Lepr Rev (2004) **75,** 214–216

What lessons can we learn from the evaluation of GAEL?

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Accepted for publication 6 July 2004

Evaluation is a process of assessing evidence, making value judgements on that evidence, and developing recommendations that will lead to improvements in the situation based on the experience gained so far. It was necessary and very welcome that an independent evaluation of the Global Alliance for the Elimination of Leprosy (GAEL) was carried out in 2003. It is now up to the concerned collaborators in the field of leprosy to reflect on the experience, and to plan for the future in a way that learns from the experience.

All evaluation should result in a balanced assessment which recognizes the strengths of a situation, as well as offer recommendations which address the weaknesses. The independent evaluation report of GAEL highlights the strength of the GAEL experience, especially the value added to what were previously loosely structured collaborative partnerships among the various agencies and governments involved in leprosy work. GAEL injected a new energy and commitment that resulted in new collaborating agencies, raised the political profile of leprosy especially within government circles, and resulted in an acceleration of many government programmes.

The evaluation report also draws out the concerns that were being raised during the early years of GAEL; especially the use of over-optimistic slogans, and the pressure to achieve the goal set by the World Health Assembly (WHA) in 1991,[1] which was increasingly being questioned and considered unrealistic by the scientific community. This dynamic came to a head in 2002 when the International NGO agencies in the form of ILEP were excluded from GAEL; and the International Leprosy Association (ILA) meeting in their Brazil Congress passed the resolution 'that available evidence strongly suggests that significant leprosy problems will continue to exist for many years to come . . .'. The evidence of the ILA Technical Forum[2] which was presented to the Congress and led to this resolution challenged the assumption on which the original goal of the 1991 WHA resolution was founded.

However, the dynamic behind the 1991 WHA resolution needs further consideration, and may help in formulating a more realistic approach for the future.

After the experience of increasing difficulty with monotherapy in the 1970s, multi drug therapy (MDT) was introduced as the standard regimen for leprosy treatment in 1982.[3] Over

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 0305-7518/04/064053+03 $1.00

the following years, experience in using this new treatment built up, and the proportion of new leprosy patients able to receive it started to rapidly increase. These were exciting times with a new technology, and the WHO was right to seize the initiative and recommend a goal to the WHA. At that time this goal of reducing point prevalence to below 1 case per 10,000 population was considered achievable, and mobilized many international agencies into redoubling their efforts.

Much experience was gained during the early 1990s as MDT coverage rose to include almost all new cases. However, during the same period there was an increasing body of evidence from some of the best managed programmes that suggested the detection of new cases was unfortunately not reducing as quickly as had been expected.[4] It was not until 2002 that the Technical Forum of the ILA was able to fully analyse this evidence and publish its results. This evidence challenged the viability of the WHA goal of bringing the prevalence of leprosy below 1:10,000 by an early date (which by then had been moved to 2005).

Although it takes a considerable measure of grace to step away from a goal that has been set by an international body such as the WHA, there are good reasons for doing so. It is interesting to note the comment in the evaluation report of GAEL that the reputation of some collaborators may be damaged if this kind of well researched evidence is not taken into account.

While the WHA resolution of 1991 and the formation of GAEL in 1999 were instrumental in mobilizing support for leprosy programmes and integrating leprosy work into general health services, the continued use of a global target at this point in history has to be seriously questioned. The evaluation report of GAEL has given clear recommendations that the concerned agencies need to work together in close collaboration and this needs to be strengthened at all levels.

But does such a collaborative forum need to be driven by an agreed goal? At the moment, although the elucidation of the *Mycobacterium leprae* genome may lead to the development of new tests for early diagnosis, the true potential of these developments has yet to be realized. New collaborative efforts cannot rely on the goal of MDT therapy set over a decade before, and which has become generally discredited by the scientific community in the intervening years.

Meanwhile, research initiatives like the COLEP study[5] are being undertaken by collaborating agencies, and this has the potential of a breakthrough that could result in a major step forward in leprosy control strategies that could dramatically reduce the incidence of leprosy. When that day comes it may be possible to again agree an exciting achievable goal and fully mobilize the major collaborators into a more formal alliance. But until then, collaborative efforts should quickly move on from the GAEL experience, and focus on bringing all parties together in a way that best meets the needs of the people who have leprosy.

These people need proper treatment, accurate information, and for some, ongoing support; and they need it as close to their homes as possible. This needs to be worked out in each country, yet this level of collaboration has continued to grow throughout, and even in spite of the GAEL experience. Recent interaction between the Government of India and the International Federation of anti-Leprosy Associations (ILEP) is just one example of such collaboration. At international level there needs to be a positive climate that strengthens relationships between agencies, and recent informal discussions between WHO and ILEP have brought new hope into a previously troubled relationship.

Thus it is essential to build and foster the right climate in which the concerned leprosy agencies and governments can strengthen their natural links. An alliance driven by a

discredited goal cannot achieve this: a more informal network with stronger local partnerships will keep key players working well together till the time is right to respond to the next major research breakthrough. In this way energies can be focused where most needed—responding to the needs of the patient.

References

[1] Leprosy Resolution WHA 44.9, Forty-fourth World Health Assembly, 13 May 1991.
[2] *International Journal of Leprosy* Volume **70**, No.1 (supplement) March 2002.
[3] Chemotherapy of Leprosy Control Programmes. Report of a WHO Study Group, *TRS* **675**, 1982.
[4] Richardus JH, Meima A, Croft RP, Habbema JD. Case detection, gender and disability in leprosy in Bangladesh: a trend analysis. *Lepr Rev*, 1999; **70:** 160–173.
[5] COLEP is a prospective sero-epidemiological study on contact transmission and chemoprophylaxis in leprosy. The project is a collaboration with KIT Biomedical Research (Amsterdam, The Netherlands) and the Department of Public Health of the Erasmus University (Rotterdam, The Netherlands), in partnership with the Danish Bangladesh Leprosy Mission (DBLM), funded by The American Leprosy Missions and The Leprosy Mission International. It began in July 2001 and will run to June 2007.