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# Second Meeting of Partners on Tropical Diseases Targeted for Elimination/Eradication

*The Report*
*Jakarta, Indonesia, 14-15 February 2007*

World Health Organization
Regional Office for South-East Asia
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# Contents

# 1. Introduction

## 1.1 Background

The WHO South-East Asia Region has the highest burden of tropical diseases targeted by WHO for elimination/eradication. Over one billion people in the developing world are victims of these diseases, which are poverty-related and affect the poor, most vulnerable and most marginalized populations. The diseases targeted for elimination as public health problems are **leprosy, lymphatic filariasis** and **leishmaniasis (kala azar),** and that targeted for eradication is **yaws**. Though these diseases kill few people, they cause disabilities and deformities resulting in a heavy economic burden and loss of livelihood, and often expose the unfortunate victims to stigma and discrimination.

Despite the fact that there are cost-effective interventions to tackle these diseases, they are generally considered "neglected" because of inadequate policy support, insufficient resource allocation, low priority accorded in research and development, and ineffective implementation of available interventions, in coverage as well as in quality.

In order to address the above issues, WHO/SEARO organized a meeting of partners on "Tropical diseases targeted for elimination/eradication" in Bangalore, India in November 2005. The meeting culminated in the adoption of the "Bangalore Declaration".

One of the important recommendations made to WHO in the Bangalore Declaration was to consider the inclusion of "neglected tropical diseases" in the agenda of the Regional Committee meeting. Accordingly, "Regional initiatives for tropical diseases targeted for eradication/elimination" was included as an agenda item at the 59th Meeting of the Regional Committee held in Dhaka in August 2006.

The partners' meeting in Bangalore generated interest among the participating agencies in neglected tropical diseases (NTDs) and received wide media coverage. Since the Bangalore meeting in November 2005, the Region has made noteworthy progress and achievements such as (a) elimination of leprosy as a public health problem in the Region as a whole; (b) elimination of leprosy in India, the country which traditionally accounted for the highest burden of leprosy, globally and regionally; (c) elimination of yaws in India; (d) a policy change in India to switch from a single-drug (diethylcarbamazine [DEC]) to a two-drug (DEC + albendazole) regimen for mass drug administration (MDA) for lymphatic filariasis (LF); (e) implementation of a kala-azar elimination programme in all the endemic districts of Bangladesh, India and Nepal using the drug miltefosine.

Though significant progress has been made, Member States of the South-East Asia Region (SEAR) are not able to scale up interventions for diseases targeted for elimination/eradication and intensify efforts, mainly because of resource constraints, and insufficient policy and political support.

It was therefore felt necessary to organize a second meeting of partners in order to sustain the gains made so far, enhance the interest generated at Bangalore, involve more partners, enhance advocacy for the cause of NTDs, especially those targeted for elimination/eradication such as leprosy, LF, kala-azar and yaws, and explore the possibility of increased assistance to Member countries for activities related to elimination/eradication of these targeted diseases.

It is expected that this second meeting of partners will lead to a greater appreciation of the problems, needs, and available tools and strategies for elimination/eradication of the selected diseases. It would hopefully result in strengthened collaboration, partnerships and regional/international networking, and stimulate intensified efforts towards achieving WHO goals and objectives pertaining to elimination/eradication of these diseases.

## 1.2 General objective

The objective was to share the progress made so far and enhance the commitment of partners towards elimination/eradication of the targeted tropical diseases in SEAR.

