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Priorities and Cooperation. Blueprints and Guidelines

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Whatever the special field of leprosy work we are at present engaged in, and whether we are full-time or part-time, medically qualified or members of one of the ancillary professions, general practitioners in leprosy or high-powered specialists, we all have in some measure the power of choice, and the privilege and duty to use our knowledge and influence to help determine trends of policy and practice. As doctors, nurses, physiotherapists, social workers, or what you will, we need to possess—and to help make as we go along—some kind of blueprint for the future, some guiding principles, flexible and open to necessary modification, that will keep us and the whole leprosy campaign moving along the best and most profitable lines. To this end, as we approach the final session of this Congress, I invite you to stand and stare for a brief spell, and together look at the continuing problem of leprosy in the world and at both our meager material resources and our spectacularly new investigative apparatus.

With the power of choice entrusted to us, we must eschew the urge to uncooperative individualism. As workers together, in the larger sense, we each have need of others: the laboratory researcher needs the field worker, the epidemiologist needs the reconstructive surgeon, and the medical administrator must somehow catch the warm glow of the concerned social worker. The best-laid plans of thymectomized mice and soulless men may oft go awry, and be seen as hopelessly impractical if the human factor is ignored. Our decisions as we draw the blueprints and lay down the guidelines must therefore be intelligent and informed, made in such a way as to carry conviction and inspire collaboration. The strength, the initiative, the glorious individualism of the scientifically or medically eminent, must be harnessed to the humdrum everyday problems of the ordinary man in the village who is responsible for the application of the results of research.

The patients. In the determination of priorities in leprosy, we have to take cognizance of certain inescapable but often ignored factors. The most important of these is, of course, the patients themselves: their total number in the area considered, their proportion in the community, their dispersal in population groupings. Next, we have to think of the means of communication—the roads and railways, the footpaths and the watercourses—that may facilitate or render well-nigh impossible bringing antileprosy services within reasonable reach of those who need them. The social environment is another important factor, whether we think of Norway a century ago, with its overcrowded farmhouses in the wintry fiords, or of far-off China, with the whole family huddled together over a heated brick *kang*, or think of the endless rice fields of Thailand, or Venezuela with its isolated mountain-held communities of German extraction. Another sort of social environment confronts us in the juxtaposition of burgeoning towns in Mexico and a primitive rural population. Then, of course, there are the great and growing conurbations that harbor leprosy—São Paulo, Bombay, Madras, Calcutta, Hong Kong, Kinshasa, and many another, where the leprosy endemic is modified and conditioned by a wide range of social and environmental factors. In these varied and everchanging conditions, the leprosy endemic is to be tackled by those who are guided well by statistical data, by humanitarian considerations, and by determination and perseverance.

Then, too, there are political and military factors. I speak in a most chastened mood, because the two countries in Africa that had the most highly developed and the

most successful leprosy control programs are, or have been, in the throes of internal strife; and these two programs, which between them had a few years ago well over a quarter of a million people under treatment, are now in ruins. I refer, of course, to the Congo and Eastern Nigeria.

Then there is the question of attitudes toward the disease. Thirty-two years ago, when I first conducted leprosy surveys in part of the uncharted equatorial forest in the Congo, I was met by villagers who greeted me with the words, "We all get these patches sooner or later—we don't bother." And it was a fact that at any one time over half the people had leprosy in those village communities. Fortunately, 60 per cent was of the self-limiting, self-healing varieties. But in other parts of the world that I have visited during the past few years, we meet an attitude to leprosy that regards it as the ultimate, the worst possible, as "venereally transmitted," a disease that has to be "sold" to someone else.

The diseases. The second important group of factors is concerned with the disease itself, and with its most interesting geographic variations—more serious and more crippling the further one gets from Central Africa—and its fascinatingly variable type incidence from country to country. In Hong Kong, Thailand, and the Philippines, these serious manifestations vary enormously; we see the severe polyneuritis of Southern Korea, or the curious picking out of the radial nerve as the seat of a localized mononeuritis, in Japan, the Philippines, and in Papua and New Guinea. Attitudes engendered and determined by the various forms of the disease must be taken into consideration as we formulate our blueprints and guidelines for the future. To some, leprosy is inevitable and incurable, and deformity its inexorable consequence; to others, leprosy is so common, that it can be ignored—almost.

And then the frequency and severity of persistent reaction, as we see it in wards full of patients in the Philippines, in Thailand, in Brazil, in Venezuela, must naturally color our thinking as we determine our priorities.

The setting. Then there is the setting. Leprosy is one of many diseases, nutritional states, parasitic infestations and other conditions that now and again hit the headlines. The World Health Organization readily votes vast sums for easily controllable diseases like smallpox and malaria, diseases that are controllable at less expense than is leprosy.

Then the politicians have to heed the rival claims of education and defense, which swallow up (to our distress) an enormous proportion of the budgets of the poor developing countries, and leprosy, the nonkilling disease that takes time and money to cure, tends to remain hidden, ignored, and perhaps neglected.

