FIRST MEETING OF
THE GLOBAL ALLIANCE FOR
ELIMINATION OF LEPROSY

- G A E L -

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1. INAUGURAL CEREMONY

The first meeting of the Global Alliance for Elimination of Leprosy was inaugurated by Dr C. P. Thakur, Honourable Union Minister of Health and Family Welfare, Government of India. A formal invocation and the ceremonial lighting of the lamp, followed by observance of a one-minute silence for the victims of the earthquake in Gujarat, preceded the opening ceremony.

In his message, which was read by Mr A. Raja, Minister of State for Health, the Honourable Prime Minister of India, Mr Atal Behari Vajpayee, affirmed his commitment to eliminating leprosy in India. He said that, despite tremendous scientific progress during the last century, which had led to the availability of a simple and effective treatment, it had not been possible to eliminate leprosy, the oldest scourge of human kind, from India. Most of the disease burden and the onus for elimination rests with endemic countries. In the new millennium, therefore, it was appropriate that a Global Alliance had been formed to join hands, mobilize resources and strengthen efforts in order to eliminate this disease. «All must pledge to attain the target of elimination in the next five years», the Prime Minister stated. Since both the size and population of India meant it bore a disproportionate percentage of the global burden, he gave his assurance that the Government of India would give the highest priority to elimination efforts.

Dr C. P. Thakur stated in his inaugural address that hosting the first meeting of the Global Alliance on the occasion of Martyr’s Day was a great privilege. This day was also observed every year as World Leprosy Day in recognition of the great concern that was shown to leprosy patients by Mahatma Gandhi throughout his life. The Global Alliance, formed on the initiative of WHO, had brought together all partners working in the field of leprosy elimination and the 12 countries most affected by the disease, which together bore about 90% of the global burden. The Alliance aimed to ensure that all remaining leprosy cases in the world, currently estimated at around 2.5 to 2.8 million, were detected and cured by the year 2005.

He recognized that India carried about 61% of the global burden and stated that significant progress had been made in the last few years, owing largely to the adoption of the campaign approach, intense awareness-raising activities and efforts to integrate leprosy into the general health services. There was now a firm commitment to carry this momentum forward and Dr Thakur expressed his optimism about this, stressing that the pool of knowledge and experience that has been gained so far would undoubtedly assist in strengthening further efforts. Dr Thakur concluded by saying that societies were often judged by the way in which they treated their most disadvantaged citizens and the next five years would be a testimony to such actions.

Dr Gro Harlem Brundtland, Director-General, WHO, conveyed in her video message that the Alliance, which had been launched in Abidjan in 1999, had proved itself to be a true partnership. She noted with pleasure that the national authorities of leprosy-endemic countries had become the key players in leprosy elimination activities and she warmly acknowledged the important support extended to these efforts by all partners in the Alliance. Outlining the importance of the tasks ahead, she summarized the objectives by stating clearly the need to find every single per-
son suffering from the disease and ensure their treatment and cure using multidrug therapy (MDT).

Dr Upton Muchtar Rafie, WHO Regional Director for South-East Asia, emphasized that all leprosy elimination efforts needed to focus on The Final Push strategy agreed by the Global Alliance. He also noted that this meeting was opening on World Leprosy Day, given that it was also the anniversary of the death of Mahatma Gandhi, who had taken up the cause of leprosy patients with such passion. Dr Rafie stressed that adequate supplies of multidrug therapy (MDT) were available free of charge from WHO and that countries should ensure that this treatment became available to every patient. Primary ownership of leprosy elimination should now rest with general health workers with specialized leprosy staff providing referral support where necessary. Massive media campaigns and advocacy efforts needed to be undertaken in order to ensure voluntary reporting and early detection. The message that leprosy was curable and that treatment was available free of cost needed to be disseminated as widely as possible.

Dr David L. Heymann, Executive Director, Communicable Diseases, WHO, cited the tragic social and psychological consequences that leprosy had brought to those affected by the disease and their families owing to the disfigurement and disfigurement that it could cause. Each and every one of us was now empowered with the knowledge and resources to change that situation, and we had an unique opportunity to rid mankind of this age-old scourge. All persons diagnosed with leprosy could now be treated and cured within six to 12 months. Leprosy was no longer a medical challenge but one of logistics and infrastructure, of determination and dedication.

At the end of 1999, in Abidjan, delegates of the 3rd International Conference on Elimination of Leprosy, endorsed collectively The Final Push strategy to intensify activities in the endemic countries. The major thrust of that strategy, Dr Heymann stated, focused on integrating leprosy into the general health services, on teaching health workers at all levels to diagnose and treat leprosy, and on building an appropriate infrastructure. All available techniques should also be deployed to make communities demand their right to live in a world without leprosy.

Mr Yohei Sasakawa, President, The Nippon Foundation, Japan, stated that the mission of the Foundation was to provide humanitarian assistance throughout the world. Education and public health were two major areas of activities and, within this sphere, the control of leprosy had for a long time been one of its most important projects. Since 1991, when the World Health Assembly resolution was passed to eliminate leprosy as a public health problem, significant efforts had been made towards this goal. At the 1st International Conference on Elimination of Leprosy, in Hanoi, in 1994, The Nippon Foundation had committed US$ 50 million to WHO for the purchase of MDT. Since then, an effective system of procurement and distribution had been established by WHO and MDT had become available throughout the world. At the 3rd International Conference, in Abidjan, in 1999, a further US$ 24 million had been pledged to the implementation of WHO's Final Push strategy. To date, The Nippon Foundation had contributed a total of more than US$ 200 million to leprosy elimination.
However, Mr Sasakawa informed participants that there was a Japanese proverb that said "In a 100-mile journey, the 99th mile is only half-way". That final mile still remained to be accomplished and he reminded participants that it would be a difficult path. He requested health leaders and members of the media to disseminate as widely as possible the message that leprosy was a curable skin disease and its treatment was available free-of-cost at as many health centres as possible. Paying tribute to Mahatma Gandhi, he recalled the famous words that this legendary hero had spoken when asked to open a leprosy hospital in 1945: «Opening a leprosy hospital is not a big matter, but I shall come to close it". These words echo unmistakably the shared goals of the partners in the Global Alliance.

Shri J. A. Chowdhary, Health Secretary, Government of India, stated that most of the national nongovernmental organizations in India had been set up by major public figures in the days before independence. Citing once again the contribution of Mahatma Gandhi to the cause of leprosy, he emphasized the need for global efforts to eliminate this disease and prevent it from causing further physical and social disability. The Nippon Foundation and many other organizations were working together in India and had played a significant role in improving the leprosy situation in his country. He felt it was the considered opinion of all concerned that India was now well on the way to being able to win the battle but, as Mr Sasakawa had pointed out, the last mile is the most difficult. Cautioning against complacency, Mr Chowdhary reiterated the country's commitment to crossing that last mile at the earliest opportunity and gave his assurance that these efforts would be backed by the highest possible level of dedicated motivation.

The ceremony closed with a vote of thanks offered by Mr J. V. R. Prasada Rao, Additional Secretary, Ministry of Health of India.
2. REVIEWING THE COMMITMENT OF MEMBER COUNTRIES AND PARTNERS

The first plenary session included addresses by Ministers of Health of member countries. The honourable ministers affirmed their commitment to leprosy elimination activities and briefly presented the particular achievements, policies and programmes of their respective countries. All expressed the view that the deliberations of this meeting would further hasten activities towards leprosy elimination. During the session, two minutes’ silence was observed by delegates in memory of Mahatma Gandhi.

Angola

Dr A. J. Hamukwana, Honourable Minister, viewed this meeting as a unique opportunity to draw up a joint strategy for endemic countries to reach the goal of eliminating leprosy by 2005. Angola was represented within the group of most endemic countries with a prevalence rate of 2.62 per 10,000 population, 17% new patients with Grade 2 disabilities, and a considerable number of child leprosy cases. The Minister said that the Ministry of Health in Angola was already implementing a programme that aimed at intensifying activities through the reinforcement of information, education and communication (IEC), involvement of the community, early detection and treatment with MDT, and social/professional rehabilitation of persons cured from the disease. Despite the many adversities her country was facing as a result of the ongoing war which impaired the access of patients to treatment, the Minister assured the firm commitment of her Government to the struggle against this terrible disease, which placed a heavy social and economic burden on her country.

Central African Republic

Re-emphasizing the importance of the Global Alliance, Dr Gilbert Dimanche Nzil’Koue, Director-General, Health and Population, stated that there was a need in his country for coordinated efforts in terms of supplying both materials and finance if leprosy was to be eliminated. In the 1980s, effective mobilization of information related to medical research helped to develop an effective treatment. This treatment (MDT) had succeeded in greatly reducing the leprosy problem, although the disease remained a public health problem in about 20 countries. The major obstacles to this had been identified as being linked mainly to organizational management and those now needed to be addressed and overcome as a matter of urgency. The formation of the Alliance imposed on the countries a sense of solidarity. The governments of the different African countries had already appealed to other countries to help each other in order to make a concerted effort to ensure that leprosy was completely eliminated.

Democratic Republic of Congo

Speaking on behalf of Professor Mashako, Minister of Health, Dr Miaka Mia Bilenge stated that the geographic coverage of leprosy elimination activities in his country was about 56% despite the ongoing war and the recent tragic assassi-
necation of the President, His Excellency Mr Laurent Desire Kabila. The new President, together with the entire 60 million population, were strongly committed to leprosy elimination. It was, however, one of the priority areas that had been described as having a well-organized national programme. Agreement had already been set up with existing partners working in this area of his country and included their participation in the decision-making process and identification of each of their roles. The country had adopted in 1999 a sectoral policy for the elimination of leprosy and task forces had been set up for this at both national and provincial levels in July 2000. The task forces had adopted the national plan of action. Dr Miaka said that, in 1982, the country had been divided into 307 health zones, each with about 20 health centres taking care of about 100,000 people. The Government was planning to increase the number of health zones to about 500 in order to facilitate access to health care. Citing the success of his country in the polio eradication campaigns of 1999 and 2000, he stated that he felt sure that this concerted partnership effort would also be a key to the success of the leprosy elimination programme.

Guinea

Professor Mamadou Saliou Diallo, Honourable Minister, confirmed his Government's solidarity and support for the Alliance and stated that discussing the problem of leprosy in detail should be a priority for all members. Leprosy was one of the diseases that had not yet been eliminated in Guinea and, even though it had been given high priority, it remained a major public health problem. The Ministry was looking for more efficient methods of enhancing the process of elimination and special efforts were being made to tackle the various obstacles. Representatives of regional and international organizations were working with national authorities in this direction. Great efforts were being made to reach the goal of elimination in the near future and it was felt that this was within reach of the national health framework. The geographical coverage of leprosy services was complete, but the quality of the services needed to be improved. Particular attention was also being paid to community involvement and activities in difficult-to-reach areas. Refresher courses were being provided to health workers in order to train them in the diagnosis and treatment of leprosy. Some organizations were focusing their efforts on regions where there was a particularly high prevalence of leprosy but work was being strengthened in all areas to ensure that elimination of leprosy kept abreast of the global target.

