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Meeting of National Programme Managers for Leprosy Elimination

*Report of the Intercountry Meeting
Colombo, 19-21 November 2002*

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1. INTRODUCTION

1.1 Background

By the middle of 2002, the WHO South-East Asia Region (SEAR) was the only Region where the prevalence of leprosy was above 1 per 10,000 population. Currently, it accounts for 78% of the global caseload, with three countries – India, Myanmar and Nepal yet to attain elimination. Though Bangladesh, Bhutan, DPR Korea, Indonesia, Maldives, Sri Lanka and Thailand have reached the elimination goal i.e. prevalence of less than 1 case per 10,000 population at the national level, programmes need strengthening in order to attain the elimination goal at the sub-national level i.e. province and district levels.

More than 10 million persons have been cured of leprosy using multidrug therapy (MDT) since its inception in 1985. The prevalence of leprosy has shown a remarkable 92% reduction. The commitment to implement the Final Push Strategies to achieve the goal of elimination in the three remaining endemic countries by the end of 2005 needs to be reaffirmed. The progress of integration of MDT services into general health services and the simplified information system as recommended in the previous Programme Managers meeting held in December 2001 at New Delhi need to be followed-up. Furthermore, there is a need for a forum to share country experiences and facilitate learning from each other, recognizing the needs for closer collaboration with partners. With this as the background, the Inter-country Meeting of National Programme Managers for Leprosy Elimination for 2002 was organized in Colombo, Sri Lanka.

Thirty-nine participants from 8 Member Countries including the National Leprosy Programme Managers attended the meeting. India and DPR Korea could not participate. The national programme manager from Timor-Leste attended the meeting for the first time. Representatives from the Sasakawa Memorial Health Foundation, Danish International Development Assistance, The Leprosy Mission International, Damien Foundation, German Leprosy

Relief Association, Amici Di Raoul Follereur and staff from WHO/HQ, Geneva and WHO/SEARO and WR India also participated. Please see list of participants at Annex 1 and the agenda at Annex 2.

1.2 Objectives

The main objective of the meeting was to review activities of the Final Push Strategies for leprosy elimination in Member Countries. The specific objectives were:

- (1) To review the progress of implementation of leprosy elimination in the member countries during 2001-2002.
- (2) To review the progress made towards integration of leprosy elimination into general health services.
- (3) To share experiences both in technical and operational aspects of leprosy elimination with partners to foster cooperation and coordination in partnership towards the elimination goal.

2. OPENING SESSION

Dr Kan Tun, WHO Representative to Sri Lanka opened the meeting and read out the message of Dr Uton Muchtar Rafei, WHO Regional Director for South-East Asia. In his message, Dr Uton called for higher priority for the leprosy elimination programme. He said that it is commendable that seven of the Region's ten countries had achieved the goal of leprosy elimination at the national level; and that Myanmar, Nepal and India are expected to reach the goal by 2005. To ensure this, leprosy elimination efforts would have to be intensified to find untreated cases, and to fully integrate leprosy treatment into the general health system. He also called on the health system to ensure that all patients suffering from the disease have access to early diagnosis and prompt treatment with MDT, and can be cured without any residual deformity. Dr Uton acknowledged the key role played by the Nippon Foundation who continued to fund the programme, and the Novartis Foundation for Sustainable Development, for donating the MDT drugs to all Member Countries through WHO. He also noted with gratitude the important role of the World Bank, DANIDA/DANLEP and other national and international voluntary organizations in leprosy elimination programme.

Dr Derek Lobo, STP-CEE WHO SEARO, read out the message of Dr David L Heymann, Executive Director, CDS, WHO HQ. In his message, Dr Heymann cautioned against complacency in the wake of the landmark achievements made by countries thus far. He said that the task of eliminating leprosy remained unfinished, particularly in the six most endemic countries (of which three are in the South-East Asia Region), where the prevalence rate is still four times higher than the target. The challenge was to reach the remaining cases, which are typically in areas which are difficult to access geographically, are inadequately covered by health facilities and are plagued by other, more urgent public health problems. Dr Heymann urged the National Programme Officers to define ways to implement key activities in line with the field realities. He added, "To reach the elimination target by 2005, we have to continue to go all out and implement the focused strategy over the next few years. This means that we need to move and to move fast."

