

DISEASE ELIMINATION AND ERADICATION

LESSONS LEARNT FROM LEPROSY

State of the Art Lecture – by Dr Maria Neira, Director Control Prevention and Eradication, WHO

Ladies and Gentlemen, dear colleagues and friends,

WHO is honored to cosponsor this important event together with the Ministry of Health of Brazil, ILA and ILEP. We are especially grateful to Government of Brazil and members of the Organizing Committee for planning and organizing the Congress. This is the second important meeting which the Brazilian authorities have kindly hosted this year - the first being the meeting of the Global Alliance for Leprosy Elimination.

But before proceeding any further I would first like to position leprosy in the overall public health debate and discussion. According to the World Health Report 2000, infectious and parasitic diseases—most of which are preventable or treatable are the primary causes of death worldwide. Disability causing diseases claim a very high toll – not so much in terms of mortality but in terms of the long term consequences of these diseases. The numbers of people affected is staggering. These illnesses belong to the group of diseases labeled as the neglected diseases - diseases that often pose an enduring major unmet medical need because of a lack of affordable, easy to access, and easy-to-use treatments. Neglected diseases fall into two categories: those like malaria and tuberculosis (TB) which affects patients in the developed world too and remains of interest for private R&D efforts, and diseases like buruli ulcer, leishmaniasis, leprosy, schistosomiasis, intestinal parasites, human African trypanosomiasis, Chagas disease, and lymphatic filariasis, for which there is virtually no market. Patients do not simply suffer from an episode of illness - the deformities related with the conditions are so severe that they are at times cast out of society and the work force.

However the global public health debate focuses primarily on improving access to HIV AIDS, malaria and TB as well as research for neglected diseases. The numbers of people in need of treatment for these three diseases over shadow most other diseases. Improving access to treatment for these conditions is extremely complex.

New unconventional solutions need to be found to address these pressing public health problems. It is becoming increasingly evident that no single player can resolve the major problems at hand- One approach which has been proved to be very successful are public private partnerships. These partnership have different specific objectives but all revolve around improving patient access to treatment. They are reducing human suffering, disabilities and deaths, leaving behind sustainable and permanent solutions and above all helping healthy populations pull themselves out of poverty.

All of us working in leprosy are extremely fortunate – we have a highly effective cure at our disposal – Multi drug therapy or MDT continues to remain effective after almost 2 decades of use. We are providing it free of charge to all patients in the world. We are not plagued by complex diagnostic procedures – clinical diagnosis has proved to be good and effective. MDT blister packs are easy to use in the field and primary health care staff can provide the treatment after basic training.

Yet our experience in leprosy shows how complex improving patients' access to treatment is. And our experience also shows that it is possible to improve patients' access to treatment on a sustainable basis by working through existing health services and structures. It is crucial for us to ensure that leprosy elimination is included in the global debate on combating neglected diseases as others can benefit from our experience and insight – and we from theirs.

The 16th International Leprosy Congress convenes at a crucial time - the prospect of eliminating leprosy from every country in the world is tantalizingly close. Tremendous progress has been made in improving patients' access to leprosy treatment, particularly in the underserved areas. New approaches are being adopted to address the gender imbalance. Leprosy is even getting celebrity support in many countries - for example with the involvement of Bollywood in India and Ney Matogrosso from Brazil.

At the same time as we approach the elimination target a different set of issues are emerging which need to be discussed and debated - issues which have put on the back burner but now need to be looked at closely such as validation of leprosy elimination, ensuring the continued treatment of patients, coverage, etc.

Another issue which we all need to consider is the role of different players in a changing environment. With the increasing burden and challenges on health care services due to other major public health concerns which taking a huge toll and reversing development gains made over the past decades and demand more attention and resources. We therefore need to be increasing effective and cost effective with our resources.