India

Dr C. P. Thakur, Honourable Minister of Health and Family Welfare, said that India was presently at the top of the list of endemic countries. It bore a burden of 0.46 million leprosy patients, out of which 56% were cases of consequence. The country was fully aware of this and of the need to give it priority. Achievement-wise, the first phase of the national leprosy elimination project had been completed successfully and not only was the project's target reached, but it was surpassed. During the first phase of the project, the country detected 3.8 million new
patients, and it was noted that more than 72% of all new patients detected globally were from India. The Indian programme is therefore starting a second phase of activities spanning the next three years. The second phase of the project envisaged coordinated efforts on the part of all partners. It was estimated that a total of 1.15 million patients would need to be detected and cured during the three-year period. Most of these were concentrated in a few states and the health ministers of those states were present at the meeting to share a common purpose and a common resolve. The project envisaged intense activities to generate awareness, full integration of leprosy into the general health services to increase accessibility to MDT, and continued campaign approaches in endemic areas. Dr Thakur confirmed that the country was fully committed to eliminating leprosy within the next five years.

Indonesia

The representative of the Ministry of Health, Professor Umar Fahmi Achmadi, Director-General, Communicable Diseases Control, stated that Indonesia had the fourth largest caseload of leprosy in the world. At the national level the country had reached elimination with a prevalence rate of 0.99 per 10 000 population. However, about one-third of the country’s population lived in rural areas which had a prevalence rate of more than one case per 10 000. The staff of primary health care centres were currently providing MDT services. On 27 January 2001, however, the Government had signed a memorandum of understanding with donor agencies and organizations for capacity building of health workers and facilitating the provision of referral services. The quality of MDT services would be improved, particularly in endemic areas, and access to treatment would soon become much easier for patients. Reiterating the country’s firm commitment to eliminating leprosy, Professor Achmadi stated that further plans were being made to intensify activities to promote the campaign approach to case-finding in selected areas. Though this task was not simple, it should be possible to accomplish it through renewed efforts. The country was looking forward to a global plan of action which was simple and practical and which was capable of reaching the elimination goal in the stipulated time.

Madagascar

Describing the country’s leprosy situation, the Honourable Minister, who was also Co-chair of the Alliance, Dr Henriette Ratsimbazafimahefa Rahantalalao, stated that although Madagascar’s national leprosy elimination programme had inadequate strategic tools to assess the exact situation, organized efforts were being made to improve those efforts. The programme was now able to detect more than 50% of cases and to make MDT and other facilities available to them. Reporting forms had been prepared to collect information regarding the current leprosy situation at national and regional levels. Plans had been prepared for district-level activities, which could possibly also be used as a reference by other countries to intensify their own struggle against leprosy. The Minister felt that it was time to mobilize all technical tools available that would assist in making the struggle a
more organized effort and would lead to the final goal of eliminating this age-old disease. The various obstacles encountered during the last few years, which had already been identified in other meetings, had provided valuable experience that could be used both in Madagascar and in other countries. The Ministry of Health in Madagascar had decided to decentralize leprosy services to regional health authorities under the guidance of the national programme. Other strategies that had been adopted included social mobilization efforts and IEC campaigns, as well as special "leprosy weeks" to generate more active participation of communities.

Mozambique

Dr Alexandre Manguele, Director of Health, renewing the commitment of the people and the Government of Mozambique, indicated that, with the assistance of WHO and other partners, the country would proceed in taking new measures to eliminate leprosy as a public health problem from Mozambique by the year 2005. Recent priorities had been aimed at boosting health promotion activities, with more intense community involvement and an integrated approach to overcome difficulties caused by limited manpower. Intersectoral collaboration was a priority target and being achieved through the education sector and grass-roots level community health units, amongst others. Leprosy elimination campaigns had proved to be of great value, though they required high levels of resources. The programme primarily placed stress on community involvement and on training activities, both of which also need more effort and resources.

Myanmar

Presenting the country's leprosy situation, Professor Kyaw Myint, Deputy Minister of Health, stated that the Government of Myanmar had launched an antileprosy campaign in 1955. Repeated surveys at that time had shown a high prevalence rate and a distribution of the disease that was not uniform, with pockets of particularly high endemicity in some parts of the country. By 1991, the national leprosy control programme had been fully integrated into the basic health services and the health personnel, especially the midwives, who are known as "Red Angels", had become service providers of MDT. Over 200,000 people have been detected and treated during the last 10 years thanks to their efforts. Observing that leprosy remained the eighth priority disease of the national health plan, the Deputy Minister stated that the programme was implemented through the Leprosy Elimination Steering Committee, which consisted of responsible personnel from both the intrasectoral and intersectoral departments, ministries and nongovernmental organizations. A task force had also been formed at the central, state, divisional and district levels to advise, supervise, monitor and evaluate technical and operational aspects of the programme. In addition, a Leprosy Elimination Coordination Committee was formed in April 2000 with representatives from the National Task Force, WHO and international nongovernmental organizations. Since 1997 a concerted effort had been launched with health service personnel joining hands
with related ministers, departments, social organizations and media personnel. As a result, the prevalence rate of leprosy had been drastically reduced from 53 per 10 000 in 1987, to 2.3 per 10 000 in the year 2000. He stated, however, that there was a need to look for more backlog cases in order to ensure their early detection and treatment with MDT, to create community awareness, to improve the quality of patient care and to strengthen partnerships for sustaining the momentum of leprosy elimination activities. Stating also that Myanmar was within the "last mile", he reconfirmed the country's will to double its efforts in the coming years in order to eliminate leprosy from the country by the year 2003.

**Nepal**

Presenting Nepal's leprosy situation, the Representatives of the Ministry of Health, Dr B. D. Chautau, expressed appreciation for the recent efforts made by WHO and welcomed the formation of the Global Alliance. He stated that the Government of Nepal was committed to eliminating leprosy by 2003. The World Health Assembly resolution of 1991 urged Member States to eliminate leprosy as a public health problem by the year 2000 and many countries had already achieved this goal while the remaining countries aimed to do so by 2005. A meeting had recently been held in Nepal to discuss elimination activities at which it had been agreed that it would be possible to eliminate the disease from the country by 2003 subject to the availability of resources. The leprosy elimination campaign undertaken two years ago had revealed that the disease burden in the so-called low-endemic areas was much higher than estimated. An in-depth analysis of the situation had therefore been undertaken recently and, following identification of high-endemic districts, a training programme for all health workers had been introduced in order to empower them to provide quality services at all health facilities. Leprosy elimination campaigns had been planned with the collaboration of all donor agencies working in Nepal to detect the remaining hidden cases. The Government of Nepal was optimistic that with their continued support the country will reach its desired goal.

**Niger**

Presenting the country's situation, the Honourable Minister, Mr Assoumame Adamou, stated that elimination of leprosy was a challenge when health service coverage was estimated at around 42%. Some high-endemic zones remain: out of a total of 38 districts, eight have a prevalence rate higher than five per 10 000.

A National Task Force had been created and started functioning in the first quarter of 2000. Major strategies to reach elimination goal were social mobilization, participation of village volunteers, and decentralization of leprosy elimination activities to the district level.
3. ADDRESSES BY WHO REGIONAL DIRECTORS AND PARTNERS

WHO Regional Office for Africa: On behalf of Dr Ebrahim M. Samba, Dr Antoine Kabor, Director, Disease Control, stated that a concerted effort was being made in the Region to eliminate the disease by 2005. He was hopeful that the exchange of information and experiences during this meeting would further assist in undertaking new activities to reach the goal of elimination from all endemic countries in this Region. Until now there had been very weak dissemination of education and sensitization of people about this disease but it was expected that this would be overcome by continued efforts. In an effort to eliminate leprosy, partners in this Region were ready to extend every kind of help and assistance in attaining the goal of elimination. Resolutions had been renewed last year to reduce the prevalence rate in member countries and since then 41,000 cases had been detected. Rehabilitation work for people who had already suffered disabilities owing to leprosy continued simultaneously.

WHO Regional Office for the Americas: On behalf of Dr George A. O. Alleyne, Dr Clovis Lombardi, Regional Adviser for Leprosy, noted that the first step towards global elimination, the introduction of multidrug therapy (MDT), had been completed and had resulted in millions of patients throughout the world being cured. PAHO and countries of the American Region had been committed to the goal of elimination from the very beginning and had cooperated strategically and operationally to ensure that overall the Region reached the elimination target before the year 2000. However, referring to the challenges lying ahead, he pointed out that some countries had not achieved elimination so far and that there was a need for renewed and sustained effort to achieve it in the shortest possible time. Countries that had achieved elimination target must consolidate and monitor results already obtained by focusing on more peripheral geographical levels and making sure that possible hidden pockets of leprosy were detected and treated early. He further reaffirmed AMRO’s support to the Global Alliance and continued active collaboration in The Final Push, as well as implementation of the Strategic Plan 2000-2005.

WHO Regional Office for the Eastern Mediterranean: Dr Hussein Gezairy stated that countries of the Eastern Mediterranean Region had made significant progress in implementing the resolution of the Forty-fourth World Health Assembly, which committed Member States to promoting all control measures necessary in order to attain the global elimination of leprosy as a public health problem. The political commitment of Member States was expressed in the adoption of the Regional Committee resolutions on the elimination of leprosy. A review of progress showed spectacular achievements in the Region and the regional prevalence of leprosy had decreased from 0.99 cases per 10,000 population in 1990 to 0.22 in 2000. The MDT coverage was 99.2% and surveillance and reporting of new cases had improved considerably. The number of patients with Grade 2 disabilities had come down from 22.8% in 1995 to 18.3% in 1999. Significant efforts had also been undertaken to mobilize communities in leprosy elimination activities and empower local health services in the detection and treatment of patients. In the majority of countries case-finding activities and treatment have been the responsibility of primary health care services. Dr Gezairy affirmed the commitment of the Region to eliminating leprosy and noted that the challenges ahead included dealing with pockets of infection in some countries with high prevalence and removing the social stigma related to the disease.
WHO Regional Office for South-East Asia: Dr Uton Muchtar Rafei pointed out that the South-East Asian Region contributed 76% of all global leprosy cases, with India, Myanmar and Nepal classified as Group 1 countries. Special efforts were needed in these countries. WHO would continue to provide technical support to member countries to vigorously implement the best course of action, which included: enabling all health facilities in endemic districts to diagnose and treat leprosy, ensuring easy and uninterrupted access to MDT, ensuring high cure rates through patient-friendly drug delivery systems, generating community awareness which results in earlier self-reporting, sustaining high geographic coverage, and the prevention of disabilities programmes.