Mr P Dayaratne, Hon'ble Minister of Health, Nutrition and Welfare, Sri Lanka, in his inaugural address said that Sri Lanka had made tremendous progress in leprosy elimination, having achieved the elimination goal at the national level by 1995. Today, all health institutions in the country had adequate stocks of MDT blister calendar packs; more than 70% of medical officers had been trained on management of leprosy prior to integration, and forms and registers were simplified in preparation of integration. By 2003, MDT services will be completely integrated with the general health services. He, however, cautioned that in five of the country's 25 districts, prevalence of leprosy was between 1 and 2 per 10,000 population. The challenge was to ensure that leprosy elimination activities were strengthened.

Dr Yo Yuasa, Executive & Medical Director, Sasakawa Memorial Health Foundation, appreciated the progress made and assured continued support to WHO/SEAR to intensify leprosy elimination efforts.

Dr WA Sunil Settinayake, Director, Anti-Leprosy Campaign, Sri Lanka, was elected as Chairman, Dr Jaya Prasad Baral, Director, Leprosy Control Division, Nepal as Vice Chairman and Mr Kaka Tshering, Programme Officer from Bhutan, as Rapporteur for the meeting.

3 TECHNICAL PRESENTATIONS

3.1 Elimination of Leprosy as a Public Health Problem: Current Status and Challenges Ahead – Dr Denis Daumerie, Group Leader, Leprosy Unit, WHO/HQ

The World Health Assembly (WHA), in 1991 called for the “elimination of leprosy as a public health problem by the year 2000”, defining elimination as attaining a level of prevalence below 1 case per 10,000 population. Among the 122 countries where the disease was considered endemic in 1985, 108 achieved the goal of elimination at the national level. Fourteen countries have not been able to reach the target including India, Myanmar and Nepal. The delay in access to and low coverage of MDT treatment in the high endemic countries, operational factors and the existence of vertical structures are some of the reasons for a few countries to have missed meeting the elimination deadline by 2000. WHO will continue working intensively with GAEL partners, ministries of health, national programmes, and nongovernmental organizations to ensure that the diagnosis and treatment of leprosy becomes an integral part of the national primary health care system.

Major Achievements

- By the beginning of 2002, more than 12 million cases had been cured;
- Among newly detected cases, 17% are children (below the age of 15), 39% are MB based on the clinical classification (more than 5 skin lesions), 9% are single skin lesion leprosy and 4% present grade II disability at the time of diagnosis;
- The number of relapses is low, at less than one case per 1000/ patient per year;
- No drug resistance following MDT has been reported;
- The number of countries showing prevalence rates above 1 per 10,000 population has been reduced from 122 in 1985 to 14 at the end of 2001;
- There are fewer uncovered areas, including those which are difficult to access or contain refugee populations, though this remains problematic;
- Gender imbalance has decreased significantly;
- An increasing number of countries are requesting WHO for free supply of MDT drugs;

- At the beginning of 2002, the number of registered leprosy patients was nearly 635,000, as reported by 106 countries. About 760,000 new cases were detected during 2001. Global detection increased in 2001 compared to 2000, mainly because of a significant increase in detection in India; and
- In 2000, 115 countries reported 677,180 new cases with classifications, of which 261,713 (39%) were MB, 352,347 (32%) PB, 61,091 single lesion PB (9%) and 29 cases for which classification was unknown. The proportion of MB cases is high in the Eastern Mediterranean, Western Pacific and European regions and particularly low in the South-East Asia Region.

3.2 Leprosy Situation in South-East Asia Region: Problems and Future Needs - Dr Derek Lobo, Regional Focal Point for Leprosy Elimination, WHO/SEARO

The South-East Asia Region is one of the two WHO regions which has not achieved the leprosy elimination goal. The Region contributes 78% of the global registered cases and accounted for 85% of the new cases detected in 2001- the highest among WHO regions.