We have possibly come to the most difficult phase of leprosy elimination - getting to the more intractable areas. Leprosy remains a problem in parts of the world with uncertain political, economic and social climates. The on-going strife places additional strain on an already weak national health-care networks. Significant progress has been made towards changing the negative image of leprosy but much more needs to be done to make sure that no individual suffers from discrimination due to present or past leprosy.

The 16th International Leprosy Congress will give us the opportunity to reflect on where we are, where we are going, to learn from each other, discuss and debate these issues and return with more ideas and implement at least some of the approaches presented and debated over the coming week. This will undoubtedly benefit all us who are concerned with leprosy elimination as a public health problem and in the care of leprosy patients throughout the world. We look forward to the exciting opportunities that the Congress will provide for the exchange of information on advances in the study of leprosy, and for the continuing education of all who work toward the conquest of the disease and its consequences.

A glimpse at history

We have certainly come a very long way from the 1st International Leprosy Congress which was held in Berlin in 1897. The only points on which all experts agreed was that leprosy was incurable, and that the only immediate solution was to isolate patients. The first formal attempt to estimate the global leprosy burden was made by WHO in 1966, resulting in an estimated total number of cases of about 11 million, 60% of whom were not registered for treatment. It was obvious by the mid-1970s that the efforts to control leprosy by long-continued, even life-long, dapsone monotherapy were failing, leading to the establishment of WHO/TDR research programmes directed at development of an effective protective vaccine (IMMLEP) and of more effective therapy (THELEP). Multiple surveys showed widespread primary and secondary resistance to dapsone. By analogy with tuberculosis, it was believed that treatment by regimens composed of two or more drugs, each acting by a different antimicrobial mechanism, would prevent relapse with dapsone-resistant *M. leprae*. A Study Group conveyed by WHO recommended combined-drug regimens based upon the supervised intermittent administration of rifampicin for both MB and paucibacillary (PB) leprosy. These WHO "Study-Group regimens" were then widely applied in programs of leprosy-control and, as we now know, are very effective, well tolerated, and are well accepted by both patients and medical staff.

Due to the substantial progress in leprosy control through MDT, the World Health Assembly (WHA) in 1991 was prompted to call 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. The figures and trends at the time suggested that this ambitious goal could be achieved. Based on available information and its interpretation, global estimates had dropped from 10-12 million in 1985 to less than one million in 1998. The resolution had the effect of galvanizing governments, non-government funding agencies (such as

those of ILEP), and communities, and, in the subsequent years, WHO developed the concept of LECs (Leprosy Elimination Campaigns), and SAPELs (Special Action Programs for the Elimination of Leprosy), with the purpose of detecting and treating all patients, including those in "unreachable" geographic areas. The result was that the global prevalence of leprosy has been reduced below one per 10 000 at the turn of the millennium.

Although the reduction in prevalence is dramatic in historical terms, today there is clearly a distinct drop-off in the reduction curve. Thus, the present elimination approach needs intensification in some countries.

Why disease elimination and eradication are important?

There has been a considerable debate over definitions. Last has defined these three terms as (Last, 2001):

- **Control:** Ongoing operations or programmes aimed at reducing incidence and / or prevalence, or eliminating such conditions.
- **Elimination:** Reduction of case transmission to a predetermined very low level; e.g., elimination of tuberculosis as a public health problem was defined by the WHO (1991) as reduction of prevalence to a level below one case per million population.
- **Eradication:** Termination of all transmission of infection by extermination of the infectious agent through surveillance and containment

These issues were considered at length in a Conference on Global disease Elimination and Eradication as Public Health Strategies in Atlanta, USA 1998 and new definitions were proposed.

