

REPORT OF THE TECHNICAL COMMITTEE ON EDUCATION AND SOCIAL ASPECTS¹

Importance of educational and social aspects.—Conditions governing leprosy are so varied, even in one country or one region, that no one formula can deal with all problems raised by the disease. Our approach to the various methods prevailing in different regions of the world has to be tolerant and understanding.

In the past the absence of proved remedies and lack of methods of prevention of deformity cast a gloom over the whole subject of leprosy, which was illumined only by charitable missionary endeavor. Leprosy suffered from professional isolation and leprosy patients from social isolation. With the effectiveness of modern treatment, the medical and public health aspects of the leprosy problem naturally assumed priority. The educational and social aspects of leprosy, however, are so closely related to the medical and preventive aspects that it is a grave mistake to underestimate them. It is essential that they form an integral part of the leprosy campaign, and adequate budgetary provision for these activities should be made in control campaigns. Otherwise the very success of our treatment and control programs may be retarded.

Need to improve standards of living.—No clear relation is apparent between leprosy prevalence and state of nutrition, climate, social customs, etc. The important contributing factor appears to be low economic status and the level of hygiene, as reflected particularly in overcrowded and insanitary housing. It becomes important, therefore, that while we should do everything in our power to diagnose cases early and bring them under treatment, we should also endeavor simultaneously to improve the standard of living of the endemic regions, and especially to improve housing and inculcate hygienic habits among the general public, the patients, and their contacts.

Prejudice and ignorance.—These should be combated actively. While prejudice against leprosy and discrimination against leprosy patients seem to have declined in some measure, especially in areas where planned leprosy control activities have been in progress, the deep-rooted prejudices against leprosy are very slow to die. These prejudices, besides causing mental pain to patients, hinder their early and willing resort to treatment. This is true especially in the more sophisticated levels of society. On the other hand, it is a fact that in many of the areas where leprosy is more prevalent, one meets total indifference to the presence of leprosy in the community. Such indif-

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ference is equally harmful to successful leprosy control measures. Our educational objective should therefore be to evoke in the public at large, patients, and their families, a reasoned attitude toward leprosy, which neither exaggerates its dangers nor minimizes it.

Scope of education.—Education with regard to leprosy has to cover many aspects, and must be directed toward many sections and groups of the public, including the patient and his family. First and foremost, the medical student should receive adequate teaching in leprosy. Hospitals attached to medical colleges and schools should promote active interest in leprosy and a reasoned attitude toward it among medical students, by making leprosy treatment an integral part of the work of the hospital. Health officials should also be reoriented in modern concepts of leprosy, so as to bring into its handling an outlook similar to that upon other communicable diseases. Since the leaders of society largely have to influence the action of government and community in matters relating to social affairs, it becomes necessary to inform them of the modern approach to leprosy and secure their influential support for forward-looking policies with regard to the disease. Frequently the educated are as ignorant as the uneducated with regard to leprosy. In fact their prejudices may be more deep-rooted and act as a hindrance to intelligent measures of leprosy control. Persistent attempts should be made therefore to educate the educated and win the cooperation of leaders of society at all levels and of administrators as well. Such an attempt is essential, especially in highly endemic regions where special efforts to control and eradicate leprosy are needed.

Importance of educating teachers, social workers, etc.—Teachers should be enlightened on the facts of leprosy and on ways in which they can help by disseminating information among their pupils, their parents, and the general public. All social workers should be given an orientation in the modern approach to leprosy with particular reference to the social problems arising from it. Curricula for schools and colleges of social work should include instruction in leprosy. Leprosy workers should seek opportunities constantly to make contacts with social workers in general and to address groups of them. Some of the social problems created by the indigence of leprosy patients can be solved only when social workers come to regard leprosy without fear and with understanding, and are prepared to bring those disabled by leprosy or rendered destitute by it, and the uninfected children of leprosy patients, within the scope of general welfare services for the handicapped, children, etc.

Education of the general public.—With reference to the general public, our approach has to be one of providing the right type of information and education and the correct attitude to leprosy rather than one of publicity. Every medium of education should be employed.