Seven countries of the Region, namely Bangladesh, Bhutan, DPR Korea Indonesia, Maldives, Sri Lanka and Thailand, achieved the elimination of leprosy as a public health problem at the national level, before the target date of 31 December 2000. These countries have to progress towards achieving sub-national (district) level elimination. In addition, some of these countries continue to have areas with prevalence above 1/10,000 population and therefore need assistance to attain elimination in these areas.

Table 1: Number of Registered Leprosy Cases and Prevalence Rate in Countries of South-East Asia Region in 2002

Country	Population (in '000)	Number of registered cases	Prevalence rate per 10,000	Data as on
Bangladesh	129,248	8,006	0.62	June 2002
Bhutan	659	35	0.53	June 2002
India	1,047,042	439,782	4.20	April 2002

Indonesia	209,102	16,180	0.77	October 2002
Maldives	270	17	0.63	November 2002
Myanmar	51,293	6,411	1.25	July 2002
Nepal	24,154	10,657	4.41	July 2002
Sri Lanka	19,123	1,578	0.83	January 2002
Thailand	61,879	2,081	0.34	October 2002
Timor-Leste	849	337	3.97	November 2002
Total all countries	1,543,619	485,084	3.14	
Total all countries excluding India	496,577	45,302	0.91	

Main Problems

- (1) The consistently high case detection rates in some countries, particularly in India are a serious concern. A careful analysis of new case detection trends in India, Nepal and some areas in Bangladesh, suggest that the following Operational Factors could be contributing to high detections:
 - (a) Setting of case detection targets at all levels and incentives or awards to workers exceeding targets.
 - (b) Reduced accuracy of diagnosis and factor of "over-diagnosis". This could be due to not strictly following the WHO-recommended case definition of leprosy or could be linked to achieving targets or in the case of "vertical" staff, an insecurity of losing their job if elimination is reached.
 - (c) Recycling (re-registration) of cases.
 - (d) Active surveys targeting groups like school children, industrial workers or whole population surveys, which accentuate over-diagnosis and re-registration.
- (2) Need for continued support to areas which have not yet achieved elimination in countries like Bangladesh, Indonesia and Sri Lanka.
- (3) Slow progress of integration of leprosy into the general health services, and decentralization in some countries and some States of India.
- (4) Under-served communities - There are still areas and communities, which remain underserved in many endemic countries. Special efforts

and innovative approaches will be needed to provide MDT services to these communities.

- (5) Urban Leprosy Control - Urban leprosy poses a big problem in many countries of the Region, especially in large metros with huge slums and floating populations. Special efforts and approaches are required to successfully achieve elimination goals in urban areas.
- (6) Ensuring high cure rates through patient-friendly drug delivery systems. The MB cure rates in most countries are in the range of 90%, which cannot be considered perfect.
- (7) Establishment of effective supervision, monitoring and evaluation systems. Supervision and monitoring is a weak component in many countries
- (8) Sustaining political commitment and mobilization of resources, especially in countries, which have achieved national level elimination but have to progress towards sub-national elimination.

Areas needing further attention

- (1) Strengthening the capacity of general health services to provide quality leprosy services.
- (2) Capacity building of key groups such as general medical practitioners, medical/nursing/paramedical teaching faculty and students.
- (3) Intensification of IEC, Awareness and Advocacy activities to promote voluntary reporting of cases and integration of cured patients into the community. The key groups to be targeted are local community leaders, religious leaders and the media.
- (4) To identify and involve more partners and strengthen the collaboration and coordination with existing partners.
- (5) To establish mechanisms of validating elimination at national and sub-national levels

3.3 Country Presentations

Nepal

The leprosy situation in Nepal is quite serious with the prevalence rate (PR) at 4.41/10,000 in 2002. A total of 17 out of 75 districts have a PR of over 5 cases/10000. A PR of less than 1 case/10000 was reported in 24 districts. In 2001/2002, a total of 13,830 new cases were detected. Leprosy elimination campaign (LEC) was undertaken in 17 high endemic districts in July 2002.