"Disease "elimination" (connoting something less than global implementation and requiring continued control measures) and "eradication" (connoting global implementation with no need for continuing control measures) have been in use for many years and have become common and useful terms to many public health practitioners. In 1997 the Dahlem Workshop added further legitimacy to these terms. However, discussions at the Conference on Global Disease Elimination and Eradication as Public Health Strategies confirmed the feelings of many that the distinction between elimination and eradication is difficult to convey. The two terms are synonymous in many languages. Adding to the confusion is the imaginative, but imprecise, use of the term elimination as, for example, in "elimination of the disease as a public health problem". The group reviewed the concerns expressed at the Conference and concluded that discontinuation of the term "elimination" be considered, using instead degrees of control leading, where feasible, to eradication. For example:

Control: The reduction of disease in a defined geographical area as a result of deliberate efforts. Control is a relative term that should be quantified to indicate the extent of reduction to be achieved.

Eradication: The absence of a disease agent in nature in a defined geographical area as the result of deliberate control efforts. Control measures can be discontinued when the risk of disease importation is no longer present.

Extinction: The specific disease agent no longer exists in nature or the laboratory.

In effect, the term elimination is replaced by the concept of "regional eradication". The group recognizes that the sentiment expressed at the Conference to revise the definitions comes only a year after endorsement and refinement of the terms at the Dahlem Workshop, where it was suggested that the term regional eradication is contradictory.

The World Health Assembly introduced a limited concept of leprosy elimination, as a public health problem (WHO, 1991). Leprosy elimination is a globally accepted programme, and its definition and target are used for public health management purposes.

The debate surrounding definitions is unlikely to end here. Words are defined by common usage. What is really important is that we have very effective tools for elimination which will enable countries to reach a very low level of leprosy burden.

Leprosy is one of the few infectious diseases that meet the demanding criteria for elimination - namely:

- practical and simple diagnostic tools;
- the availability of an effective intervention to reduce its transmission; and
- a single significant reservoir of infection – humans.

These tools are simple: early correct diagnosis of a case of leprosy and prompt treatment with multidrug therapy. Over the last two decades it has been demonstrated that MDT is effective in arresting the disease progression, bring about complete cure and prevent the emergence of antimicrobial resistance. This evidence is somehow unique in the history of the control of any infectious disease.

Leprosy and poverty alleviation

Eliminating leprosy has far greater implications than simply resolving a public health problem. Leprosy is closely linked with poverty and leprosy elimination contributes to poverty alleviation efforts.

Poverty is both a cause and result of leprosy. A cause insofar as poor people are more prone to suffering from leprosy as they have weaker immune systems and live in close proximity to one another resulting in higher risk of contracting the disease.

Leprosy also leads to greater poverty, as it is a leading cause of permanent disability in the world. The chronic symptoms often afflict individuals in their most productive stage of life, and impose a significant economic and social burden on their families and society at large. Leprosy elimination efforts can make a direct assault on poverty.

For a Nation, persisting burden of leprosy is a prime example of the link between ill health and lack of sustainable development.

What is the leprosy elimination strategy?

The strategy for the elimination of leprosy as a public health problem is based on early case detection and cure with multidrug therapy. The target defined aims at reducing the prevalence, in any given endemic area, to less than one case per 10 000 population.

However, the strategy is based on certain assumptions which need to be understood.

- MDT treatment, together with early case-finding, is the best way available today for dealing with the problem of leprosy and its consequences;
- The reduction of the disease prevalence to very low levels will lead, in the course of time, to reduction in transmission to insignificant levels;
- As leprosy has a long incubation period and an insidious onset, new cases will continue to appear for several years;
- Impact of MDT on the disease incidence can only be possible, when there are no more "hidden" cases and when MDT coverage reaches optimal levels,
- New case detection figure is a poor proxy indicator for incidence and it mainly reflects the operational performance of the programme.

Where do we stand today?

The defined elimination level at the global level was attained at the end of the year 2000. This was a tremendous achievement, thanks to thousands of health workers in the endemic countries, who spent most of their life in fighting this dreadful disease against all odds.