Newspapers can be very helpful. But due care must be taken to see that they refrain from sensational presentation of news relating to leprosy. Otherwise newspaper publicity may be a hindrance rather than a help. Persistent attempts should be made to approach writers for the press and induce them to view leprosy in the right perspective, as a preventable and curable disease. It should be impressed upon them that news, stories and pictures regarding leprosy that appear in the press should dwell on the more hopeful aspects that have emerged recently and that in whatever they say they should not add to the prevailing ignorance and misunderstanding of the disease. We should also urge that magazines, novels, movies, etc., refrain from exploiting the theme of leprosy by undue dramatization and sensational presentation. They should be urged constantly to avoid use of the word "leper," which carries an ancient stigma with it, and to refer to those who suffer from leprosy as leprosy patients.

Providing information on leprosy for the public at large is a task to be approached with caution. Theoretical and speculative information, no matter how thrilling to the research worker, should be withheld from the public. For newspapers are apt to give undue prominence to these items, and the public, already full of doubts and fears regarding leprosy, are apt to become more confused in their approach to the disease and more confirmed in their old-time notions. Although much is still to be learned about leprosy, this limitation should not prevent our working out a realistic leprosy education program. That program must take into account the "knowns" and "unknowns" and present these to the public in an understandable and reasonable way. Writers should aim at promoting a leprosy control policy based on what is known, what can be deduced, and what can be carried out humanely.

Education of the patient and his family.—The education of the patient and his family is important. Our aim should be to get them to view leprosy without fear, but with the respect due to it, as a communicable disease from which patients' families and the community at large must be protected. Patients must be encouraged to take a hopeful attitude toward their condition, to persist in treatment, to cooperate in preventive measures, and to learn to look after themselves in such a way as to avoid and overcome deformity. The family should also be instructed in such a way that they will help in keeping up the morale of the patient, give him the necessary sympathy, and at the same time take preventive precautions to control the spread of infection.

Protection of children.—In many countries where leprosy is endemic, infection occurs more commonly in childhood and it becomes necessary to pay special attention to the protection of children. Often children constantly exposed to infection need special attention. Insistence on regular treatment by the patient and observance of pro-

phylactic measures within the household, are the most practical means of protection. Uninfected children who find themselves cut off from parents or relatives under hospital care, or whose parents or relatives are unable to care for them satisfactorily, should be admitted to general child-care institutions. But arrangements should be made to have them examined periodically. This should be done without any publicity that may mark them from other children. The best procedure perhaps would be to arrange their examination for leprosy as part of the medical check-up of school children. In the case of infected children, except where their condition warrants otherwise, school authorities should be made to cooperate in letting them take treatment in an outpatient clinic while attending school. These children may need special help for their education where their parents or relatives are too poor to pay for it. Under some circumstances, preventoria or healthy children's homes may have to be run. But with the education of social service organizations and social workers in the correct approach to leprosy, it should be possible to arrange for the care and education of children in general child-care institutions. As far as possible, the family unit should be maintained and attempts should be made for the protection and care of the children in family surroundings.

Special legislation in leprosy.—In the light of modern knowledge, there is no need for special legislation on leprosy, and any legal measures dealing with leprosy should form part of general public health regulations. Wherever there is legislation on leprosy that is not in conformity with the modern approach to the disease, governments should be urged to revise such legislation suitably. It is recommended that governments still enforcing compulsory segregation, abandon this policy.

Social and economic assistance to patients.—Due attention should be paid to the social and economic difficulties of patients and their families, and attempts should be made to relieve them. Methods for such relief will depend on particular circumstances in a country or a region. In countries where public assistance of various types is available to the unemployed, sick, disabled, destitute, etc., the leprosy patient and his family should be eligible for such assistance. Although in countries with a low economic standard priority has to be given to treatment and control measures, the social and economic difficulties of the patient should not be ignored. They must be given attention, if only because assistance to patients to relieve their difficulties will win their cooperation in treatment and control measures. In these countries the problem of the disabled and the destitute patient is a serious one. Governments should encourage the care of these patients by voluntary institutions by suitable grants to them, and also promote their care through social welfare departments.

RECOMMENDATIONS

1. In view of the urgency and importance of combating ignorance and prejudice among the public, an active program to educate all sections of the public should be promoted. Popular ignorance is a great hindrance to leprosy control campaigns, and therefore health education through every available medium should form an integral part of leprosy control campaigns. Moreover, the goal of integration of leprosy services with public health services will be achieved only when there is an enlightened and active participation of the community in leprosy control programs. It is therefore recommended that adequate budgetary provision for health education be made in these programs.