### 1.3 Specific objectives

(1) To review the progress made by programmes related to diseases targeted for elimination/eradication in the Region vis-à-vis the Bangalore Declaration;

(2) To develop mechanisms for strengthening partnerships and collaboration in support of eliminating/eradicating the targeted diseases;

(3) To establish a Partners' Forum to promote advocacy for the cause of tropical diseases targeted for elimination/eradication

## 2. Inauguration

### 2.1 Inaugural address by the Regional Director, Dr Samlee Plianbangchang

(read by Dr Georg Petersen, WHO Representative, Indonesia)

The Regional Director highlighted some of the noteworthy achievements since the First Meeting of Partners on Tropical Diseases targeted for elimination/eradication held in Bangalore in November 2005:

(1) Achievement of the goal of elimination of leprosy as a public health problem in the Region, including in India, which accounted for the highest burden of leprosy, globally and regionally;

(2) Elimination of yaws in India and intensified yaws eradication activities in Indonesia and Timor-Leste;

(3) Intensification of the kala-azar elimination programme in Bangladesh, India and Nepal;

(4) A policy change in LF strategy in India of switching from a single drug (DEC) to the WHO-recommended two-drug regimen;

"Regional initiatives for tropical diseases targeted for eradication/elimination" was included as an agenda item in the 59th Session of the Regional Committee held in Bangladesh in August 2006.

Dr Samlee thanked the three co-sponsors of the meeting – the Federal Ministry for Economic Coooperation and Development – Germany (BMZ/GTZ), Sasakawa Memorial Health Foundation – Japan and the Global Alliance for Elimination of Lymphatic Filariasis (GAELF), as well as the representatives from partner agencies and Member States. He hoped that the meeting would not only sustain the interest of partners in the targeted diseases but also lead to stronger collaboration, better networking and intensified joint efforts.

Dr Samlee emphasized that SEAR accounted for 68% of all new leprosy cases detected globally in 2005, and harbours 65% of the population at risk for LF, 20% of the estimated kala-azar cases and a substantial burden of yaws. "These are major challenges but so are the opportunities to effectively eliminate or eradicate these age-old scourges," he said. Dr Samlee concluded by saying, "I believe we can together make a huge impact on the health of our people, on poverty reduction and on achievement of the Millennium Development Goals through adequate policy support, priority and resources to these neglected tropical diseases."

## 2.2 Keynote address by Mr Yohei Sasakawa, WHO Goodwill Ambassador for Leprosy Elimination and Chair – The Nippon Foundation, Japan

Mr Sasakawa suggested that the theme of the meeting as well as the thrust of advocacy should be changed to "Not to be neglected diseases" and urged all partners to work towards ensuring that the selected tropical diseases are not "neglected".

He pointed out that the achievements of WHO's Global Leprosy Programme have some important lessons for programmes related to other tropical diseases: (a) the high political commitment; (b) a clear goal, target and time-frame to achieve the goal, which stimulated endemic countries to allocate sufficient resources and make sincere efforts to reach the goal; (c) drug security – provision of a free supply of drugs to all countries and to all patients since 1995; (d) the involvement and support of a large number of partners and the effective coordinating role played by WHO; (e) the need for continuous advocacy with policy-makers and key groups such as the media; (f) attention to human rights and issues related to stigma and discrimination.

Mr Sasakawa said that the fight against leprosy was primarily to ensure correct public information – that it is curable, that drugs are available free of charge and that discrimination towards those with leprosy has no place in our society. Though 15 million people have been cured with multidrug therapy (MDT) since the early 1980s, the aspects of stigma and discrimination had not received sufficient attention until recently. Mr Sasakawa urged the participants to join his efforts in bringing these issues to the attention of the UN Human Rights Commission and the National Human Rights Commissions, and in joining the Global Appeal to end stigma and discrimination.

Mr Sasakawa commended WHO for promoting integration of leprosy into the general health services and joining forces with many partners, and emphasized the need for involving more partners such as the United Nations Development Programme (UNDP), UNICEF, the Human Rights Council and the corporate sector, which is increasingly willing to contribute to social causes as part of their "corporate social responsibilty". Achievements that have been made through drug donations by companies such as Novartis for leprosy and GlaxoSmithKline for LF need to be broadcast.

Mr Sasakawa informed participants that for four months each year he travels to various countries to lobby with top political leaders, encourage those working in the field, and seek the cooperation of the media and other key groups. He stressed that it is no longer enough to merely cure a disease but "priority has to be given to preventive aspects and the people in general must own the health programmes", he concluded.