- by the beginning of 2002, more than 12 million cases treated and had been cured;
- the numbers of relapses remain low, at less than one case per 1000;
- no drug resistance following MDT has not 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.
- more and more programmes are being integrated within existing general health services
- there are fewer uncovered areas, including those which are difficult to access
- the gender imbalance has decreased significantly
- increasing number of countries are requesting for free supply of MDT drugs

But this is not the end of the story. This was probably the less difficult part. We are now moving to a far more challenging phase.

Is everything going well?

The prevalence of leprosy is still over four times the target level in the 6 most affected countries - India, Brazil, Madagascar, Mozambique, Myanmar and Nepal. These countries represent approximately 90% of the global leprosy burden.

The reasons for these countries missing the deadline are varied, most important among these being the limited geographical coverage with MDT services. A major operational problem is that leprosy diagnosis and treatment remains a highly centralised activity, often only conducted by specialised staff. In addition the guidelines followed in some countries are very rigid and complex. As a consequence, patients have poor access to MDT drugs in these countries. This in part explains the substantial hidden caseload which still remains and serves as a reservoir of infection, spreading the disease in communities. Other reasons are limited community awareness about the availability of free and effective treatment, and prejudice. These often lead to tragic consequences such as late diagnosis, high disability rates and low cure rates. Intense fear of leprosy still persists, leading to stigmatisation of affected persons and their families.

In addition there are country specific problems:

- India: persistence with highly centralised vertical programme, poor MDT coverage and administrative target setting for case detections
- Brazil: highly specialised programme, complex information systems and highly migrant population groups.
- Madagascar: high disease burden, lack of health infrastructure and isolated population groups.
- Mozambique: lack of health infrastructure, heavily dependent on NGO projects, political conflicts and natural disasters.
- Myanmar: limited coverage in many states/provinces, lack of infrastructure, political insecurity and lack of resources.
- Nepal: difficult geographical areas, dependent on specialised NGO projects, low political commitment and lack of resources.

In addition, some countries facing civil conflicts and economic turmoil have experienced severe damage to their health infrastructure, affecting all developmental projects.

What is needed is the implementation of a more simplified approach to diagnosis and treatment, using the general health worker at the village level and making services "patient-friendly" and uncomplicated, so that patients are able to complete the course of treatment with minimum disruption to their daily lives .

Overcoming these problems requires special actions. And special action is being taken.

There is new political commitment and policy changes.

Brazil and India are implementing the policy of decentralization and integration with mixed results.

However, new challenges are emerging in Nepal and Madagascar in terms of political instability and insecurity.

The problems in Mozambique and Myanmar are being solved with the help of all partners.

The question is: in the face of limited time available, how many of these countries will be able to implement the revised strategy and reach the goal of elimination?

The challenges are both technical and operational. I trust that technical issues will be discussed in detail during the Congress. I would therefore focus my lecture on the main operational challenges.

The issue of stable, or even increasing detection in some countries, or some parts of a given country calls for in depth discussion.

Many experts interpret the current high detection as a failure of the elimination strategy. Today, as the expansion of MDT services is reaching previously uncovered or poorly covered areas, most of the new cases detected each year comprise cases that acquired the disease several years earlier but remained undetected for various reasons. This increase in "new" cases in the short term is not only inevitable but also desirable as large numbers of previously undetected cases are now coming forward for diagnosis and treatment. Only a small percentage are true "incident" cases i.e. experiencing onset of the disease within last one year. One or more good campaigns should be able to detect almost all backlog cases in the community. In fact information from the majority of endemic countries clearly shows that after repeated leprosy elimination campaigns detection trends are showing significant decline.

However the alarming increase in the number of new cases detected in some major endemic countries, notably India, is a major concern. This is mainly the result of several operational and administrative shortcomings, rather than to epidemiological factors. Concerned national authorities should undertake urgently critical analysis of the situation. All programmes should strictly follow the definition of a new case of leprosy at all levels and establish mechanisms to validate data on case detection before their publication. The practice of setting targets for case detection and case discharge given by some countries should be discontinued and instead focus on increasing programme coverage and cure rates.