2. Health education should cover all sections of the community. It is most important that school teachers, social workers, and community leaders receive orientation in the modern approach to leprosy, so that they can spread knowledge to their respective spheres and promote proper action for the control of leprosy and the problems of leprosy patients.

3. It is of the utmost importance that medical undergraduates receive adequate teaching in leprosy, so that the general medical practitioner can and will take active part in leprosy control programs, which should become more and more integrated with public health services. It is recommended that instruction on leprosy be linked with instruction in dermatology, neurology, public health handling of communicable diseases, etc., so that the age-old professional isolation of leprosy can be broken and leprosy be regarded as one disease among many entitled to the interest of all physicians. Refresher postgraduate courses should be arranged frequently for the medical profession.

4. The social and economic difficulties of leprosy patients should be relieved in ways appropriate to each region, so that patients, feeling happier, can cooperate in treatment and control measures. The needs of the "individual" should not be forgotten in concentration on the "mass" of the problem for purposes of planning.

5. Special attention is needed for children constantly exposed to infection by leprosy patients. Uninfected children cut off from parents or relatives unable to care for them satisfactorily, normally should be admitted to child-care institutions. In some areas, however, preventoria or healthy children's homes may have to be run.

6. Since lack of personnel of various types greatly hinders advance of leprosy control programs, governments and all interested in promoting leprosy control should finance and encourage training programs, preferably in medical institutions and medical research centers or in association with them. In areas where such institutions do not exist, a well-staffed and well-equipped leprosy center or institution

should be recognized as a training center; such training centers should be supported adequately by governments.

7. The Congress invites increasing and more active and enlightened interest in the problems of leprosy on the part of newspapers, the radio, movies and other media of communication. But those controlling such media should adhere to concepts of leprosy consistent with present scientific knowledge of the disease and refrain from a sensational approach, based on medieval notions, and also from undue dramatization of situations and episodes in stories with a leprosy background, lest by doing so they increase existing misunderstanding concerning the disease.

8. The Panel endorses the Report of the Panel on Physical Medicine, Rehabilitation, Surgery and Vocational Training, insofar as it relates to educational and social aspects. In doing so, the Panel stresses the importance of social and psychologic rehabilitation of the patient, as well as that of physical rehabilitation and vocational training. The ultimate goal of rehabilitation is not only economic self-sufficiency but social and moral welfare leading to wider opportunities and responsibilities of normal life.

REPORT OF THE PANEL ON PHYSICAL REHABILITATION¹

By rehabilitation is meant return of a patient to normal social life and economic independence with maximum possible restoration of physical and mental well-being. The greatest barrier to rehabilitation from leprosy has been difficulty in cure of the disease. A second barrier is public ignorance and prejudice. Each of these is being considered by other panels, and we are glad to note improved methods of medical treatment, and measures proposed for education of the public.

In this panel we are concerned with a third great barrier to rehabilitation, the presence of physical deformity and disability. This is particularly serious because it continues after the disease is cured and makes return to normal life difficult even when public prejudice is absent.

A study group sponsored by the World Health Organization, the International Society for Rehabilitation of the Disabled, and the Leonard Wood Memorial, met in 1960 to evaluate progress in prevention and treatment of deformity in leprosy. This group emphasized that the great majority of the deformities and disabilities of leprosy are preventable and that those which cannot be prevented can be corrected by reconstructive surgery.

¹The Panel was composed as follows: Dr. P. W. Brand, *chairman*, Dr. J. J. Arvelo, *secretary*, and Drs. N. H. Antia, J. O. Benimeli, R. Borsani, M. Brand, R. Camain, A. Canayon, J. E. Faggin, J. C. Hargrave, M. Itoh, A. Marzetti, M. Nakita, Mrs. K. Nimbkar, Drs. E. Ode, D. E. Paterson, E. W. Price, D. C. Riordan, L. Silveira, D. Ward, E. Zamudio, *members*.

Surgical correction of deformities demands specially trained personnel and special equipment, neither of which is readily available in most countries where leprosy is common. This panel wishes to emphasize that prevention of deformity is much easier than its correction. With little training and inexpensive equipment it is possible for every doctor and paramedical worker to prevent development of deformities in many of his patients.