Again, we must never forget the community, with all its fears and its prejudices and its own legitimate priorities, which we do well to respect. We must certainly give leprosy the place its importance merits on humanitarian and on sheer economic grounds. Leprosy is a costly disease, costly to the individual, to the family, to the community, to the country. Not only does its victim become a nonproducer, but he himself swallows up some proportion of the country's economic production.

These, then, are the factors we must recognize as we try to formulate our priorities in leprosy. We must be careful not to overemphasize the disease we are concerned with, not to sentimentalize it, or exaggerate its importance, and not to overemotionalize it. Our ideal is a happy combination of strict scientific detachment and warm humanitarianism that will commend itself to all, and inspire emulation.

We must also be aware of the danger of leprosy's becoming a vested interest with proprietary rights, often associated with buildings and equipment. Far too much money may be locked up in bricks and mortar and remain static, rather than be mobile and available in petrol for Landrovers. Control of leprosy in a rural community will never be achieved by an in-turned service that waits for self-diagnosed patients with advanced disease to come knocking at its doors.

Our priorities, of course, must be sufficiently convincing to the administrator and the politician and to those who hold the

budgetary purse strings. These, quite rightly, demand a program based on knowledge, and an increasing willingness to intergrate leprosy in the urban and rural health policy. Coupled with this, we can foresee our increasing involvement in education—of the public, the politicians, the doctors, the medical students, and, in particular, the medical auxiliaries, who are in many countries an essential part of the rural and urban attack on leprosy.

Priorities in leprosy programs. Then, we must examine our priorities in leprosy itself. In their thinking about leprosy, some folk get into a groove, which becomes a grave, the only difference being one of depth. Others may wear the blinkers of prejudice, and fail to recognize legitimate differences of approach and of emphasis. In this Congress, I am pleased to note, the surgeons and the epidemiologists are on speaking terms. May this dialog continue! Each needs the other, and neither must over-emphasize his own program or his own contribution to leprosy control and eventual eradication. One of the most potent and indirect effects of the cooperation of the surgeon in a leprosy control program, as in Papua and New Guinea, is its advertising value: everybody can see that deformity need not happen, but if it does, it can be corrected.

The cost. In deciding on our priorities in any given situation, we are confronted at the onset by *cost*. It is by no means a matter to be regretted or resented that leprosy control must justify itself before the hard-headed and hard-fisted keepers of the economic purse. We should all become cost-conscious as we plan and work. There is at present, and will be in the future, a tremendous disparity from country to country in the budgetary allocations for leprosy programs, supplemented as they are by subventions from voluntary agencies and by international bodies. On the one hand, some poor countries have available for *all* health services, including leprosy, the almost derisory sum of eight shillings (one dollar U.S.) per head per year, while others may count on an astronomic figure of £10 (or 25 dollars U.S.) per day per head, for leprosy alone. There is a great gulf between poor Lazarus and affluent Midas.

The solution lies not in the global apportionment of this treasure—putting all the cash into one great bag as it were, and then dividing it out—or in persuading the richer countries immediately to pour all their financial and human resources into the developing countries. The better-off countries are under a continuing moral obligation to render all assistance they can, but it surely behoves the developing countries to put their own houses in order and plan their leprosy control programs realistically and competently. Good planning and good administration, on their part, are a *sine qua non*, an essential prelude to the successful outworking of any scheme. There must not be any "empire-building" of surgeons or physicians, or laboratory or fieldworkers, no implied attitude on the part of the departmentally hidebound that unless they push and push hard, they will be denied a legitimate share of a restricted or depleted budget. There must be a scientific and dispassionate appraisal of the conflicting claims of the component parts of the leprosy program—competing claims that should be cooperative and coordinated. As we think of survey and education and treatment, of necessary segregation for some, of domiciliary treatment for the many, of hospital beds and Landrovers, reconstructive surgery and preventive medicine, prostheses and pills, we must not invest too much in those things that will not pay good, adequate, immediate and remote dividends in the task of leprosy control and leprosy eradication. The cost-conscious leprosy worker should be appalled at the disproportionate overheads of some projects, at the abnormally high expenditure on "patient-beds for burnt-out cases," and the costly deployment of staff that bears little apparent relation to reduction of the leprosy endemic. It is to be feared that some leprosy schemes create self-perpetuating vested interests. In some situations, of course, resources devoted to educating key people—politicians and doctors and village headmen—may be money very well invested; it may do much to change attitudes and initiate the repeal of repressive and discriminatory legislation, thus increasing

the effectiveness of the whole leprosy campaign.

The richer countries should provide increasing aid for the developing countries in the provision of expert advice, travelling fellowships, equipment and facilities. They can help in a real (and costly) way by fostering research that is quite beyond the resources of small countries. They can train doctors, postgraduate workers, and undergraduates. I see an enormous field of helpfulness opening up in opportunities for education at all these levels.