## 2.3 Address by Honorable Minister of Health – Indonesia: Dr Siti Fadilah Supari

(read by Dr Nyoman Kandun, Director-General of Health, Government of Indonesia)

The Minister thanked WHO for selecting Jakarta as the venue for this important meeting and said that the Government of Indonesia is fully committed to the elimination/eradication of the diseases being discussed at this Second Meeting of Partners. She regretted that in spite of the advances in public health and medicine, these diseases that can easily be cured, are still lingering due to lack of funds and interest, as well as the low priority accorded to them.

Dr Supari said that of the four diseases, leprosy, LF and yaws are major public health problems in Indonesia. Though Indonesia has achieved the target of elimination of leprosy as a public health problem, the country still records about 20 000 new cases annually, 10% of them in children and 9% with visible disabilities. Thus, the fight against leprosy needs to go on for some more years. Indonesia reported about 5000 cases of yaws in 2006 but she said that "we are committed to eradicating yaws by 2010". With regard to LF, she mentioned that about 150 million people are at risk and the country has about 10 000 cases of chronic filariasis in 376 districts. About 7.5 million people in 54 districts received MDA in 2006.

The Minister reiterated the commitment of Indonesia to achieve the MDGs by the year 2015. She pointed out that one of the main MDGs is reduction of poverty and that NTDs are linked to poverty. In order to eradicate these diseases, the overall development of the community has to be thought of. "This is a gigantic task requiring a multi-player approach," she said and sought the support of partners in assisting Indonesia to achieve the elimination/eradication goals.

## 2.4 Nomination of chairperson and rapporteurs

Dr Jai Narain, Director, Department of Communicable Diseases, WHO/SEARO proposed the following as Chairpersons and Rapporteurs:

Chairperson:

Day 1 – Mr Douglas Soutar, ILEP, UK

Day 2 – Dr Nyoman Kandun, DG Health, Indonesia

Rapporteurs for both days: Dr V. Kumaraswami and Ms Clare Creo – WHO/SEARO

# 3. Technical presentations

## 3.1 Overview of the situation – Leprosy: Dr S.K. Noordeen

Leprosy is no more a serious public health problem except in a very small number of countries and some pockets in a few of the previously high-endemic countries. Since the initiation of MDT in the early 1980s, the

decrease in prevalence at the global level is >92% and in SEAR >94%. The decrease in new case detection at the global level is around 63% and in SEAR about 71%. The regional prevalence of leprosy has declined from 4.6/10 000 cases in 1996 to 0.79/10 000 cases as of September 2006 and the regional new case detection rate has declined from a peak of 47.76/100 000 cases to 11.9/100 000 cases in 2006.

Except Nepal and Timor-Leste, all other countries in SEAR have attained the goal of leprosy elimination, i.e. national prevalence of <1 case per 10 000 population. Among the 10 top countries that accounted for new case detection in 2005, four were from SEAR – India (highest), Indonesia (third highest), Bangladesh (fifth highest) and Nepal (sixth highest).

The factors that contributed to the success of leprosy elimination in SEAR include the availability of the highly effective MDT free of charge, strong political commitment, exemplary support from partner agencies and strong leadership from WHO, keeping public health orientation at the centre of the strategy.

The remaining challenges are (a) to reach unreached patients and provide them with MDT; (b) to develop and implement strategies for effective leprosy services in integrated settings; and (c) to build appropriate referral systems and rehabilitate the disabled.

The new opportunities are (a) to move further from the goal of elimination to that of eradication; (b) to fight discrimination and stigma as part of the human rights agenda; (c) to package leprosy within a group of diseases with common elements to enhance cost-effectiveness; and (d) to promote research aimed at priority areas such as preventing and curing nerve damage.

