.

(iii) Where static (fixed) centres do not exist, travelling or mobile clinics should be provided.

(iv) Where by reason of many known cases, an area is thought to be highly endemic, surveys should be carried out with a view to case finding.

(v) The cooperation and support of the G.P., in order to assist in the case finding programme, should be enlisted and to further this medical education in Leprosy should form an essential part of the curriculum.

(vi) The case finding potential of other medical institutions such as clinics, O.P. services and hospitals should receive attention.

(vii) The education of the public and through it, the leprosy patient, that the disease is curable, would encourage sufferers to report for treatment more readily.

2 Case Holding

(i) It should not rest on the idea of compulsion except in places where eradication is possible.

(ii) Emphasis should be on domiciliary or out-patient services.

(iii) Institutions for those needing hospital treatment should be provided.

(iv) In suitable areas the creation of settlements and villages would be an additional advantage, and may even be necessary.

(v) Persons disabled on account of leprosy, but declared cured or arrested, and requiring care, should be admitted to institutions for the disabled (as a whole).

(vi) Babies of leprous mothers should be separated and where possible fostered.

3 Mass Treatments as an instrument of Public Health

(i) As far as possible, it should be on a voluntary basis.

(ii) Treatment must be sustained, regular and adequate with a sufficient concentration of the drug in the blood.

(iii) Health visiting is essential in order to persuade patients to continue regular treatment. If such staff is inadequate, it should be increased.

4 Health Education

There is great need to provide Health Education of the public, the patient and the profession on a sustained and repetitive basis. The Public should be taught to accept leprosy as it does almost all other diseases. The group emphasized the importance of this item and recommended that it be pursued vigorously. Furthermore, it should be remembered that leprosy is only one ailment to which humanity is subject.

5 Legislation

The group is of the opinion that since there is adequate legislative cover in most countries, there is little or no need for new legislation.