Again, the speedy dissemination of new knowledge and of the results of fundamental research, through the leprosy journals, is a most important feature of this task. The interpretation of this new knowledge and bringing it to the fieldworker in leprosy, in practical and practicable advice, must never be neglected. The gap between the research laboratory and the needy patient must be constantly narrowed as medical auxiliaries take new methods and new drugs to the individual patient and the mass treatment scheme.

Cooperation. We welcome a growing understanding, on the part of other scientific workers, of the special problems encountered in leprosy—its microbiology, its immunology, its pathology in general. Leprosy is indebted to many scientists in related branches. The time has now come for leprosy to repay these debts by providing investigative models in such fields as neurohistopathology, cellular immunology, and enzyme chemistry, for those who have helped in the past with their methods, their drugs and their control measures. There must be a working together of professional people, of doctors themselves, and a constant dialog between those engaged primarily in leprosy and those "coming into leprosy" from other branches and disciplines of medical and general science.

The miraculous key to leprosy control will not be found by any one person working in isolation, but rather in the cooperative efforts of many working together, discussing their problems with wide knowledge and deep sympathy, planning realistically in the light of the local administrative and medical situation. There can be no one ideal plan for every area, but in any given context there must be one plan, locally applicable and locally feasible, that is better than all others. Let us together find that plan and put it into operation.

Then let us pause to consider cooperation between leprosy workers and those in other fields: We have heard much this week, in the realms of electron microscopy, of biologic and experimental procedures, of new technics in chemistry, immunology, biochemistry, and physics; we have heard of the application of more sophisticated measuring devices to our problems in leprosy. And then, on the nonscientific plane, we have listened to accounts of the happy collaboration in many countries between governments and voluntary agencies. All such still have a vital part to play in this continuing dialog and in this continuing cooperation, working together with overall and efficient planning.

The question is often asked, what proportion of available resources could be, or should be, devoted to reconstructive surgery and rehabilitation? The answer varies with circumstances. My reply, as I travel the world, is: "Probably not more—in any given situation—than 10 to 15 percent of the leprosy budget can reasonably be devoted to reconstructive surgery, prostheses, rehabilitation, sheltered workshops, etc." But, proportions do vary according to circumstances. Tackle the leprosy problem, rather than over-treat the over-privileged few; bear continually in mind the untreated many, and try to lessen the leprosy endemic by reducing the infectivity of those with heavily bacillated skin and nasal mucosa.

The size of the hidden and unacknowledged and perhaps unsuspected leprosy reservoir might frighten both the politicians and the doctors if the truth were to become known. I am more frightened of ignorance about leprosy than I am of leprosy itself. Let us cooperate in this priority, and determine the extent of the endemic by systematic surveys, and make provision for the treatment of all leprosy sufferers at whatever stage. This will mean, for some of us, getting out of our comfortable institutions and getting into the rough and tumble of

urban and rural leprosy survey work, going where the patients are, finding them, treating them, and saving the rising generation from infection. It may mean, if the immunologists can provide us with a definite answer, devoting more time and energy and money to preventing leprosy by mass vaccination. Thus our flexible priorities may suddenly undergo a change of emphasis, as new knowledge is acquired and the validity of new methods of control becomes established scientifically. Only by so doing can we hope to reduce the level of infection in the community. Repetition of the familiar should reinforce our concern, not dull us into complacency: "early diagnosis; adequate treatment; prevent deformity; break the circle of transmission." These are the overriding priorities.

And they can be attained, and put into practice, only by cooperation. There must be more joining of hands, and working together: the official bodies, like governments, and the great voluntary agencies to which the world of leprosy owes so much, The Leprosy Mission, Leonard Wood Memorial, LEPRA, and many another. These were the pioneers. The Leprosy Mission, in particular, having shown concern when nobody else cared, has led the way in medical and surgical treatment, and in fostering widespread interest in the leprosy patient as a *man*.

The International Leprosy Association can help, as a catalyst and stimulator and coordinator. I am hopeful that the Association will be known not only as the sponsoring body of quinquennial congresses such as the present, but as a scientific godmother encouraging a continuing interchange between workers in special fields, communicating and perhaps meeting from time to time between congresses. I express the fervent hope that the World Health Organization may work even more closely with our Association in the future. Then, UNICEF has a great function today, with its practical outreach in the provision of drugs and transport and technical advice, all available, on request, to governments that ask. The United States and Japan have shown what can be done at the level of international cooperation in the cause of leprosy. May other nations follow suit!

Cooperation is being achieved, and must be the future pattern and basis of successful leprosy work, between those possessing a deep Christian faith, and those of other faiths or of no faith, men and women of altruistic goodwill, cooperating happily and worthily in the huge task still confronting us.

Let us, then, continue the dialog with the fruitful interchange of language and ideas and intuitions, in research and the application of the results of research and new knowledge to the practical tackling of this great and growing problem of leprosy in the world. Let us get our priorities right, and then let us work together. If only we could together apply existing knowledge, it is not beyond the realms of possibility that leprosy could be controlled in our generation and eradicated in the next.