“Accompanied” MDT should be promoted to improve cure rate in remote areas. Regional and district health services should be strengthened and actively involved in the development of plans of action for leprosy elimination.

Myanmar

The PR at the end of June 2002 was 1.25 /10000. While 9,687 new cases were detected in 2001, the number was 3,701 in 2002. Ten of the 14 States/Divisions have achieved the elimination targets; 4 States/Divisions - Ayeyarwady, Bago, Magway and Sagaing - are yet to achieve elimination. In 2001 and 2002, WHO supported LECs in 151 and 120 Townships respectively.

Updating of registers, LECs in selected townships strengthening of integration, making townships “own” leprosy elimination activities and strengthening monitoring and supervision at township level received high priority in 2002. The country is most likely to achieve the goal of elimination by 2003.

Bhutan

At the end of June 2002, the number of cases under MDT treatment was 35, all MB. The prevalence rate was 0.53/10,000. The country still follows the 24-dose regimen for MB cases. It has requested for a leprosy monitoring exercise to validate leprosy elimination.

Bangladesh

Bangladesh achieved the goal of leprosy elimination at the national level in 1998 and has maintained the status. The deformity grade II (visible deformity) among new cases declined from 21.4% in 1993 to 6.5% at the end of June 2002. The prevalence rate in Dhaka Metro has been increasing due to migration from rural areas. However, 12 out of 64 districts are yet to achieve

the elimination goal. Eight NGOs are supporting the government in providing MDT services in 29 districts.

Indonesia

The PR decreased from 1/10,000 in March 2000 to 0.77/10,000 in October 2002. Attainment of the leprosy elimination goal at national level had created a sense of complacency. Advocacy meetings were planned for political leaders and administrators to seek their support till the goal at province/district level is attained. New case detection rate (NCDR) in 2001 was 6.9/100,000. The disability rate was still high (8.9%) in new cases. MB type leprosy was 76.6 per cent among new cases. Eleven of the 30 provinces and 109 of 330 districts had PR of more than 1/10000. Irian Jaya, Maluku and Sulawesi provinces with high PR were receiving high priority. LECs were undertaken in villages with MB cases and 7,639 new cases were detected during January-September 2002.

Maldives

The country achieved the elimination goal in 1997 and has maintained the status. The number of new cases detected in 2002 from January to October was 17, (4 MB and 13 PB). The programme has been integrated into the primary health care system. IEC activities are being intensified to create awareness on leprosy in the community.

Sri Lanka

The elimination goal was achieved in 1995 and has been maintained. However, it is of some concern that the prevalence rate increased from 0.6 in 2001 to 0.83/10,000 population in January 2002. It would be useful to find out the reasons for the increase. Integration of leprosy elimination activities into the general health services would be completed by the end of 2003.

Thailand

The national PR was 0.34 /10,000 in October 2002. Only one of the 76 provinces had PR of more than 1/10,000. The NCDR declined from 2.1/100,000 population in 1966 to 0.15/100,000 in 2002. The disability rate remains high (13.5%) and the child rate low (5.7%). Sixty per cent of new cases were MB type. A total of 79 of the 926 districts in 25 Provinces had a

PR of more than 1/10000. The third Leprosy Elimination Campaign was planned to coincide with the celebration of His Majesty the King's Birthday on 5th December 2002. Leprosy control has been totally integrated into the general health services. The Leprosy Division was earlier merged with the Rajprachasamasai Institute to provide technical support to general health services.

Timor-Leste

The prevalence rate was high in Oecusse (47.5/10,000) and Dili (5.4/10,000). The country would need a lot of support from WHO to develop and implement the plan of action for leprosy elimination.