Why integration is now essential?

Integration of leprosy into the general health services is a key component in the strategy for leprosy elimination. It improves the coverage of leprosy services and makes it an integral part of basic health services provided to communities. This is considered to be the most effective method to ensure that the significant gains in leprosy elimination are sustained. We know that new cases will continue to appear for several years, although in reduced numbers, even after the elimination has been achieved due to the long incubation period of the disease. Once the general services assume responsibility for the diagnosis and treatment of leprosy, patients' will continue to have access to diagnosis and treatment - even after elimination.

There is, in my opinion, irrational fear among some experts that integration will lead to poor quality services to leprosy patients. These experts even suggest that leprosy diagnosis and management may be difficult for the general health workers.

This is disrespectful to the dedicated general health staff who are everyday dealing with much more complicated, often life threatening conditions.

Why an intensified strategy is needed?

An increasing number of voices from the scientific community, governments and donor agencies were raised to argue that elimination should relate to reduction in incidence. Today, the main concern is about the detection remaining stable over the last few years, with well over 500 000 cases being newly detected every year.

It is a fact that the number of health facilities capable of providing MDT services, even in an endemic district is extremely limited. In addition, such services are accessible to the community only for a limited time during the month.

Considered as a special issue, diagnosis and treatment of leprosy remains isolated from general health services and considered beyond their capacity and responsibility.

To overcome these difficulties, WHO and its advisory bodies have developed several mechanisms, both technical and operational.

Endemic countries are provided with:

- simplified guidelines for case management,
- training to strengthen local management capacity,
- free supply of MDT drugs in blister calendar packs and
- direct financial support for special activities.

Ensuring that MDT services are available and readily accessible to patients at the nearest health facility is the most critical element in the elimination strategy.

The intensified strategy aims at focusing activities at the district level, particularly in countries at risk of not achieving elimination.

I will touch on some of the key components of the revised strategy:

MDT services integrated into general health facilities:

The integration of MDT services within the general health services is regarded as the key to achieving elimination.

The rationale behind this approach is that the general health services are generally relatively more widely distributed, and have close and frequent contact with the local community.

Involving the general health services will improve case-finding and case-holding activities, as well as cost-effectiveness of the programme.

In addition, such integration will help to reduce stigma and increase awareness about the disease in the community.

How to do it?

Successful integration can be achieved only if the process is well planned, simple and practical.

The tasks assigned to health workers from the general health services should be clear and in line with their daily routine activities, including the information systems.

It is important to maintain an element of a specialized programme in all endemic countries, either at the central level or -- in some large countries -- at intermediate level. This specialized element for leprosy should provide technical guidance, monitor activities and evaluate progress towards elimination.

Promoting community action

The participation of the community in the elimination activities needs to be increased in order to positively change the image of leprosy and reduce the fear of leprosy and the stigma attached to the disease.

This will require identifying obstacles to community participation and developing strategies for promoting community action.

The main difficulty encountered currently is ignorance about the symptoms/signs and curability of the disease.

The local community and its leaders should play a key role in improving public awareness of the signs, symptoms and treatment of the disease and the availability of free and effective treatment.

Advocacy

Leprosy has always had certain very special features, as a disease affecting mainly under-served populations and generating intense emotions linked with the age-old stigma against those affected by it.

As a result, the fight against leprosy has traditionally been undertaken by a relatively small group of people, although highly dedicated they are often reluctant to share the responsibility for the disease and its control with a wider audience.

This explains to some extent why the tremendous achievements in leprosy control during the last two decades are not well known, or are even underplayed.

Today we know leprosy to be curable, but making it interesting and attractive to the public, the scientific community, the decision-makers and the politicians does not seem to be easy. However many countries are now adopting a positive communications approach to change the image of leprosy, using the mass media together with community mobilization, with considerable success.