In leprosy, rehabilitation must begin as soon as the disease is diagnosed and persist throughout treatment. Leprosy rehabilitation services should be integrated closely with other rehabilitation programs in general hospitals and clinics, even where the antileprosy campaign as a whole still has to be organized as a separate unit. As a first step it is wise to obtain the interest and cooperation of orthopedic, plastic and ophthalmic surgeons from medical schools or general hospitals. Their position and action will be influential. Simultaneously, physiotherapists, occupational therapists, medical social workers and councilors for vocational guidance, must be drawn into the program.

This panel encourages every leprosy worker to participate in the preventive aspect of deformity, but strongly discourages attempts at reconstructive surgery by medical officers who have no special training, have to work in centers where aseptic conditions are doubtful, and/or lack trained physiotherapeutic help in preparation and reeducation of patients. The Panel recommends that in these circumstances this Congress call on voluntary agencies to cooperate. The rehabilitation agency of the World Health Organization and the International Society for the Rehabilitation of the Disabled should call together some of the organizations already interested in leprosy work, and also societies dedicated to work among the crippled and the blind. Strategic centers, perhaps in medical schools, could be selected for establishment of reconstructive and rehabilitation units.

THE EYE

Eye involvement in leprosy is exceedingly common, reaching about 90 per cent in lepromatous patients by the fifth year of the disease. Once an eye has become involved, directly or indirectly, it may at any time become seriously affected and sight may be permanently damaged. Most blindness in leprosy is avoidable. Far more people lose sight from neglect than because there is no treatment for their condition. Leprosy workers, including doctors, often fail to look for signs. They should remind patients to report eye trouble at once, and organize a time and a place where every patient can have a *regular* examination.

The paramedical worker in the village must be able to check visual acuity. The doctor in charge of an institution or clinic must, in addition, be able to examine in a dark room, using a well focusing light and magnifying loupe ($\times 10$). Paramedical workers must have special

classes and demonstrations in the course of their training, so that they can be on the watch constantly for early eye lesions and see that patients are referred promptly to a doctor.

Broadly speaking, leprosy causes blindness in three ways: (a) By damage to the facial (7th cranial) nerve, causing partial or complete paralysis of the lids. The exposed cornea is liable to drying, trauma and infection. Corneal ulcer may develop and lead to total destruction of the eye. Impairment of corneal sensation, found particularly in conjunction with chronic lepromatous lesions of the eyes, adds seriously to the dangers of lagophthalmos.

(b) By sensitization of the tissues of the eye to substances produced by the bacilli or their breakdown products. The most serious manifestation of this effect is acute plastic iridocyclitis, characterized by early formation of dense synechiae, and complicated sometimes by secondary glaucoma.

(c) By direct invasion of the anterior segment of the eye by leprosy bacilli. Low grade keratitis and later iridocyclitis develop. The latter may flare up with acute symptoms from time to time. Complicated cataract frequently develops. Sight is gradually lost as the ciliary body is destroyed by the lepromatous granulomata. Where the tissues of the eye are sensitized acute inflammation occurs. Nodules, resembling erythema nodosum leprosum, develop at the limbus; simultaneously acute iridocyclitis develops. Left untreated, there is very little spontaneous regression.

Essential principles in the care of eye lesions are as follows:

1. *Lagophthalmos*.—Patients in early stages often lose their symptoms and improve lid function by: (a) exercise of lids daily; (b) prevention of drying, especially during sleep, by bland oil; (c) minimizing infection by mild bacteriostatic agents, and (d) use of dark glasses.

Where corneal sensation is impaired, the palpebral fissure *must* be reduced. The best operation for this is the temporalis transfer. If a surgeon is available, a tarsorrhaphy should be done pending the better operation. Various other procedures have been devised for reducing the palpebral fissure; while not as effective as the temporalis transfer, they are simpler to perform and the results are less unsightly than a tarsorrhaphy. If keratitis or a frank ulcer develops, full treatment for these conditions must be instituted.

2. *Acute plastic iridocyclitis and acute phases of the chronic granulomatous form*.—These demand: (a) cessation of antileprosy drugs followed by cautious restart after inflammation has subsided; (b) full dilation of pupil with mydriatics; (c) countering inflammations by local heat, corticosteroids and, where necessary, by anti-inflammatory drugs. If glaucoma is present, Diamox 250 mgm., t.i.d. for three days, usually reduces intraocular tension. Full iritis treatment is

instituted at the same time. Anterior chamber puncture may be necessary.