Table 2. Number of Registered cases and Prevalence Rate in Timor-Leste as on November 2002

District	Number of registered cases	Prevalence rate/10,000
Aileu	3	0.87
Ainaro	2	4.16
Baucau	28	0.25
Cualima	12	2.30
Dili	75	5.43
Ermera	14	1.51
Maliana	3	0.40
Manatuto	15	3.34
Same	2	0.41
Oecusse	223	47.53
Total	337	4.28

4. SPECIAL PRESENTATIONS

The following special presentations were made:

4.1 Integration of Leprosy Activities into General Health Services

The programme managers of Sri Lanka and Thailand highlighted the genesis, evolution and current status of integration in their respective countries. The issues that emerged from the presentations included: concern on the duties of vertical staff to avoid omission/duplication of required tasks, simplification of recording and reporting system.

Representatives of DANIDA/DANLEP, Sasakawa Memorial Health Foundation, The Leprosy Mission Trust India, Damien Foundation India Trust, Amici Di Raoul Follereur, Damien Foundation, and German Leprosy Relief Association reiterated their support to strengthen and sustain integration.

4.2 Building Partnerships for Leprosy Elimination

The national programme managers of Bangladesh and Myanmar highlighted the role and involvement of various partners supporting the leprosy elimination activities in their countries. In Bangladesh, the Government had executed a Memorandum of Understanding with a group of NGOs through which 29 of the 64 districts were allocated to NGOs for providing leprosy services, in collaboration with the Government. There was also active collaboration with Bangladesh Scouts, the media and religious leaders. In Myanmar, local NGOs, the media and a well-known actress actively supported the national leprosy programme.

4.3 Simplified Information System adopted in India – Dr Tej Walia, Ag. WR India

India had recently adopted a Simplified Information System which consists of a one-page format with information required on only nine essential indicators. The salient features of this user-friendly information system were presented.

4.4 Role of Partners in Leprosy Elimination - Dr C S Walter, ILEP Coordinator for India

NGOs and voluntary organizations have always played a vital role in leprosy control in India. About 290 voluntary organizations including 8 members of ILEP are involved in leprosy work. A national workshop for re-defining the roles and responsibilities of NGOs/VOs in the context of leprosy elimination and integration of leprosy into the general health services was held in July 2002.

4.5 Support of DANLEP for NLEP-India - Dr S K Mohanty, Senior Advisor, DANLEP

DANLEP has decided to phase-out their leprosy elimination activities in India. It supported leprosy elimination activities in Tamil Nadu, Orissa and Madhya Pradesh for more than 15 years, with special emphasis on communication strategies at village level.

5. GROUP WORK

The above WHO, Country and Special Presentations served as the basis for the Group discussions that followed.

The participants were divided into two groups. While Group 1 discussed Case Detection and Achieving High Cure Rates, including Accompanied MDT, Group 2 focused on Acceleration of Elimination and Integration including Strategies for phasing out Vertical Structures.

6. SPECIAL PROGRAMME FOR THE MEDIA

The opportunity was used to organize a special programme for the media, which was coordinated by the SEARO Information Officer.

A separate "Technical Briefing" for the media was also organized, attended by 19 media persons from the print and electronic media from Colombo. In his welcome address WR Sri Lanka emphasized the important role the media can play in supporting leprosy elimination activities and in providing the correct information to the public. This was followed by three presentations on:

- (1) the leprosy situation in the Region – Dr Derek Lobo;

- (2) the leprosy situation Sri Lanka – Dr Sunil Settinayake, National Programme Manager, Leprosy, Sri Lanka; and
- (3) the role of the media in leprosy elimination – Mrs Harsaran Pandey, Information Officer, SEARO

The representatives from the donors – Sasakawa Memorial Health Foundation, Japan, and Novartis Foundation, made statements about their support to the global leprosy elimination programme.

Since most of the media participants were from the local language press, there was limited interaction. However, leprosy received wide publicity for several days and it is hoped the information provided during the technical briefing will help the media to project leprosy in the right perspective.