Re-motivating the research community

Nowadays there is an element of desperation within the leprosy research community because epidemiological research on new drug development and diagnosis has largely disappeared. If the current elimination strategy is to have an effect on transmission, it is unlikely to be obvious immediately because of the long incubation periods. Epidemiometric modeling suggests that the declined incidence rates are likely to be rather gradual, and in the order of halving every 30-40 years. Many factors other than MDT influence incidence rates, including BCG immunization, socio-economic improvement and reduced overcrowding. Therefore, sustaining the reduction in prevalence by ensuring effective case detection and treatment of all new cases is crucial.

Priorities set for leprosy research should support the leprosy elimination program. These would include the development of tests for leprosy exposure (both skin tests and simple blood tests), tests for the prediction of reactions, and better means of prevention of nerve damage. In the long term, research could provide tools for surveillance of transmission, reactivation of disease, detection of non-human sources of infection, and emergence of drug-resistant leprosy strains. Active preventative interventions identified by research would further help reducing the incidence of leprosy.

Taking into account that our arsenal against leprosy is limited, it appears fully justified to maintain and support key research activities, relevant to elimination and beyond. New optimal methods for the early detection and treatment of reactions and neuritis need to be developed and novel approaches to their prevention explored.

In addition, there is a particular need to encourage and strengthen the capacity for epidemiological and operational research.

A Uniform MDT regimen for both multibacillary and paucibacillary leprosy would be of great advantage. Such regimen would make chemotherapy simpler, particularly in the context of integration and sustainability of elimination. Later you will have the opportunity to hear more on this subject.

Prevention of disabilities and rehabilitation

Early detection and MDT is the best strategy to prevent development of deformities. For those who are detected late, simple disability prevention and management components must be incorporated within leprosy elimination programmes.

The approach for rehabilitation of those who are severely affected-physically, socially and economically-will be to strengthen collaboration with other relevant services and organizations working in this field.

Any attempt to create special services only for leprosy an afflicted individual is likely to fail, as it will perpetuate stigma, will not be cost-effective or sustainable.

Some examples of countries which benefit from the intensified strategy

- In India, detection rates are among the highest in the world (about 60 per 100 000). The case detection trend is not showing any appreciable decline, and there is no single clear explanation for the persistence of this situation in spite of a highly specialized and expensive vertical programme being in operation for close to 50 years. The first problem may lie within the system itself, which burdens the field workers with annual case detection targets and reduces the specificity of diagnosis. Secondly, the reluctance to fully involve a the reasonably well-developed primary health care system in leprosy elimination activities prevents adequate geographical coverage and limits accessibility to MDT services for individual patients. Thirdly, the uneven burden of the disease in different States of India, and the disparate distribution of resources and activities based on historical attitudes, have resulted in intense activities in certain States and limited activities in others. It is possible that there are other reasons for the confusing detection trends in India. An in-depth assessment of the situation is urgently needed in order to reorient the programme towards the elimination goal. The government with other national and international partners has taken a bold decision to decentralise the programme, giving its ownership to the states. In addition, many innovative approaches are being implemented to bring about a well-planned transition from the current vertical programme to full integration within the well-established primary health care system.
- In Madagascar, a significant increase in number of cases detected in recent years cannot be explained just by the intensification of activities. The likely reason for such a constant increase, with a high proportion of MB patients, is the slow expansion of leprosy services to previously uncovered areas. This is further complicated by the current political and economic turmoil. There are hopeful signs that the situation is improving and the political commitment for leprosy elimination will be forthcoming.
- In Brazil, the detection trend in terms of number of new cases detected is more or less stable or even has shown an increase, as it did since the inception of the national programme. However, leprosy elimination campaigns did not contribute significantly in detecting "hidden" cases. The programme is still managed as a highly specialised programme with limited stress on integration within general health services. Many new initiatives have been introduced to decentralize the programme to municipalities, improve community awareness through mass media and gaining high political commitment for the elimination efforts.
- In Myanmar, the programme coverage was mainly concentrating on a limited number of states/divisions, which were historically regarded as high endemic areas. The activities in the remaining parts of the country were negligible for various reasons, including problems of insecurity in the border areas. In recent years Myanmar has taken concrete steps to expand the MDT service coverage to all the states and divisions. The programme is fully integrated within the basic health services with referral and specialised support provided by a handful of vertical staff. The country is most likely to achieve the goal of elimination very shortly.