These principles also hold for the eye that develops erythema nodosum nodules. In addition the following measures may be considered: (a) localized nodules may be shaved from the cornea and the limbal vessels cauterized; (b) tarsorrhaphy to give protection is indicated where there is lid weakness and a nodule on the lower lateral limbus.

THE FOOT

1. *Plantar ulcer*.—Damage to the neuropathic foot may occur superficially or deep between bony skeleton and soft tissues as a result of pressure and stresses during walking. Deep damage proceeds to ulceration. Ulceration can be avoided by early recognition and treatment. Healing can be obtained by avoidance of the stresses of walking. The simplest measure is bed-rest with elevation of the foot, but rigid-soled footwear, firmly attached, is as effective. So also is a walking plaster cast. Uncomplicated ulcers will heal within six weeks. Bone involvement may delay healing, but will not prevent it if immobilization is prolonged. Removal of sequestra may accelerate healing. Operation should aim at production of a plantigrade foot. If the deformity is too severe, amputation may be necessary.

Recurrence of plantar ulcer is avoided by proper footwear. In severe cases footwear is needed with a rigid sole, soft insole, a rocker or rocker-shaped sole, and firm strapping of heel to footwear. Walking should be limited. Education of the patient is essential.

2. *Neuropathic bone and joint*.—Bone and joint damage follows repeated microtraumata at any anesthetic joint, and is to be suspected whenever a painless swelling occurs. X-ray examination should be made. Treatment of the neuropathic joint is directed to achievement of undeformed stability by surgical or nonsurgical methods.

3. *Footdrop*.—Paralysis of dorsiflexion and eversion of the foot follow popliteal neuritis. In acute cases, immediate plaster immobilization, with the knee in slight flexion, may succeed in preventing permanent palsy. Permanent footdrops should be corrected to prevent toe and plantar damage.

4. *Clawtoes*.—Clawtoes result from posterior tibial neuritis; they expose toe-tips and the sole to possible damage, and make shoe-fitting difficult. The deformity can be corrected by tendon transplant or by arthrodesis at the interphalangeal joint.

5. *Infective vascular lesions*.—Infection of blood and lymph vessels of the foot and lower leg is common during repeated and uncontrolled septic episodes of the foot. Early recognition and treatment are important; regular hygiene of the foot will arrest development of the lesions.

Conclusion.—With modern treatment, no complication of leprosy in the foot should hinder the rehabilitation of a patient recovering from the disease.

THE FACE

All deformities of the face are amenable to correction by surgery. Their correction is important in the general problem, for the lay person often associates deformity with active disease. Operative treatment is based on the principles and techniques of plastic surgery. Any physician undertaking this type of surgery must be trained adequately in this speciality.

Deformities of the face in leprosy consist of: (1) depressed nose; (2) loss of eyebrows; (3) deformity of ears; (4) wrinkling of the facial skin and (5) lagophthalmos. Except for lagophthalmos, all these deformities are the result of lepromatous disease, and correction should be deferred until the disease is arrested.

1. *Nose.*—Deformity of this organ is the most prominent stigma of this disease. Saddle nose is the result of primary ulceration of the mucous membrane followed by necrosis of the underlying cartilage and bony framework. Generally the skin, though infiltrated, is not ulcerated.

It was formerly general practice to incise the remains of the nose and reconstruct a new nose by a forehead skin flap. This is not necessary in most cases where skin and nose-tip are intact. The missing lining is replaced by a forehead flap of a free skin graft. This is produced by freeing the skin from its anchorage to the underlying bone. The skin graft is carried on a mold, which is later replaced by a dental prosthesis. Permanent support may be given by a bone graft. In minor nasal depression an implant of cartilage or bone may be undertaken without a preliminary skin graft. In the rare cases of total destruction of the nose, a forehead rhinoplasty is undertaken.

2. *Eyebrows.*—Correction of eyebrow deformity is of psychologic importance. It may be carried out by grafting hair-bearing scalp.

3. *Ears.*—Ear deformity may be in the form of an elongated lobule or irregular destruction of the border. It can be corrected by suitable incisions.

4. *Facial wrinkling.*—This results from loss of normal skin elasticity and produces an appearance of premature aging. It is corrected by incision of the redundant skin.