WHO Regional Office for the Western Pacific: While presenting the experiences of leprosy elimination in the Western Pacific Region, Dr Shigaro Omi assured full commitment to the vision and objectives of the Global Alliance. He stated that the target rate of less than one per 10,000 had been reached in 32 out of 37 countries at the end of 1999. The success of leprosy elimination reflected the technological advancement and commitment of all Member States of the Region. He continued by saying that the introduction of MDT had been a turning point in the history of leprosy elimination and that it was the responsibility of all Member States to implement MDT as widely as possible in their countries. Success for this was particularly attributed to the donor agencies and partners. All of them deserved commendation for their initiative. The challenges ahead in the Western Pacific Region, Dr Omi added, were to reach elimination level in the remaining five countries, to sustain elimination in the countries that have already achieved the target, and in those countries to move beyond national level to subnational levels and highly-endemic pockets. There was also a need to strengthen prevention and management of disabilities through community-based rehabilitation. Further reaffirming the Region's commitment to leprosy elimination, he endorsed the partnership approach that had been vigorously pursued so far.

Danish International Development Assistance (DANIDA): The statement of the Danish Ambassador, Ms Birgitte Storgaard, was presented by Dr B. F. A. M. Peters, Chief Adviser to DANLEP, based in New Delhi. Dr Peters pointed out that DANIDA has been a partner of the National Leprosy Elimination Programme (NLEP) in India since 1986 and had mainly been operating through the Government system in the states of Madhya Pradesh, Orissa and Tamil Nadu. DANIDA was directly involved when support to NLEP was being planned and appraised, and it was therefore rewarding to see that the major issues that DANIDA had tried to promote were now being mainstreamed into the national programme. At that time, the question was raised on DANIDA's Board as to whether support to a vertical programme was not going against DANIDA's commitment to the concept of primary health care and integrated services. It was therefore particularly gratifying to know that it was now the Government of India's intention to actively promote integration throughout the country over the next few years. The innovative interventions developed by DANLEP over the years were based on two mainstays of the DANIDA development policy – namely, the promotion of gender equity and the reduction of poverty. Ensuring women's access to leprosy services had been a crucial issue, espe-
cially given the social stigma attached to the disease. Recognizing that the fight against leprosy was not just a medical battle but one where social and cultural aspects had an enormous influence, DANIDA had actively sought to promote full community participation to change attitudes in society and ensure that leprosy patients were not ostracized but accepted in their local communities. Although the target of eliminating leprosy may not have been achieved right on the set date of December 2000, tremendous progress had been made so far, indicating that this target would be achieved in the foreseeable future. DANIDA reaffirmed its continued commitment to the elimination of leprosy, in close collaboration with Indian counterparts, at least until the end of 2003. Encouraged by the welcome gesture of Novartis to supply antileprosy drugs, DANlep would shortly submit a proposal for an alternative use of the funds that had been earmarked for the purchase of drugs. This proposal would focus once again on activities and interventions directly benefiting those people who belong to the most vulnerable and disadvantaged groups in society: women, children, the elderly and, last but not least, the tribal people in India.

International Federation of Anti-Leprosy Associations (ILEP): Briefly introducing the Federation, ILEP's President, Mr Terry Vasey, stated that it was founded in 1966, although some of its member associations had been in existence for longer than that. Many of them were not only dedicated to the fight against leprosy as a public health problem, but also for the eventual eradication of all problems related to the disease. The slogan of ILEP was "Work Together for a World Without Leprosy", which directly reflected the wording of The Delhi Declaration recommending that "members of the Global Alliance for Elimination of Leprosy collaborate in the true spirit of partnership". Mr Vasey said that true partnership distinguished the work of ILEP and its members and that ILEP had contributed considerably in the course of its involvement. He stated that the global budget for this year to implement the strategy would be US$ 60 million, which would be used to cover a range of activities including early diagnosis and treatment. ILEP members were also involved in research, particularly into the complications of leprosy reactions, and this would continue with renewed commitment in partnership with all concerned. Successes achieved so far, resulting in over 10 million patients being cured, had brought joy to all concerned and he felt that everybody involved in this remarkable achievement should be congratulated. He pointed out, however, that there was still a lot left to be done with the "last mile" often the toughest. Transforming and integrating a vertical programme into a combined health service programme was very difficult, requiring an intensive process of making services available to others. Many instances exist, even today, of people suffering from leprosy being ostracized from society and being excluded from normal social life. Overcoming this remained a gigantic task for all those participating in the fight against leprosy.

The Nippon Foundation: Briefly narrating the history of the Sasakawa Memorial Health Foundation, its Chairman, Professor Kenzo Kiikuni, stated that the founder of The Nippon Foundation, Mr Ryoichi Sasakawa, had committed his life-long work to the elimination of leprosy. He had founded The Nippon Foundation 50 years ago with one dedicated pharmacologist whose work had been linked with the invention
of dapsone. In 1974, on his 75th birthday, Mr Sasakiawa made his first donation of US$ 1 million to WHO with the sole stipulation that it be used as effectively as possible for the welfare of leprosy patients. That was the beginning of a long and fruitful collaboration between the two organizations. During the last 25 years since then, the Foundation had donated more than US$ 200 million for the cause of leprosy and other activities. So saying, Professor Kikuni pointed out that forming the Global Alliance was very important for the cause of leprosy elimination. He felt that it was even more encouraging that the highest level of political commitment was now forthcoming through the health ministers of the countries involved. No attempt should be spared to remove the stigma prevailing in society and to ensure that leprosy patients are not treated like outcasts.

**Novartis Foundation for Sustainable Development:** Expressing commitment towards the goal of eliminating leprosy by 2005, Ms Penny Grewal stated that Novartis had a long association with leprosy, starting with the development of the two key components of MDT, carrying out the first clinical trials to establish once-monthly use of Rifampicin and designing the first blister calendar packs (BCP) for MDT. MDT is the cornerstone of leprosy elimination and BCPS had simplified its use, leading to improved patient compliance. Since 1985 the Foundation had been actively involved in leprosy programmes in Africa, Asia and Latin America. In addition, it was also developing innovative methods to provide comprehensive patient care at community level in India and other countries. Novartis, in 1999, had pledged to donate to WHO the treatment required for all patients throughout the world up to 2005. In the first year of the commitment, over nine million blister packs had been shipped to various countries. There was close coordination with WHO in planning, production and supply including maintaining a buffer stock to the tune of 30% of the requirement to meet any emergency requests. Being completely aware that drugs alone were not going to eliminate leprosy, the Foundation strongly believed in working together closely with partners of the Alliance to help ensure that the drugs were actually accessible to patients in the communities where they live. Novartis fully appreciated the contribution of the partners, particularly of the National Governments, to the Alliance and their role in making MDT available in all health facilities. Ms Grewal concluded by emphasizing that the Global Alliance was a formidable power and never before had the goal of elimination been so much within reach.

**The World Bank:** Mr Peter Heywood, Principal Health Specialist, confirmed that The World Bank was committed to leprosy control as part of its overall commitment to control communicable diseases (CDS), particularly in a number of projects all over the world and in several parts of India. As such, the Bank’s commitment was part of its poverty alleviation strategy and referred to it as the externality of control of CDS. Curing a person of a communicable disease obviously affected many people in due course and justification of the Bank’s funding was based on this principle. The Bank had increased its general support significantly during the 1990s, particularly for projects in India. The projects were organized in collaboration with national governments and, in the case of leprosy, with WHO and international donor agencies, such as the Sasakiawa Memorial Health Foundation, bilateral agencies such as DANIDA, nongovernmental organizations such as ILEP, and partners in
the private sector such as Novartis. WHO provided technical leadership. In the
control of CDS, the Bank was insistent that projects supported were sustainable by
integration into the general health services. The Bank was fully committed to lep-
rosy control, supporting several of its components. In India, it had a substantial project
because of the magnitude of the problem and the number of people involved, with
the Government of India being the major partner. The first phase of the project had
already been completed and the Bank intended to continue to support the second
phase of the project, details of which would soon be finalized with the Government.
It intended to pursue leprosy control in those states and districts where the disease
continued to be a major problem. As before, the second phase of the project would
involve the whole range of partners and was a good example of the collaborative
effort required if leprosy were to be eliminated as per target. The World Bank looked
forward to continuing its active involvement in this important activity.

WHO Headquarters: Dr Maria P. Neira, Director of Control, Prevention and Eradi-
cation, stated that the global resources available to eliminate leprosy as a public
health problem have probably never been higher, and the opportunities and politi-
cal commitment to finally put an end to the disease as a public health problem
never greater. A large part of the credit for this enviable situation should go to the
continuing commitment of national programmes in their elimination efforts, and
the all-round support provided by various partner agencies of WHO including the
international donor community, and nongovernmental organizations (NGOs).

Much of the initial impetus for this progress was provided by the resolution of the
World Health Assembly in 1991 which committed all the leprosy-endemic Member
States of WHO to a global target of reducing the prevalence of leprosy to less than
one case per 10,000 population, with a target date of the year 2000 to achieve this.
The elimination strategy, as expounded by WHO, was based on simplified approaches
to case-finding at the community level, early treatment with MDT and epidemi-
ological surveillance, and this has subsequently been seen as one of the most cost-
effective interventions in the public health domain. Evidence for the soundness of
the WHO strategy is clear enough. The reduced physical, psychological and social
suffering that these figures represent, as well as promoting an improved health im-
age for countries, was truly immeasurable.
4. THE DELHI DECLARATION

The Delhi Declaration, endorsed by GAEL partners, recommended that all Alliance members collaborate in order to eliminate leprosy as a public health problem from every country by the year 2005. It acknowledged that, despite significant progress, access to diagnosis and treatment of leprosy in many endemic countries remained unacceptably low. It expressed concern that other more pressing public health priorities might push some authorities to ignore leprosy and lose this window of opportunity. The Declaration supported the strategy of The Final Push to eliminate leprosy in all endemic countries and emphasized the need for leprosy to be integrated within the general health services. It urged all concerned to ensure an uninterrupted availability of free MDT treatment at all health centers, to dispel the negative image of leprosy, and to improve community awareness of the availability of the treatment.

5. PRESS CONFERENCE

After the opening ceremony and renewal of commitment by all partners, a press conference was held under the chairmanship of Dr C. P. Thakur, Union Minister of Health and Family Welfare, Government of India, at which copies of The Delhi Declaration were distributed. Sharing ideas with Dr Thakur were the Minister of State for Health and Family Welfare, and the Secretary, Ministry of Health and Family Welfare, along with Dr David L. Heymann, Dr Uton Muchtar Rafei and Dr Maria P. Neira, from WHO. State Health Ministers from various regions of India, including Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Uttar Pradesh and West Bengal, participated. The event was moderated by Mrs Harsaran Bir Kaur Pandey, Information Officer, WHO/SEARO, and Ms Melinda Henry, Information Officer, WHO/HQ.