What could happen in the near future?

If no urgent action is taken?

Although significant progress has been made towards eliminating leprosy as a public health problem worldwide, it is clear that some countries will not reach the elimination target at the national level by end of the year 2005.

In those countries, which have reached the target at the national level, there is still a need to achieve elimination at the sub-national levels and to sustain elimination activities for a number of years.

If detection trends are not closely evaluated?

It is evident that due to improved disease control activities, the detection of new cases has increased over the last few years. This does not mean that the transmission is on the increase or has not been interrupted. This status simply reflects the inadequacy and inefficiency of the programmes which were relying (and some are still continuing) on keeping the ownership of leprosy elimination with the highly specialised leprosy services. This approach has not only harmed the control of the disease but has also perpetuated and even increased the negative image of leprosy in the community.

If issues related to disabilities and rehabilitation are not addressed?

Leprosy is feared because of the occurrence of disabilities it causes. Very little has been done in this area. There are several reasons for this:

- inadequate efforts to develop effective tools and
- failure to address the issue through integrated services for all disabled in the community.

The problem, in socio-economic and human terms is enormous and we will need many partners to solve it, including the affected communities in the endemic countries. In the meantime, early detection and treatment with MDT will remain the best strategy for preventing the occurrence of disabilities.

If we continue to do 'more of the same'?

Today the main challenge could be to accept the fact that we, the "leprosy-workers", are the greatest obstacles to the necessary "change" we are so passionately trying to bring about.

Can we build capacity of our colleagues in the primary health care services and hand over the leprosy elimination mission to them? Other diseases like malaria, tuberculosis and AIDS, which are on the increase and continue to absorb most of the resources available for health globally. This is totally justified.

However, within this context it will be important to ensure that leprosy is kept on the health agenda and the opportunity for its elimination is not lost.

The role of WHO

WHO's is a developmental agency. not a funding agency but its role is to assist countries in developing more effective & sustainable health systems.

It sets global standards and pleads the cause for a global advocacy to elimination of leprosy as a public health problem.

Over the next few years, WHO and its partners will focus their attention on the countries where the disease remains a public health problem.

It will make all possible efforts to sustain elimination in those countries which have recently reached the target.

We believe that the implementation of an intensified strategy will promote and sustain the political commitment required to achieve elimination, especially in countries that will require additional efforts.

Although WHO is pursuing a public health policy to eliminate leprosy, we believe that there should be no compromise in ensuring that all patients receive the best possible treatment and care. The level of excellence for individual patient management will largely depend on the capacity and resources available to the national programmes.

In most of the endemic countries, for obvious economic reasons, WHO's advice is to follow a simple, cost effective policy which will benefit all communities. This is based on two governing principles: equity and sustainability.

It is often said that "best is the enemy of good".

With limited resources and competing priorities, WHO and its member states are trying to implement what is good for all (some may argue that this may not be the best for one).

We also believe that leprosy is not a complicated, difficult to manage or expensive to treat disease. Most, if not all, patients can be diagnosed by typical clinical signs alone.

All patients can be managed by any trained health worker in a primary health centre.

Every patient can benefit from the standard MDT regimens, supplied free of cost to all endemic countries.

In spite of this, a small number of patients will require special attention. This is true for any communicable disease or for that matter any disease.

We as partners, including the experts present here today need to find a balance.

We should not discard what is GOOD for ALL, in preference to what is BEST for a FEW.

Let us discuss and find ways how to combine the public health approach with individual care. Let us take the best in both and make something which is BETTER for all.