following:

- continue efforts to achieve elimination of leprosy through existing MDT services in the remaining states/ Union Territories;

- focus attention on :
  - endemic districts
  - endemic urban localities
  - districts showing high disability rates
  - states with a high proportion of child cases;

- continue efforts to provide quality diagnostic and treatment services for leprosy in each peripheral health institution; provide services on all working days; underscore necessity for correct diagnosis by a PHC medical officer; continue process of validation by District Nucleus/District Technical Support Team; carry out proper counseling and case follow-up for better case-holding;

- improve capability of the GHC staff in prevention and management of leprosy disability, along with increasing the number of reconstructive surgery centers; plan for a three-tier system of prevention of disability services;

- continue capacity-efforts for all categories of staff whose involvement in the program is essential, both in rural as well as urban areas;

- continue to increase awareness about leprosy among the masses with the aim of bringing about attitudinal change and removing stigma against the disease;

- draw up a special activity plan for the year 2006-07 for the 29 districts remaining with a PR of more than 2/10,000.

LESSONS LEARNT

1. Repeated Modified Leprosy Elimination Campaigns (a total of five in eight years) with specific strategies for different areas helped detect nearly 0.99 million leprosy cases in a relatively short period of time (six days). Each successive MLEC showed detection of a much smaller number of cases, indicating that hidden cases were being flushed out and transmission potential reduced. New case detection dropped only after the 4th MLEC, which is very significant.

2. Mass awareness about leprosy was possible only through these campaigns organized at regular intervals. Interpersonal communication at village and community level has a big advantage over other IEC methods in NLEP.

As awareness of leprosy increases, stigma diminishes

3. Integration of leprosy services with the GHC system has helped patients a lot, not only because of increased accessibility but because of the confidence they gain from consulting with the Medical Officer. This creates greater acceptance and leads to more voluntary reporting.

4. The inexperience of GHC staff, the self-interest of vertical leprosy staff and lack of patient awareness of the importance of completing treatment during the prescribed period caused certain "operational factors" to develop, which initially kept the leprosy case load higher than it actually was. Leprosy Elimination Monitoring surveys were carried out during the years 2002, 2003 and 2004 through independent agencies, which helped in pointing out deficiencies in the integrated system, availability of service in all health facilities, status of community awareness and operational factors.

Once these operational factors — wrong diagnosis, re-registered cases, non-existent cases, non-release of patients from treatment even after completion, irregularity in drugs collection by patients, lack of follow-up — were identified and corrected, the results were soon apparent.

Although the goal of leprosy elimination as a public health problem at the national level has been achieved, the government will continue with its program of leprosy eradication, to bring the benefits to people living in all parts of the country. There is no place for complacency at any level. The face of leprosy in India during the next six years is expected to be hugely different from the past. ■