7. CONCLUSIONS AND RECOMMENDATIONS

The meeting was attended by participants from all the Member Countries (except India and DPR Korea) who shared the progress, current status and plans to strengthen programmes towards leprosy elimination and to sustain the achievements. MDT has clearly emerged a winner in all the countries. The technology and support provided by WHO to the Member Countries and financial support by several donor agencies/NGOs has contributed to the attainment of the goal of leprosy elimination in six Member Countries before 2000. A marked decline in prevalence rates was observed in the remaining three countries - India, Myanmar and Nepal). Intensified efforts on critical activities, especially effective integration of leprosy services into the general health services would continue till the goal is reached in all the countries. The meeting enabled updating of knowledge and sharing of experiences in the march towards the goal of leprosy elimination in the Region. Countries which have attained the goal at the national level, should sustain efforts to achieve the goal at sub-national levels. Based on the inputs provided during technical presentations and the discussions during the group work, the following recommendations emerged.

Recommendations

- (1) It is gratifying to note that all Member countries have endorsed and accepted the policy of integration of leprosy services into the general

health services. However, concrete plans for integration should be formulated and implemented and the process of integration accelerated.

- (2) The plans and processes of integration should include phasing out vertical structures, within a definite time frame.
- (3) It is recognized that "over-diagnosis" and "re-cycling" of cases are responsible for static reporting of a high level of new case detection in the Region. The following measures are recommended to prevent these factors:
 - (a) Case definition laid by WHO should be strictly and uniformly applied by all Member countries.
 - (b) Promotion of self-reporting of cases should continue to receive the highest priority and all active surveys, except family contact survey, should be discouraged.
 - (c) Updating of leprosy registers should form part of routine activity.
 - (d) Leprosy Elimination Campaigns (LECs) should be restricted to only the unreached and the known under-detected areas.
 - (e) Setting of case detection targets should be discontinued.
- (4) Accompanied MDT should be encouraged as a good option to promote high treatment completion and cure rates.
- (5) In order to accelerate the elimination of leprosy as a public health problem in Member countries (at national and sub-national levels), the following activities should receive high priority:
 - (a) 100% MDT coverage and accessibility
 - (b) High treatment completion and cure rates
 - (c) Involvement/Strengthening of partnerships
 - (d) Inclusion of leprosy in the training curricula of all categories of the general health staff.

Annex 1

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STP-LEP

WCO, Sri Lanka

Dr Kan Tun
WHO Representative to Sri Lanka
Dr Lokky Wai
Public Health Administrator

Annex 2 PROGRAMME

Tuesday, 19 November 2002

0745-0815 hours Registration

0830-0900 hours **Agenda Item No.1 - Inaugural Session**

- Opening by Master of Ceremonies
- Welcome Address & RD's Message by WR Sri Lanka
- Address by Director General of Health Services, Sri Lanka
- Address by Health Secretary, Sri Lanka
- Inaugural Address by Hon'ble Minister of Health, Nutrition and Welfare
- Address by *Dr Yo Yuasa*, Executive & Medical Director, SMHF
- Message from *Dr David Heymann*, Executive Director CDS HQ

0900-0930 hours Tea Break

0930-1000 hours **Opening Session**

- Objectives of the Meeting and Introduction of Participants - *Mr Sathian Yovapue*
- Nomination of Chairman, Co-Chairman and Rapporteur - *Mr Sathian Yovapue*

1000-1045 hours **Agenda Item No. 2 - Technical Presentation**

- Global review, strategy and plan of action for leprosy elimination – *Dr Denis Daumerie*, Group Leader LEP HQ
- Regional review, strategy and plan of action for leprosy elimination – *Dr Derek Lobo*, STP-CEE, SEARO

Agenda Item No.3- Country reports on Leprosy Elimination

1045-1155 hours ***Nepal***

- National level – *Dr J P Baral*, Director of Leprosy Control Division (15 minutes)
- Regional level – *Drs Padam B Chand, Saroj P. Rajendra*