Dr Thakur indicated that although GAEL had a gigantic task ahead to detect and cure all remaining leprosy patients by the year 2005, estimated at around 2.8 million, it was a task which was achievable. He confirmed that India, which bore over 60% of the total global burden of the disease, had made significant progress during the past few years and intended to maintain this momentum. The Minister thanked all partners who support India’s National Leprosy Elimination Programme, particularly by supplying drugs free of charge. Dr Uton Muchtar Rafei, WHO Regional Director for South-East Asia, was adamant that we could not afford to miss the new 2005 deadline for eliminating leprosy. He stressed that vigorous efforts would be needed, particularly in the case of the high-endemic countries, and that, whereas there were adequate supplies of free treatment available to treat patients, it was
important that the primary ownership of leprosy elimination activities should now shift to the general health services, supported by leprosy specialists. Dr David L. Heymann, Executive Director, Communicable Diseases, WHO/HQ, confirmed that the major thrust of future efforts would be to integrate leprosy services into the general health services and to ensure that all health workers received training in how to diagnose and treat the disease even at the most peripheral levels. Dr Heymann reiterated WHO’s commitment to giving every support possible to the global effort to eliminate the disease.

6. COUNTRY-LEVEL SITUATION AND PLANS FOR INTENSIFYING ACTIVITIES

Global challenges in eliminating leprosy as a public health problem: Dr Maria P. Neira, Director of Control, Prevention and Eradication, WHO/HQ, described the start of the new millennium as a unique opportunity. WHO’s elimination strategy, which was endorsed by the Alliance in Abidjan in 1999, was based on simplified approaches to case-finding at the community level, early treatment with MDT and epidemiological surveillance. It had been seen as one of the most cost-effective interventions in the public health domain; MDT was safe with very few side effects and, thanks to the support of partners, had been distributed throughout the world by WHO since 1995 and made available totally free-of-charge to all patients.

Although the original target date for elimination by the end of year 2000 may not quite have been met, this should not be interpreted as a failure of the strategy itself but rather as evidence that the strategy was successful but not applied sufficiently vigorously in some national programmes. WHO was concerned that the prevalence rates still stood at above four per 10,000 in the most endemic countries, which together represented about 90% of the global leprosy problem. Many of the constraints still facing these countries were structural in nature resulting in poor geographical coverage of MDT services. Lack of community awareness about the nature of the disease and the availability of free treatment with MDT had often led to tragic consequences, including late diagnosis and high rates of disability, as well as high defaulter rates. Dr Neira further stated that the national programmes would have to work hard with all partners in the field to bring the diagnosis/treatment services to community level, thereby improving the geographic coverage of MDT services and patients’ access to it. In Dr Neira’s view, the key obstacles are the same in most of the high-endemic countries. In addition to highly-centralized management of leprosy elimination activities, with vertical programmes and very poor coverage of MDT services, could be added inadequate training of general health care
workers, inadequate community awareness and difficult access to services. National task forces had now been created to provide managerial, technical and logistic support to local health services in most endemic countries and detailed planning meetings with partners had taken place in each priority country. High-level representatives from the Ministry of Health had participated in these discussions, clearly demonstrating the political commitment of Governments to eliminate the disease. She outlined briefly the national programmes and plans of action for the most endemic countries, details of which were then given by their representatives as follows:

Angola

The Ministry of Health would like to increase partnerships and showed a strong will to decentralize leprosy activities. The fight against communicable diseases, including leprosy, was considered a priority, and a task force had now been created. There remained a great difference in carrying out leprosy control activities between the cities and in provincial populations. Communication between the provinces and districts remained low, and accessibility was poor owing to insecurity. Moreover, it was difficult to recruit health staff at the district level.

Some 70% of the health infrastructure had been destroyed by armed conflicts. The number of new cases continued to increase (it was low in 1994 but reached over 1800 in 1999, and more than 2000 in 2000). MDT coverage ranged from 35 units out of a total of 935 health facilities in 1997 to 198 units out of a total of 1023 health facilities in 2000.

By the end of 2000, the following planned activities had been achieved: distribution of MDT drugs at peripheral level; case detection and treatment of displaced people in collaboration with other programmes and NGOs; and the translation into Portuguese, reproduction and distribution of the technical tools kit for training and supervision activities in the whole country.

About 56% information data on leprosy had been obtained from the municipalities and the plan to cover more than half of the health units had been about 20% realized. More activities were ongoing but have been slowed down due to lack of funding.

Brazil

Describing the trend of leprosy in his country during the last 15 years, Dr Gerson Mendes Pereira stated that Brazil was a large country with five regions, 27 states and a high population. Leprosy existed in all states although the distribution was not uniform and it had been eliminated in two of them in 1997. There remained a high prevalence in the north, north-eastern and mid-west regions but low prevalence in the south and south-eastern regions. He noted that since the introduction of MDT in 1985 there had been a considerable decline in the national prevalence rate of up to 80% in some areas. A large number of health workers had been trained and massive campaigns had been organized. The campaigns carried out
during 1998-1999 had resulted in 14,000 new cases being detected, with an estimated 10,000 new cases still needing to be detected. Dr Pereira presented the detailed organizational structure of the national programme, including areas of assistance from other agencies involved. Brazil had decided to decentralize activities and implementation of the programme at peripheral level was mainly through municipalities, which, in turn, involved individual health units. The objective of the programme, which was fortunate enough to have a large team of doctors and health workers, was to eliminate leprosy from all endemic states. The country had a considerable number of child leprosy cases, some with deformities, hence special attention was given to early detection. Dr Pereira felt confident that leprosy would be eliminated at national level by the target date of 2005 and at subnational level, in about 16 states.

Central African Republic

In order to intensify leprosy elimination activities in the Central African Republic a national plan had been proposed for 2000-2005. Many problems still had to be faced: low integration of the leprosy elimination activities into the primary health care structure; low geographic coverage of MDT; low technical capacity of the health staff; poor management of drugs at peripheral and regional levels; lack of communication/information and coordination; and limited funds.

The objectives to be achieved by 2005 were as follows: to reach the elimination goal in all prefect areas (health districts); to strengthen the competence of health staff to diagnose and treat leprosy cases in 16 prefect areas (using training sessions); to reorganize the management of patients in all areas; to reorganize drug management and information systems throughout the whole country; and to organize the monitoring of leprosy elimination in the country.

The prevalence rate was 2.5 per 10,000 population in 1998 and fell to 1.39 in 2000 while the detection rate was 1.5 per 10,000 population in 1998 and fell to 0.56 in 2000. There was 100% MDT coverage from 1998 to 2000 and cure rates were 37.3% in 1998, 27% in 1999 and 42.9% in 2000. Grade 2 disability rates were 11.6% in 1998, 9.28% in 1999 and 8.33% in 2000. There was no information on what has been further achieved in 2000. By mid 2000, two projects had been launched: a leprosy elimination campaign (LEC) in Singh Mare and Papua, and a special action project (SAPEL) in Baying, both supported by WHO.

Democratic Republic of Congo

The leprosy situation was as follows: The prevalence rate was 1.2 per 10,000 population in 1998 and 1.04 in 1999, while the detection rate was 8.7 per 10,000 population in 1998 and 6.3 in 1999. The Grade 2 disability rate was 13% in 1998 but 15.63% in 1999. Programme coverage was 56% in 1998 and remained the same in 1999.

The war was still going on in the country and, therefore, programmes and activities had been stopped in many of the health zones. The country suffered from an
economic crisis and the health staff was no longer motivated. Prevalence rates were above one per 10 000 in nine out of 18 zones.

The country was facing several epidemiological problems (low detection rate, high disability rate, many child cases, highly endemic zones, and low cure rates) together with operational problems (low geographical coverage with MDT, low health service coverage, war and insecurity, trained health staff movements; displaced/refugee populations). During the year 2000, the national programme had tried to disseminate information on the elimination policy, to create task forces, to hold meetings at local and regional levels to plan activities for 2000-2005 and to finalize the national plan.

Guinea

The prevalence rate for 2000 at the national level was 1.53 per 10 000 (i.e. 1136 cases). Some 24% of the prefects (districts) had less than one case per 10 000, 41% had between one and two per 10 000 and 35% had more than two per 10 000. The health staff taking care of leprosy patients included 45 medical officers, 38 specialized nurses and 368 supervising nurses.

The country faced many problems such as difficult-to-reach areas; logistical problems, shortage of trained personnel, lack of community information and participation, existing zones of high prevalence; poor disability case-management in the health centres, and low MDT geographical coverage (around 45%).

In order to improve the situation it was planned to strengthen the technical capacities of district teams, to train health agents, to mobilize communities, to make MDT drugs available in all health services, and to strengthen the integration of leprosy activities into general health services at all levels.

In 2001, it was proposed to organize information seminars to raise community awareness of the disease, to train 431 health agents in health posts, 736 chiefs of health centres and leprosy supervisors, to organize the training and re-training of 40 specialized nurses, the training of 300 private sector health agents on leprosy elimination, and to re-train 200 supervising nurses. It was also proposed to create a task force to organize an information/media campaign, to create regional, subregional and local committees, to develop community services in difficult-to-reach areas, and to distribute MDT drugs to all health services.

India

Dr N. S. Dharma Shakti spoke about the current situation, the challenges ahead and plans for intensifying activities for the elimination of leprosy. The country bore over 60% of the global caseload. The overall achievements of the country had been phenomenal during the last 15 years, with a prevalence rate of 57 per 10 000 in 1983 declining to 4.6 per 10 000 at the beginning of 2001. Out of the 556
districts, 204 had a prevalence rate higher than five. Ten States and Union Territories had already achieved elimination, while six States or Union Territories were close to that goal. A total of 8.9 million cases had already been cured, 99.8% of registered cases were receiving MDT, and deformity had been prevented in about 1.4 million patients. Regarding the disease profile, 50.3% of all new cases were MB with child cases and Grade 2 deformity rates amounting to 20% and 3.1% respectively, and single-lesion cases constituting 12%. The present number of cases was still huge with an estimated 1.2 million new cases yet to be detected and treated over the next three years with many challenges laying ahead. The programme would have to tackle the high prevalence rate, which ranged from 4.0 to 13.7 in nine States and which was compounded by a migrating population and inadequate compliance in a significant number of cases. It also had to cater to the needs of 1.5 million cured individuals with disabilities and ulcers.

There was a great need to increase community awareness and plan for smooth integration of activities into the general health care system. The important but unfinished tasks at hand included designing an effective strategy for case detection in difficult areas, job redistribution to sustain the staff, functional delegation of responsibilities to States and peripheral units, implementation of a proper monitoring system and empowering the general health care staff and public through IEC and training. Dr Dharmshaktu indicated that there was a crucial need to organize a referral system for complicated cases and re-emphasized that the programme firmly believed in a partnership approach involving national and State authorities, municipality and industrial health units, WHO, donor agencies and NGOs. While there would be a mixed approach to future plans in five high endemic States, the integrated approach would be followed in the remaining 27 States. There would be attempts to strengthen State services with a timely flow of resources, campaigns undertaken for case detection and ensuring the availability of MDT in all health centres. There would be constant supervision and monitoring, through State and district level review meetings, and wider involvement of all media to generate community awareness and involvement. The services of NGOs would be re-channelled towards prevention of disabilities, IEC, training and rehabilitation. Dr Dharmshaktu concluded by stressing that the new approach would be based on three Ps: people-, provider- and patient-friendly.