GYNECOMASTIA

This is a common deformity, sometimes associated with pain. It is corrected by removing fatty and breast tissue through incision in the margin of the areola (Webster method).

THE HAND

In leprosy, the common defects, clawhand and paralyzed thumb, are often complicated by contracture, lepra reaction and absorption of phalanges. It is generally useless to attempt surgical reconstruction before the hand has been fully mobilized. It is important postoperatively to educate the patient in use of his transferred muscles. Such reconstructive surgery should be performed only by a trained surgeon where adequate physiotherapy is available.

1. *Clawhand*.—Where there is preoperative mobility with intact tendons the best treatment for clawhand is provision of a new motor for paralyzed intrinsic muscles. Those commonly used are: (a) extensor carpi radialis longus with a free graft; (b) flexor digitorum sublimis from one finger; (c) extensor indicis and extensor digiti minimi. For cases in which passive mobility is unobtainable preoperatively it is usually advisable to arthrodose the interphalangeal joints at approximately 25 degrees short of full extension.

2. *Thumb*.—The commonest complication of paralysis in the thumb is thumb-web contracture. If the thumb cannot be brought into full apposition passively, it is necessary to do some form of web-plasty before providing a motor tendon to the thumb. A web-plasty, with a full-thickness skin graft on the dorsum, and sometimes a Z-plasty, can be used. Other operations for correction of the paralysis are possible. If disability is not corrected after tendon transfer, or if there is postoperative instability of the metacarpo-phalangeal joint, arthrodesis of the joint is advisable. An operative method that has been used, is passing the extensor indicis proprius through the second interosseous space to the mid-palm and thus to the thumb.

3. *Radial palsy*.—Radial palsy occurs only with ulnar and low median palsy. Although arthrodesis of the wrist was recommended in the Tokyo report, the Panel now recommends muscle transfers, as used in poliomyelitis.

4. *Wasting in the thumb-web*.—Unsightly wasting in the thumb-web can be corrected with dermis grafts or Ivalon for cosmetic purposes.

5. *Advanced absorption of the fingers and the thumb*.—Where there is advanced absorption of the thumb, a deep web-plasty can provide further function. In very advanced absorption, consideration may be given to use of the artificial articulated hand. Many hand deformities can be prevented or minimized by the following simple methods, which should be known to every leprosy worker: (a) any hand swollen or tender, or affected directly by acute reaction, must be splinted with the fingers flexed at every joint; (b) patients with insensitive hands must be taught to protect them from injury, burns, and excessive force with tools of their trade; (c) when paralysis has limited full movement

of the hand, secondary stiffness must be avoided by massage and exercise moving each joint through full normal range.

NERVES

Early diagnosis of nerve involvement is essential if treatment is to help arrest nerve damage. The common levels of nerve involvement are the ulnar nerve above the elbow, the median nerve at the wrist, the lateral popliteal nerve at the knee, the posterior tibial at the ankle and the superior branch of the facial nerve at the level of the zygoma. Measures to combat inflammatory edema should be considered in treatment. Release of nerves at sites of compression may be of value in early stages. Such release results in relief of nerve pain. In a completely paralyzed nerve, epineurectomy is justifiable to relieve intractable pain. Further research is recommended.

RESOLUTIONS

1. This Congress is gravely concerned over the fact that under the very eyes of physicians and paramedical workers in many antileprosy campaigns, deformity and blindness are being allowed to develop, which could be prevented by simple advice and inexpensive treatment. The Congress therefore *resolves* that in every antileprosy campaign physicians and paramedical workers should be trained to look for danger signs in hands and feet and eyes, and should give advice and simple treatment to prevent deformity and blindness. The ratio of patients to workers should not become so high as to make this impossible.

2. Whereas in many countries where leprosy is common there are no rehabilitation services and no trained personnel and whereas the governmental antileprosy programs are unable to develop adequate rehabilitation services, this Congress *resolves* to call upon international and voluntary rehabilitation agencies to establish pilot projects for reconstructive surgery and physical rehabilitation at strategic centers, preferably in association with medical schools, to which staff from any country could be sent for training.

This Congress suggests that the United Nations Rehabilitation Agency and the International Society for the Rehabilitation of the Disabled should call a group of voluntary societies together to consider means of implementing this resolution.