- (10 minutes each)
- District level - *Dr Krishna K Rai* and *Mr. Ramesh P Adhikari* (10 minutes each)
 - Discussion on presentations (15 minutes)
- 1155–1310 hours **Myanmar**
- National level – *Dr Zaw Win* (15 minutes)
 - Divisional level – *Drs Kyaw Sein, Tin Aung* (10 minutes each)
 - Township level - *Drs Tun Aung Kyi, Kyaw Thu* (10 minutes)
 - Discussion on presentations (15 minutes)
- 1310-1400 hours Lunch Break
- 1400-1500 hours **Agenda Item No.3 - Country presentations (contd.)**
(10 minutes each)
- Bangladesh – *Dr Aftabun Nahar Maksuda*
 - Indonesia - *Dr Hernani*
 - Sri Lanka - *Dr W A S Settinayake*
 - Thailand - *Dr Krisada Mahotarn*
 - Discussion on presentations (20 minutes)
- 1500-1515 hours Tea Break
- 1515-1600 hours **Agenda Item No. 3 - Country presentations (contd.)**
(10 minutes each)
- Bhutan – *Mr Kaka Tshering*
 - Maldives – *Mr Umar Hassan*
 - Timor-Leste - *Ms Angelina J Martins*
 - Discussion on presentations (15 minutes)
- 1600-1630 hours Role of Media in Leprosy Elimination - *Mrs Harsaran Bir Kaur Pandey*, Information Officer, SEARO
- 1930-2100 hours Reception

Wednesday, 20 November 2002

Agenda Item No. 4 – Special Presentations

- 0830-0930 hours **Strengthen and sustain integration for leprosy elimination**
- *Dr W A S Settinayake* – Sri Lanka (20 minutes)
 - *Dr Krisada Mahotarn* – Thailand (20 minutes)
 - Discussions (20 minutes)
- 0930–1000 hours Tea Break
- 1000–1100 hours **Building partnership for Leprosy Elimination**
- *Dr Kyaw Nyunt Sein* – Myanmar (20 minutes)
 - *Dr (Mrs) Aftabun Nahar Maksuda* - Bangladesh (20 minutes)
 - Discussions (20 minutes)
- 1100-1115 hours **Simplified Information System**
Dr Tej Walia
- 1115-1130 hours **Role of Partners in Leprosy Elimination**
Dr C S Walter, ILEP Coordinator for India
- 1130-1200 hours General Discussions
- 1200-1215 hours **Agenda Item No 5 - Briefing on group work: *Dr C K Rao***
- Group 1: Case detection and achieving high cure rate including Accompanied MDT
- Group 2: Acceleration of elimination and integration including strategies for phasing out vertical structure
- 1215-1300 hours Group work
- 1300-1400 hours Lunch Break
- 1400–1530 hours Group Work (continued)
- 1530–1545 hours Tea Break
- 1545–1700 hours Group Work (continued)
- Parallel Session**
- 1300-1530 hours **Technical Briefing for the Media**
- Presentations:
- From disease to destitution by *Dr Derek Lobo*
 - Leprosy situation in Sri Lanka and introduction of PALs - *Dr Settinayake*

- Role of media in leprosy elimination - *Ms Harsaran Pandey*
- Statement - *Dr Yo Yuasa, SMHF*
- Statement - *Dr Nimal Kasturiaratchi, Novartis*
- Each of the presentations will be followed by discussion

Thursday, 21 November 2002

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| 0800-0900 hours | Group work / Discussions (contd.) & preparation of Groups' reports |
| 0900-0930 hours | Tea Break |
| 0930-1200 hours | Agenda Item No. 6: Presentation of Group Reports & Discussions
Presentation each group 30 minutes and followed by 20 minutes discussion |
| 1200-1300 hours | Agenda Item No. 7: Adaptation of the Recommendations
Presentation of the Report and Adoption of Recommendations |
| 1300-1400 hours | Lunch Break |
| 1400-1430 hours | Valedictory Session
Vote of Thanks - <i>Mr Sathian Yovapue, STP-LEP</i> |