**Indonesia**

Professor U. F. Achmadi reported that Indonesia had already reached elimination at the country level, with a prevalence rate of 0.99 per 10,000. The number of registered cases during the year 2000 was 20,672, of which 16,448 were newly-detected cases with the new case detection rate for the year standing at 10 per 10,000. Child cases and cases with Grade 2 disability constituted 10.4% and 9.8% of the newly-detected cases respectively. The overall coverage with MDT is 100% with all health centres providing it free of charge. Regarding the disease trend, the prevalence rate had gradually increased with about 60,000 cases in the year 1970, peaking to just over 120,000 cases around the year 1985. From that year onwards there was a sharp decline in the prevalence rate, which coincided with the effec-
tive implementation of MDT. The new case detection rate fluctuated between 5000 and 10,000 cases annually up to 1992 after which it had increased gradually to just over 16,000 in the year 2000. The percentage of child leprosy cases continued to remain almost constant. Passive case detection, total integration, limited IEC, reduction of paper work and quality patient care were important components of the future plan. The programme looked forward to continued support from partners while looking towards a leprosy-free Indonesia.

**Madagascar**

The following had been achieved: an increase in the detection rate and a decrease in the prevalence rate (from 27,158 cases in 1985 to 7,865 in 1999); a decrease in the number of health districts with a high prevalence and an extension of the geographical MDT coverage of the primary health care centres from 30% in 1997 to 68% in 2000. However, the actual general prevalence was still high at 5.9 per 10,000, and for 21 health districts the prevalence is above 10 per 10,000 - half of which were situated in the Province of Fianarantsoa. The cure rate remains low and there were difficulties in ensuring the follow-up of cases.

The main problems encountered included the suspected large number of undetected cases, poor follow-up of patients, over-diagnosis in some places owing to a variety of reasons, and the fact that leprosy was not always recognized as a public health problem by the local population.

MDT transportation to the primary health care centres could also be a problem, as well as the detection and follow-up of cases at PHC level. It was recommended that information campaigns, social mobilization and community participation be developed. Meetings would be organized in 2001 with various partners to plan activities at all levels and distribute information tools as required.

**Mozambique**

Dr Alcino N'deve described the population of Mozambique as being 20.6 million, of which only about 40% had access to health facilities. Leprosy was a problem in the three northern and four southern provinces. Regarding the present leprosy situation in the country, the number of cases of leprosy registered is 7,887 with a prevalence rate of 4.3 per 10,000 at the national level. The detection rate was 11.3 per 100,000 population while child cases and patients with Grade 2 disability constituted 11.6% and 13.9% respectively among new cases. The various activities undertaken included running clinical training courses for all categories of workers, organizing workshops for district managers, and undertaking LECs in the most endemic provinces. Several hurdles had to be overcome in order to successfully implement the programme. In order to improve accessibility, as many as 720 MDT distribution centres had been installed in the four provinces where leprosy continued to be a problem. It was proposed to establish district-level task forces and open even more MDT distribution points. The problems faced by district managers would
be overcome by providing adequate mobility, empowering health workers by training and by including them in district-level task forces. On the whole the programme was optimistic of achieving the goal in the near future with these new approaches.

**Myanmar**

Dr Kyaw Nyunt Sein said that Myanmar aimed at eliminating leprosy by the end of the year 2003 and planned to strengthen its programme accordingly. Regarding the organizational set-up, he explained that the National Leprosy Elimination Steering Committee was the highest policy-making body, followed by the National Task Force for Leprosy Elimination and the Leprosy Elimination Coordinating Committee. There was also a subcommittee for leprosy elimination monitoring and a technical core group for leprosy research. Members of this coordinating committee include divisional heads, representatives of nongovernmental organizations and WHO. The elimination strategy was aimed at enabling every health unit to diagnose and treat leprosy, ensuring high geographic coverage, strengthening of prevention of disabilities and providing uninterrupted access to MDT. To achieve these objectives the programme has generated political commitment at different levels, created community awareness and motivated the community towards participating actively in the early detection of new cases. Task-oriented capacity building would be provided for basic health services staff. Attention would also be paid to organizing surveillance systems at various levels and to promoting operational research and development of strategies. When the MDT programme had been launched in 1985, Myanmar still had hyper-endemic pockets and the prevalence rate was 38.8 per 10 000 population, but this had been reduced drastically and at the end of the year 2000 the national prevalence rate was 2.5 per 10 000 population.

**Nepal**

Dr B. D. Chataut said that Nepal was one of the major endemic countries with a registered caseload of 27 735, a prevalence rate of 3.9 per 10 000 and a new case detection rate of 3.2 per 10 000 population. The number of new MB cases constituted around 59%, while the number of child cases and patients with Grade 2 disabilities made up 7.8% and 6.7% respectively. In order to achieve the goal of elimination by the year 2003, the country had adopted the strategies of intensifying case-finding (mostly through campaigns), extending MDT services to sub-health posts, and building capacity by including community members in the task forces. Nepal intended to further strengthen a coordinated and integrated system to supervise both the managerial and technical aspects of the programme. By early detection and regular treatment of cases, attempts would be made to reduce the number of new cases with disabilities by 50%. There would simultaneously be expansion of physical, social and economic rehabilitation through the capacity building and research approach. The main difficulties facing the programme, however, were the continued high prevalence rate, the problems in detecting hidden cases, inadequate training of basic health services staff, and inadequate monitoring and supervision. These were further compounded by weak IEC, resulting in
inadequate public awareness about MDT and its availability free of charge. The programme realized that it has to overcome these hurdles by intensifying IEC activities, organizing campaigns for active case detection, strengthening case-finding and case-holding activities, and organizing training for basic health workers, volunteers and community members as part of the capacity building exercise. Objective-oriented periodic reviews, supervision and monitoring would be important components, as well as coordination between programme officers, partners and donors. He projected a framework for the plan of action detailing all activities to be undertaken during 2001-2003 including both the technical and financial resources required.

7. COMMITMENT TO ELIMINATION IN MOST ENDEMIC STATES OF INDIA

The Leprosy situation in most-endemic states of India: Dr N. S. Dharmshaktu explained that seven States contribute 71% of the country's total caseload, of which Bihar and Jharkhand contributed 29%, Uttar Pradesh 19%, Orissa 8%, West Bengal 8%, Madhya Pradesh and Chhattisgarh 7% and all other States the remaining 29%. Seventy-nine per cent of problem districts were from these States and periodic special campaigns had indicated the extent of remaining hidden cases. The strategy proposed for these States in the second phase of the national programme emphasized: forming and strengthening State leprosy societies; allotting resources to State societies, enabling them to assess progress in districts; ensuring availability of MDT in all health facilities through all health-care staff; adopting a campaign approach to case detection; and training of additional technical support teams to assist in preparation of plans for integration. Central services would continue to provide resources, coordinate activities of nongovernmental organizations and monitoring of the programme. Other support would include the provision of contractual staff, mobilization, media, involvement of local bodies, and training. A large number of special action projects would be carried out in these States to focus on problem areas. State Ministers were actively involved in the implementation of these activities and clear directives were crucial to their success, including appropriate use of existing vertical staff. Immediate priorities included a workshop for State leprosy officers, development of an action plan for a third round of modified leprosy elimination campaigns, special action projects, and finalizing the memorandum of understanding with the World Bank. The role of the State Ministers would include a review of progress, the promotion of leprosy elimination campaigns for early detection and treatment, and the mobilization of support from other ministries.
Bihar: Shri Sakuni Chaudhary said that Bihar continued to dominate both the global and national leprosy scenario. The burden of both the disease and disability resulting from it is unacceptably high in this State. Despite many difficulties and deficiencies, the State leprosy elimination programme had made encouraging progress recently. The modified leprosy elimination campaigns carried out in Bihar were said to have been some of the most successful in the country and had provided much needed momentum to the programme. Such achievements had mostly been in the area of case detection and treatment, expansion of MDT services, training of programme and general health staff, and widespread IEC activity. The remaining challenges continue to be huge and activities in almost all districts are clearly insufficient. Needless to say, Bihar still requires maximum support from key partners, including the Government and nongovernmental organizations. It was clear, however, that leprosy was not an insolvable problem and it could not be allowed to continue. The Government of Bihar is fully committed to eliminating leprosy as a public health problem in all districts of the state by 2005, especially with the renewed encouragement and support from all partners in the Alliance.

Chhattisgarh: While conveying the commitment of his Minister, the representative of Chhattisgarh indicated that the State had a high percentage of tribal people in its population. The high level of endemicity of leprosy is also well known and 16 districts of the new state contributed to about 60% of the caseload within the State, which had a prevalence rate of 8 per 10,000. Some districts required strong attention and information needed to be disseminated to the community regarding the availability of an effective treatment that was free of cost. Panchayats and nongovernmental organizations are becoming increasingly involved in trying to detect hidden cases, with distant and inaccessible areas receiving special attention. Sharing the overall concern of the Alliance, the State committed itself firmly to fulfilling its expectation that leprosy would be eliminated by 2003.

Jharkhand: The Honourable Minister of Health, Dr Dinesh Kumar Sarangi, assured the full commitment of the State Government to the elimination of leprosy and stated that it had recently decided to review progress and identify bottle-necks that required immediate attention, both at State and district level. He apprehended that a large number of villages needed to be thoroughly surveyed, preferably through a campaign approach. Health providers were working under adverse conditions with several deficiencies, which made programme managers view timely elimination as a challenging task. Jharkhand is a newly-formed state with a predominantly tribal population and difficult terrain. Despite all these obstacles, the Minister assured that concrete attempts would be made to eliminate leprosy, including its integration into the general health services, within the target date.

Madhya Pradesh: The state leprosy elimination programme was initiated in 1955, with the MDT being introduced in some areas in 1983 and expanded to the whole State by 1995. The current prevalence rate is 2.9 per 10,000 with over 400,000 patients having been cured since the programme started. Two modified leprosy elimination campaigns had been completed successfully with skin diagnostic camps, prevention of disability camps, and school health education campaigns conducted regu-
larly, and several special action projects carried out in problem areas. The functional integration of leprosy services was already yielding encouraging results and, with the support of the Government of India, WHO, ILEP, the World Bank and DANIDA, the state was committed to eliminating leprosy by 2003.

**Orissa:** The Honourable Minister of State, Dr Kamla Das, stated that Orissa had 3.9% of the country's population but handled 6.7% of its total leprosy caseload, with a prevalence rate of 8.37 per 10,000. The state had made considerable progress since the introduction of MDT in 1983 and it had subsequently been extended to all 30 districts of the state, reducing the disease prevalence, which had initially been 12.4 per 10,000, by 93%. Nearly 0.59 million leprosy cases had been detected during the past 18 years and all of them had been treated. Of the 31,289 cases now registered, 99.6% were receiving regular treatment. The disability rate among new cases had come down from 13% in 1983 to only 1.9% in 2000, and the annual new case detection rate from 21 to 15 per 10,000 population. Innovative steps undertaken included the adoption of an integrated approach in the first modified leprosy elimination campaign, during which 64,844 leprosy cases had been detected and brought under treatment, the generation of community participation, which resulted in an 80% voluntary reporting of new cases, special action projects carried out in 32 pockets of high prevalence and outreach areas, which detected 11,600 new cases in two-and-a-half years, and equipping general health care staff to diagnose and treat leprosy. The Minister renewed the State's commitment to sustaining and consolidating activities to achieve a leprosy-free Orissa within the next three to five years.

**Uttar Pradesh:** The Government of Uttar Pradesh regarded both the high level of population and the high prevalence rate of leprosy in the State not as problems but as a challenge and an opportunity to serve the people. The State leprosy programme had made considerable progress over the many years it had been in existence although the remaining task was still gigantic. The major problems in the state were related to identifying the large number of hidden cases and treating them. All districts had been divided into three categories - A, B and C. The expectation is to reduce the prevalence rate in category A and B districts to less than one case per 10,000 by the years 2002 and 2003 respectively. However, the problem was more difficult in category C districts and would probably require a longer amount of time and additional assistance from the Government and donor agencies. The problem, on the whole, was not only one of detection/treatment of cases but also of rehabilitation - social, economic and emotional. Despite the hurdles listed, the State was committed to making every effort to make its people leprosy free and happy within the target year.

**West Bengal:** Professor Partha De described West Bengal as being a State with a highly dense population and a complex public health scenario that included endemic levels of leprosy and several other communicable diseases. Burdened with so many public health problems, the State found it difficult to concentrate on any one particular disease. Hence progress towards the elimination of leprosy, although considerable, was not up to expectation. Sharing the enthusiasm and optimism of other participants, the Minister assured that his department would try its best to elimi-
nate leprosy by the targeted date. Nevertheless, he expressed apprehension that leprosy would continue to be a problem in at least some areas and that its elimination would require further resources and assistance. The state had a Panchayat Raj system and elimination activities might function better if the heads of Panchayats and municipalities were involved in the district leprosy societies. There are a large number of health guides in villages and health assistants in urban areas and the state/district leprosy societies needed some flexibility in using their services in exchange for some remuneration. IEC activities, prevention of disabilities (including reconstructive surgery), and economic rehabilitation utilizing the services of cured persons are some of the activities he proposed to strengthen.

8. ROUND-TABLE DISCUSSION ON PARTNERSHIPS

A round-table discussion with a number of key participants was arranged to discuss the problems faced in the elimination process and to find solutions through the Global Alliance. This was crucial because the Alliance had been formed over a year ago mainly to synergize the energy and resources being contributed individually by the donor agencies. The achievements of the Alliance over this period had been impressive, especially in the field of advocacy. The Delhi Declaration reiterated the commitment and interest shown by member countries and partners. It was now time to be more ambitious and go beyond advocacy and discuss in more detail the plan of action of individual countries. The respective governments were responsible for implementing plans, but partners in the Alliance needed to clearly identify their respective areas of support and work on those, along with monitoring activities. There were four major international partners, namely, WHO, ILEP, The Nippon Foundation and the Novartis Foundation for Sustainable Development, with DANIDA and the World Bank participating in activities in India.

It was felt that in addition to advocacy activities, partners should be more involved in implementing plans of action and various partners extended several important suggestions. These suggestions focused particularly on Brazil and India. The representatives of both countries had indicated that their plans of action have been developed for the next three years and that these concentrated on attempts at decentralizing and integrating elimination activities within the general health services.

There was a suggestion that the activities of the Alliance should be extended to state, district and municipality levels and that, donor agencies should support the national infrastructure at all levels in the execution of their plans. Coordination
meetings with partners should preferably be organized at field level in order to encourage health workers who were directly providing services to patients. In conformity with the above views, during the second phase of the World Bank support to the national leprosy elimination project in India, for example, activities would be decentralized and states would develop their own strategic plans for the next three years. Participants pointed out that the amount of money made available by donors was phenomenal but that there seemed to be some overlapping of activities and therefore wastage of resources. To avoid that, donors needed to identify areas of involvement for each so that resources could be utilized optimally. The process of decentralization made State plans more credible. Partners needed to commit their role in these activities, including monitoring. Only when a reliable monitoring system was in place would there be accountability and every partner needed to be accountable to the governments of endemic countries where they were working.

Consensus was reached on all important aspects of partnerships and the participants agreed that:

- There should be a mechanism for practical coordination between partners at country, state and district levels.
- Donor agencies should be involved in the various planning stages and should agree on their role with the governments. A reliable monitoring system needed to be established and partners needed to be accountable for their agreed activities.
- Governments were the supreme body to decide on elimination issues and should take responsibility for coordination of activities.
- Since the governments of major endemic countries such as Brazil and India have planned for maximum decentralization, partners should also work towards strengthening the infrastructure at all levels of implementation.

The round-table discussion concluded after a resolution had been adopted appointing Mr Yohei Sasakawa as Special Ambassador for the Global Alliance for Elimination of Leprosy in recognition of his contribution to the cause of leprosy and his success in mobilizing the high level of commitment required in endemic countries.
9. TECHNICAL ISSUES RELATED TO THE ELIMINATION STRATEGY

Strategic Plan 2000-2005 for Group 1 countries: Dr Denis Daumerie, of WHO, presented the latest available information on prevalence and detection by WHO Regions, followed by the current prevalence and detection rates in the top 11 countries (India, Brazil, Myanmar, Indonesia, Nepal, Madagascar, Ethiopia, Mozambique, Democratic Republic of Congo, Tanzania and Guinea). While there has been a drastic fall in the prevalence rate in most endemic countries, the detection rate and the number of cases detected annually during the period 1985-1999 had remained unchanged at about 500,000, with minor fluctuations. The core element of the elimination package included: capacity building for general health care staff, enabling them to diagnose and treat leprosy and its complications; ensuring adequate stocks of MDT at the peripheral centres; disseminating information and advocacy to increase case-reporting; and monitoring through simplified reporting systems. The main focus for 2001 would be the renewal of political commitment, broadening partnerships and the integration of elimination activities. While the current strategy is still sound, it should be adapted to suit local needs and be supplemented by task forces at the national and peripheral levels. Dr Daumerie concluded by saying that the key factors for The Final Push would be timely, speedy and large-scale implementation of the intensified strategy along with adequate flow of resources and active monitoring of the programme in order to take timely corrective action.

Recommendations of WHO Technical Advisory Group on Elimination of Leprosy: Dr M. D. Gupte, Chairman of the Group, confirmed that WHO had established a Technical Advisory Group on the Elimination of Leprosy (TAG) to advise on implementation of the intensified strategy and its monitoring, particularly in the areas of capacity building, MDT supply, IEC, monitoring and surveillance. The main terms of reference for TAG were to review and monitor the intensified strategy, advise WHO on new approaches, extend technical guidance, identify obstacles, and address research issues. The strategic plan before WHO for the period 2000-2005 had been designed to facilitate discussion among all parties to optimise utilisation of resources and to assist endemic countries to focus on key elimination activities, including networking of partners at district level. Intensified elimination activities at local level imply active involvement of general health workers and community health volunteers, and accessibility to free and unfettered treatment through effective local management.

While agreeing to retain the present definition of elimination, TAG had suggested that it be supplemented with additional indicators on the absolute number of new cases, including gender, children, disability, access to MDT blister packs, and single lesion cases. TAG was of the opinion that new antileprosy vaccines had a very limited role in view of the difficulties encountered in undertaking field trials and actual needs, although more specific vaccines might become available as a result of the recent completion of mapping of the *M. leprae* genome. TAG recommended that WHO should identify leprosy research activities, maybe through a subgroup, which could also review proposals and monitor implementation. Suggested areas included rifampicin resistance, new drugs and operational research and such research needed to be integrated with other health-related research activities.
Partnership with ILEP members at country level: Mr Terry Vasey, President, explained that ILEP operated at three levels. At the policy level, the President's participation in political fora contributed to the formulation of the overall policy for leprosy elimination activities. At the technical level, ILEP is a pool of technical expertise, exchanging information with and extending cooperation to WHO's Technical Advisory Group. At the operational level, ILEP members contributed to field activities ranging from providing consultancy services to organizing elimination campaigns. Most ILEP activities were concentrated in the 12 most endemic countries and those activities consumed about 56% of its budget. ILEP had coordinators based in all those countries in order to pursue a comprehensive approach to leprosy elimination with special efforts towards early diagnosis of disability and reducing the stigmatising effects of the disease. Mr Vasey specifically emphasized the role of ILEP in India. It assisted the national programme in capacity building of health staff and supported activities in problem districts, including referral services, training of health workers and in facilitating drug supply. It also undertook special activities such as IEC and LECs, organized consultative meetings between the Government of India and other partners, provided support to technical teams and consultancy services to the national programme at state level. ILEP's contribution to the Indian programme for the year 2001 had been increased and amounted to around US$ 20 million. Regarding Brazil, the activities include mass campaigns, training in project management, prevention of disability and rehabilitation, evaluation and operational research.

10. PLANS FOR STRENGTHENING POLITICAL COMMITMENT AND ADVOCACY

Media advocacy for elimination: Mr Peter Gill, BBC World Service Trust, said that the BBC is primarily known around the world for its news gathering and programme making. It is much less known for its effort to utilize programmes in the cause of health promotion. However, for the past 16 months, the BBC Trust, the nongovernmental arm of the BBC, had had the privilege of working with the Ministry of Health and Family Welfare, Government of India, and with Indian State Broadcasters on TV and radio material for leprosy campaigns. This had been the world's biggest ever media campaign and its impact had been significant, reaching 49% of the population in the first phase and 59% of the population in the second phase, with broadcasts in Hindi, Bangla and Oriya. Leprosy was seen in the past as an age-old, disfiguring disease with a great deal of social stigma attached to it, and this was one of the greatest obstacles to elimination. All concerned are now convinced that modern media techniques needed to be applied. There was a need for the media
to be involved in the planning and decision-making stages of leprosy elimination programmes in order to provide constant monitoring and constructive criticism of results. Results are likely to be impressive and the presence of the media in programme activities would ensure that efforts were serious.

**Raising community awareness for leprosy elimination**: Ms Santa Raye noted that there had been some mixed feelings at the beginning of the new millennium of expectation and apprehension about eliminating leprosy by the year 2005. The advent of MDT had provided a sure technical solution for this age-old problem and had considerably reduced the mental and physical suffering of patients, thereby improving the perception of the community towards the disease. It was therefore time to concentrate on further raising community awareness about the availability of this treatment in order to hasten the process of case-detection. Prevalence rates had fallen drastically but it was difficult to trace suspects by active search. Communities therefore need to be sensitized so that both suspects and sufferers sought MDT services instead of MDT services seeking them. This necessitated empowering communities with knowledge about the early signs and symptoms, the availability of MDT free of charge, and the location of the nearest health centre from which it was available free of cost. Convincing people that leprosy was now curable was not easy unless some of the myths surrounding the disease were dispelled. The necessary change in knowledge, belief and attitude (KAP) also included changes in values, emotional status and, ultimately, behaviour. Awareness campaigns are to be carried out collectively by groups of like-minded people joining hands to build a dynamic force and acting with the conviction that lay behind successful coordination and cooperation of key players, workers and members of the community. Such involvement created a feeling of honour amongst community members, who, once informed, would be able to produce more appropriate information materials better adapted to local needs and therefore comprehensible to the masses.

Beyond and above all, however, Ms Raye emphasized the role of women in such activities and declared that any programme undertaken without the involvement of women was a programme done only by half.
11. CLOSING CEREMONY

The closing ceremony of this First Meeting of the Global Alliance for Elimination of Leprosy was chaired by Mr A. Raja, Honourable Minister of State for Health and Family Welfare, Government of India. At the beginning of the ceremony, Mr J. V. R. Prasada Rao, Additional Secretary of Health, and Chair of the Alliance, summarized the deliberations of the meeting, as follows: The Global Alliance for Elimination of Leprosy, created in November 1999, had helped maintain political commitment at the highest level. In recognition of his considerable contribution to these activities, Mr Yohei Sasakawa, President of The Nippon Foundation, had been nominated Special Ambassador to the Alliance. Despite the significant progress made so far, the geographic coverage of leprosy diagnosis and treatment in many endemic countries remained low and significant fear and stigma continued to surround the disease and those who suffered from it. Implementation of key activities therefore needed to be intensified in order to detect and cure all remaining leprosy cases in the world and thereby eliminate leprosy from every country by the year 2005. Partners in the Alliance agreed to:

- focus their attention on intensifying efforts to implement the strategy;
- empower all local health services to diagnose and treat leprosy;
- dispel the negative image of leprosy and improve awareness in all communities of the availability of a free and effective treatment (MDT);
- ensure the uninterrupted availability of MDT at all health centres;
- adopt flexible approaches to ensure that patients receive a full course of treatment and are cured;
- develop referral systems for the treatment of complications;
- ensure that prevention and management of leprosy-related disabilities are an integral part of community-based rehabilitation for all disabled persons;
- actively monitor progress being made towards elimination;
- collaborate closely at field level to ensure efficient and effective use of resources;
- mobilize additional resources to facilitate speedy implementation of the strategy.

Mr Raja thanked the Honourable Ministers and other delegates whose participation contributed to the successful outcome of the meeting. The Delhi Declaration would greatly assist all member countries and partner agencies in working together to eliminate the disease and history would one day thank members of the Alliance for their efforts. He particularly welcomed the nomination of Mr Sasakawa as Special Ambassador. He felt that the involvement of such an eminent personality, already well known throughout the world for his contribution to leprosy elimination activities, would help boost advocacy efforts.

Mr S. P. Agarwal, Director General of Health Services, Government of India, stated that the recommendations made above should not remain on paper but should be converted into action without delay. He assured delegates that health facilities in India at all levels would be well equipped to deal with the technical aspects of the problem, including sensitisation through suitable training, and introduction of an effective monitoring system.
Dr Maria P. Neira, on behalf of the partners of the Global Alliance for Elimination of Leprosy, extended thanks to the Government of India for having hosted the meeting and for ensuring such excellent arrangements and warm hospitality. Particular appreciation was also extended to Mr J. V. R. Prasada Rao, Chairperson of the meeting, and Professor Henriette Ratsimbazafimahefa Rahantalalao, Co-chairperson, who both very kindly agreed to continue in these important roles for a further period of one year.

Finally, Mr Deepak Gupta, Joint Secretary, Ministry of Health and Family Welfare, Government of India, thanked all delegates for having participated in the proceedings in order to synergize their commitment and resources, and he hoped very much that they shared his belief that this meeting has provided a further step forward towards the noble goal of eliminating leprosy.
ANNEX 1

GLOBAL ALLIANCE FOR ELIMINATION OF LEPROSY (GAEL)

The purpose of this note is to summarize the concept of the Global Alliance for Elimination of Leprosy (GAEL), which was defined during the 3rd International Conference on Elimination of Leprosy, Abidjan, Côte d'Ivoire, on 15 November 1999.

The Global Alliance for Elimination of Leprosy (GAEL) was created in order to make a concerted and coordinated effort to eliminate leprosy as a public health problem from every endemic country, at the national level, by the year 2005. The core members of the Alliance currently comprised governments of major leprosy-endemic countries, WHO, The Nippon Foundation, the International Federation of Anti-Leprosy Associations (ILEP), Novartis, Danish International Development Assistance (DANIDA) and the World Bank.

GAEL was established in order to ensure that a common strategy based on experience of past leprosy elimination efforts was adopted, intensively implemented and effectively monitored. The Alliance will lead to better field-level collaboration among partners and will thereby facilitate more efficient and cost-effective utilization of resources. GAEL will permit cross-fertilization of ideas and approaches among policy-makers and programme managers. It will help strengthen political commitment from ministries of health, promote innovative solutions to specific problem areas such as logistics, reaching underserved populations, integration and disease surveillance. GAEL will also mobilize additional resources to implement agreed strategies at both national and regional levels. In addition, this broad partnership will bring renewed enthusiasm and interest for leprosy elimination among politicians, policy-makers and programme managers. It will create new opportunities to advocate globally and nationally for leprosy elimination.

MISSION OF GAEL

GAEL is a high-level political forum which is open and which will:

• advocate for elimination of leprosy;
• ensure sustained political commitment to leprosy elimination, particularly in key endemic countries;
• mobilize resources for implementation of elimination activities;
• monitor progress towards elimination;
• actively bring in new partners to join elimination efforts.
GUIDING PRINCIPLES AND GOVERNANCE

- As GAEL is a high-level political forum, representation from the top leprosy-endemic countries is crucial (Minister of Health and/or Director of Health Services).
- At least one representative from each partner agency will be invited. Selected experts may also be invited to meetings on an ad hoc basis.
- WHO will act as secretariat and coordinator of all activities related to GAEL.
- The Chair and Co-chair will be appointed for a period of one year, with a maximum term in office of two years. Extension will require the approval of GAEL.
- Members of GAEL will meet at least once a year, preferably in a leprosy-endemic country.
- New partners committed to elimination will be welcome to join GAEL.
AGENDA

Tuesday, 30 January 2001

08:45 - 09:00 DOCUMENTARY VIDEO ON ELIMINATION OF LEPROSY
09:00 - 10:00 OPENING CEREMONY

Master of ceremony: Ms Sukanya Balakrishnan

Chairperson: Dr C. P. Thakur, Minister of Health and Family Welfare, India

- Lamp lighting
- Welcome and introduction: Dr Uton Muchtar Rafei, Regional Director, WHO/SEARO
- Video message: Dr Gro Harlem Brundtland, Director-General, WHO
- Remarks: Dr David L. Heymann, Executive Director, Communicable Disease, WHO
- Remarks: Mr Yohei Sasakawa, President, The Nippon Foundation
- Remarks: Shri Javid A. Chowdhary, Secretary of Health, India
- Chairman's address: Dr C.P. Thakur, Minister of Health and Family Welfare, India
- Vote of thanks: Mr. J. V. R. Prasada Rao, Addl. Secretary of Health, India

10:30-12:30 SESSION 1: RENEWING COMMITMENT OF MEMBER COUNTRIES AND OTHER PARTNERS

Chairperson: Dr C. P. Thakur, Minister of Health and Family Welfare, India
Co-chairperson: Professor H. R. Rahantalalao, Minister of Health, Madagascar

Statements by:
- Ministers of Health (Angola, Brazil, Central African Republic, Democratic Republic of Congo, Guinea, India, Indonesia, Madagascar, Mozambique, Myanmar, Nepal and Niger)
- Dr Ebrahim M. Samba, Regional Director, WHO/AFRO
- Dr George A. O. Alleyne, Regional Director, WHO/AMRO
- Danish International Development Assistance (DANIDA)
- International Federation of Anti-leprosy Associations (ILEP)
- The Nippon Foundation
- Novartis Foundation for Sustainable Development
- The World Bank
- Dr Maria P. Neira, Director, Control, Prevention and Eradication, WHO/HQ

12:30 PRESS CONFERENCE AND RELEASE OF THE DELHI DECLARATION BY ALL PARTNERS IN GLOBAL ALLIANCE FOR ELIMINATION OF LEPROSY

Moderators: Mrs Harsharan Bir Kaur Pandey, Information Officer, WHO/SEARO, and Ms Melinda Henry, Information Officer, WHO/HQ

Speaker: Dr C.P. Thakur, Minister of Health and Family Welfare, Government of India

- Dr David L. Heymann, Executive Director, Communicable Diseases, WHO/HQ
- Dr Uton Muchtar Rafei, Regional Director, WHO/SEARO
- Dr Maria P. Neira, Director, Control, Prevention and Eradication, WHO/HQ
14:00 - 16:00 SESSION 2: LEPROSY SITUATION AND PLANS FOR INTENSIFYING ACTIVITIES IN THE MOST ENDEMIC COUNTRIES

Chairperson: Professor Kyaw Myint, Deputy Minister of Health, Myanmar
Co-chairperson: Mr Terry Vasey, President, ILEP

- Introduction to global challenges (Dr Maria P. Neira and Dr D. Daumerie)
- Presentations indicating current situation, challenges and plans for intensifying activities in the most endemic countries: Angola, Brazil, Central Africa Republic, Democratic Republic of Congo, Guinea, India, Indonesia, Madagascar, Mozambique, Myanmar, Nepal and Niger
- Discussion

16:30 - 17:30 SPECIAL SESSION: COMMITMENT FOR ELIMINATION IN THE MOST ENDEMIC STATES OF INDIA

Chairperson: Shri A. Raja, Minister of State for Health and Family Welfare, India

- Leprosy situation in the seven most endemic states (Dr N. S. Dharmshtaktu)
- Statements from State Ministers of Health:
  - Bihar - Mr Sakuni Chaudhary
  - Chhattisgarh - Mr K. K. Gupta
  - Jharkhand - Dr Dinesh Kumar Sarangi
  - Madhya Pradesh - Mr Subhash K. Sojatia
  - Orissa - Dr Kamla Das
  - Uttar Pradesh - Mr Ramapathy Shastri
  - West Bengal - Professor Partha De
- Vote of thanks: Mr Deepak Gupta, Joint Secretary of Health, India

17:30 - 19:00 ROUND-TABLE DISCUSSION ON PARTNERSHIPS WITH REPRESENTATIVES OF GOVERNMENT OF BRAZIL, GOVERNMENT OF INDIA, DANIDA, ILEP, THE NIPPON FOUNDATION, AND THE WORLD BANK

Moderator: Dr David L. Heymann, Executive Director, CDS/WHO/HQ

Wednesday, 31 January 2001

09:00 - 10:30 SESSION 3: TECHNICAL ISSUES RELATED TO THE ELIMINATION STRATEGY

Chairperson: Dr Ram Baran Yadav, Minister of Health, Nepal
Co-chairperson: Dr Denis Daumerie, Leprosy Group, WHO/HQ

- Strategic Plan 2000-2005 for Group 1 countries (Dr D. Daumerie)
- Recommendations of TAG (Dr M. D. Gupte)
- Partnerships with ILEP members at the country level (Mr Terry Vasey)
- Discussion
11:00 - 12:30 SESSION 4: PLANS FOR STRENGTHENING POLITICAL COMMITMENT AND ADVOCACY

Chairperson: Professor H. R. Rahantalalo, Minister of Health, Madagascar

Co-chairperson: Dr Maria P. Neira, WHO/HQ

- Media advocacy for elimination (Mr Peter Gill, BBC World Service Trust)
- Promoting community awareness and involvement (Ms Santa Raye, DANLEP)
- Discussion
- Conclusions and recommendations

12:30 - 13:00 CLOSING SESSION

Chair: Shri A. Raja, Minister of State for Health and Family Welfare, India

Co-chairperson: Professor H. R. Rahantalalo, Minister of Health, Madagascar

- Presentation of conclusions and recommendations
- Remarks
- Vote of thanks - Mr Deepak Gupta, Joint Secretary (Health), India
ANNEX 3

LIST OF PARTICIPANTS

COUNTRY DELEGATES

Angola  Dr (Mrs) Albertina Julia Hamukwaya, Minister of Health  
          Dr (Mrs) Adelade de Carvalho, National Director of Public Health  
          Dr (Mrs) Maria da Conceição Palma Caldas, Coordinator, National  
          Leprosy Control Programme  
          Mr Ramiro Viegas Chipéio, Cabinet Director, Ministry of Health

Brazil  Dr Gerson Fernando Mendes Pereira, Coordinator, Technical Area  
          for Sanitary Dermatology

C.A.R.  Dr Gilbert Dimanche Nzil’Koue, Director-General of Health and  
          Population

D.R.C.  Dr Miaka Mia Bilenge, Secretary General, Ministry of Health  
          Dr Mputu Luengu, Director, National Leprosy Elimination Program-  
          me

Guinea  Professor Mamadou Saliou Diallo, Minister of Public Health  
          Dr Sakoba Keita, National Leprosy Programme Manager

India  Dr C. P. Thakur, Minister of Health and Family Welfare  
          Dr S. P. Agrawal, Director-General of Health Services

Indonesia  Professor Umar Fahme Achmadi, Director General CDC and EH  
          Dr Rosmini Day, National Leprosy Programme Manager

Madagascar  Dr Henriette Ratsimbazafimahafa Rahantalahao, Minister of Health  
          Dr Many Ralambonso, Coordinator, National Leprosy Control  
          Programme

Mozambique  Dr Alexandre Manguie, Director of Health  
          Dr Alcino Ndeve, National Leprosy Programme Manager

Myanmar  Professor Kyaw Myint, Deputy Minister of Health  
          Dr Kyaw Nyunt Sein, Deputy Director (Leprosy), Department of  
          Health

Nepal  Dr B. D. Chataut, Director General, Department of Health Services  
          Dr Jaya Prasad Baral, Director, Leprosy Control Division

Niger  Mr Assoumane Adamou, Minister of Public Health  
          Dr Moussa Mamadou, National Leprosy Programme Manager
PARTNERS

Danish International Development Assistance (DANIDA)

Ms Birgitt Storgaard, Ambassador of Denmark to India
Dr B. F. A. M. Peters, Chief Adviser, Leprosy and TB Control Unit, Delhi

International Federation of Anti-leprosy Associations (ILEP)

Mr Terry Vasey, President
Dr Jürgen König, Vice-President
Dr Etienne Declercq, Chairman, Medico-Social Commission
Ms Dominique Martineau-Needham, General Secretary

Novartis Foundation for Sustainable Development

Mrs Penny Grewal-Wiliams, Head, Healthcare Sector
Mr Ranjit Shahani, Pharma Divisional Head, Novartis India Limited

The Nippon Foundation

Mr Yohei Sasakawa, President
Professor Kenzo Kiikuni, Chairman, Sasakawa Memorial Health Foundation
Dr Yo Yuasa, Executive and Medical Director, Sasakawa Memorial Health Foundation
Mr Tatsuya Tanami, Director for International Relations and Special Projects

The World Bank

Dr Peter Heywood, Principal Health Specialist, The World Bank Group, India

WHO Technical Advisory Group on the elimination of leprosy (TAG)

Professor Vera Andrade
Dr M. D. Gupte (Chairman)
Dr H. J. S. Kawuma
Ms Santa Raye
Professor W. C. S. Smith
Professor Oumou Younoussa Sow

WHO Secretariat

Dr D. Daumerie, Leprosy Group, CDS/CPE/CEE
Dr Hussein Gezairy, Regional Director, WHO Office for the Eastern Mediterranean
Ms Melinda Henry, Public Information Officer, EGB/ECP/SPO
Dr David L. Heymann, Executive Director, Communicable Diseases (CDS)
Dr Myo Thet Htoo, Leprosy Group, CDS/CPS/CEE
Dr Antoine Kaboré, Director, Communicable Diseases Prevention and Control, AFRO
Mrs Harsaran Bir Kaur Pandey, Information Officer, WHO/SEARO
Dr Mika Kawano, Leprosy Group, CDS/CPE/CEE
Dr Robert J. Kim-Farley, WHO Representative to India
Dr Vijay Kumar, Director, Communicable Diseases, SEARO
Dr Derek Lobo, Medical Officer (Leprosy), Office of WHO Representative to Bangladesh
Dr Clovis Lombardi, Regional Adviser for Leprosy, AMRO
Dr Stephen Lyons, Leprosy Group, CDS/CPE/CEE
Dr Maria P. Neira, Director, Control, Prevention and Eradication (CDS/CPE)
Dr Paul Nunn, UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR)
Dr V. Pannikar, Leprosy Group, CDS/CPE/CEE
Dr Uton Muchtar Rafei, Regional Director, WHO Office for South-East Asia
Dr Tej S. Walia, Public Health Administrator, Office of WHO Representative to India
Mr Sathian Yovapue, Technical Officer (Leprosy), CDS/SEARO
Dr Nevio Zagaria, Coordinator, Strategy Development and Monitoring for Eradication and Elimination (CDS/CPE/CEE)

Observers

Dr Thomas Abraham, German Leprosy Relief Association
Dr M. A. Arif, Netherlands Leprosy Relief
Dr Rajan Babu, The Leprosy Mission International
Ms Katie Bigmore, British Leprosy Relief Association
Mr Tilak Chauhan, British Leprosy Relief Association
Mr Luc Comhaire, Damien Foundation Belgium
Dr K. V. Desikan, British Leprosy Relief Association
Mr Jayaraj Devadas, German Leprosy Relief Association
Mr Jan Willem Dogger, Netherlands Leprosy Relief
Mr Christopher Doyle, American Leprosy Missions
Mr Trevor Durston, The Leprosy Mission International
Ms Kokoro Fujiwara, The Nippon Foundation
Mr Peter Gill, BBC World Service Trust, New Delhi
Mr M. V. Jose, Associazione Italiana Amici di Raoul Follereau
Dr D. Kandathil, Associazione Italiana Amici di Raoul Follereau (India)
Dr P. Krishnamurthy, Damien Foundation India Trust
Dr Ravi Kumar, The Leprosy Mission International
Dr Vijay Kumar, Damien Foundation India Trust
Mrs Lori Mc Dougall, BBC World Service Trust
Dr Samuel Joseph Michael, American Leprosy Missions
Dr Nagpal, Damien Foundation Belgium and British Leprosy Relief Association
Mr P. Olphe-Gaillard, Association Française Raoul Follereau
Dr Montserrat Perez, Fontilles Lucha contra la Lepra
Dr Paul Saunderson, American Leprosy Missions
Dr Atul Shah, Leprosy Management Training Centre, Mumbai
Mr D. Soutar, British Leprosy Relief Association
Ms Kimie Takebe, The Nippon Foundation
Ms K. Yamaguchi, Sasakawa Memorial Health Foundation
THE DELHI DECLARATION

"We, the participants of the first meeting of the Global Alliance for Elimination of Leprosy, convened at the initiative of the World Health Organization (WHO) in New Delhi, India, on 30 and 31 January 2001, under the chairmanship of the Union Minister of Health, India:

RECALL that significant impetus was given to leprosy elimination efforts by the 1991 World Health Assembly resolution (WHA44.9) to eliminate the disease as a public health problem by the year 2000, elimination being defined as a prevalence rate below one case per 10 000 population. In order to make The Final Push to detect and cure all remaining leprosy cases in the world and thereby eliminate leprosy from every country by the year 2005, a Global Alliance for Elimination of Leprosy was created in November 1999;

RECOGNIZE that Multidrug Therapy (MDT) is highly effective in curing leprosy, interrupting its transmission and is available free of charge for all patients. The key to eliminating the disease is to detect all persons suffering from leprosy and curing them with MDT;

ACKNOWLEDGE that despite the significant progress made so far, the geographical coverage of leprosy diagnosis and treatment in many endemic countries remains unacceptably low and that significant fear and prejudice still surrounds the disease and those who suffer from it;

EXPRESS CONCERN that in the light of other more pressing public health priorities some authorities may ignore leprosy and thereby lose this unique window of opportunity to finally consign leprosy to the history books;

ENDORSE The Final Push strategy to eliminate leprosy in all endemic countries and emphasize the need to provide leprosy services to all communities through existing general health services;

URGE all concerned:
• to focus their efforts on urgently implementing The Final Push strategy on a large scale;
• to empower all local health services to diagnose and treat leprosy;
• to dispel the negative image of leprosy and improve awareness in all communities of the availability of free and effective MDT treatment;
• to ensure the uninterrupted availability of free MDT at all health centers;
• to adopt flexible approaches to ensure that patients receive a full course of treatment and are cured of leprosy;
• to actively monitor progress being made towards reaching elimination;
• to ensure that prevention and management of leprosy-related disabilities are an integral part of community-based rehabilitation for all disabled persons;
• to collaborate closely at field level to ensure the efficient and effective use of resources for elimination of leprosy;
• to mobilize additional resources to permit the implementation of The Final Push strategy at the necessary scale;

RECOMMEND that members of the Global Alliance for Elimination of Leprosy collaborate in the true spirit of partnership in order to eliminate leprosy as a public health problem from every country by the year 2005".