Future plans should include evaluating case detection in areas where over- or underdetection is suspected; close monitoring/evaluation; ensuring drug logistics and assessing the disability burden to plan and carry out rehabilitation of the leprosy-affected.

## 3.2 Overview of the situation – Lymphatic filariasis: Dr Derek Lobo

The highest burden of LF is in SEAR. Of the estimated 1.3 billion people globally at risk for LF infection, 851 million reside in SEAR. The Region also accounts for 50% of the estimated 120 million cases with clinical

manifestations. Nine of the 11 countries of the Region are endemic for LF, the exceptions being Bhutan and DPR Korea.

The disease is targeted for regional elimination as a public health problem, i.e. a prevalence of <1 case per 10 000 population in all endemic districts by 2020. The main intervention is MDA with two drugs – DEC + albendazole, to be given to the entire at-risk population once annually for 5–6 years. All nine countries of the Region are implementing MDA. In 2006, approximately 100 million people were administered MDA.

India, which was so far implementing the two-drug regimen only on a pilot basis in seven districts, has recently announced a policy shift to adopting the two-drug regimen. The country plans to cover the entire endemic population of 554 million by 2008; thus, the regional MDA scale up is expected to cover more than 80% of the at-risk population by 2008. The Maldives, Sri Lanka and Thailand are targeting the entire endemic population and Timor-Leste is expected to cover the entire country in 2007. Sri Lanka completed five rounds of MDA in all implementation units by the end of 2006. Over 80% coverage levels have been achieved in all implementation units and all sentinel sites showed a decline in microfilaria (mf) rates after one to two rounds of MDA.

Disabilities and deformities due to LF result in a heavy economic burden and loss of livelihood. In addition, the LF elimination programme has served as an entry point for other NTDs.

Mapping for endemicity as been completed in all the nine endemic countries except Indonesia, which is expected complete it by 2007.

The challenges include completion of mapping for endemicity in Indonesia and rapid scaling up of MDA to cover the entire population at risk by 2010 to ensure that all countries can complete at least five rounds of MDA by 2015. It would be important to ensure a high level of MDA coverage through pre-MDA social mobilization, and post-MDA mopping operations and surveys to establish actual coverage. Another important factor is timely procurement and supply of quality drugs. While the supply of albendazole is assured free of charge until 2020 by WHO, thanks to the donation by GlaxoSmithKline, countries need to procure DEC on their own. The scaling up of MDA and other activities such as disability alleviation have been slow due to insufficient political commitment and inadequate allocation of resources. WHO, while continuing to provide technical

support and assistance for resource mobilization, will seek more partners to increase advocacy for political commitment, resource mobilization and effective implementation.

## 3.3 Overview of the situation – Visceral leishmaniasis (kala-azar): Dr S.K. Bhattacharya

Kala-azar is a public health problem in three countries of SEAR – Bangladesh, India and Nepal. The disease is restricted to 52 of the 600 districts in India, 45 of the 64 districts in Bangladesh and 12 of the 75 districts in Nepal, with about 200 million people at risk of infection and an estimated 100 000 cases annually.

The disease is amenable for elimination as a public health problem because man is the sole reservoir of infection; the sandfly is the sole vector; the disease is focalized to a few areas; early diagnosis can be made through the diagnostic test rk-39; effective treatment is available to cure the disease in the form of the oral drug miltefosine and injection paramomycin; and effective vector control measures are available. There is also a high level of political commitment and greater availability of resources.

The elimination goal received a boost when the Ministers of Health of the three endemic countries in SEAR signed a Memorandum of Understanding (MoU) in May 2005.

The regional strategies include early diagnosis and prompt treatment; integrated vector management; effective surveillance; social mobilization; and clinical/operational research and partnerships.

The elimination programme has already been piloted in one district in India with plans for scale-up in phases, and is expected to be launched in Bangladesh and Nepal shortly.

The challenges include mobilization of adequate resources, detection of asymptomatic cases and those with post kala-azar dermal leishmaniasis (PKDL), effective vector control, and cross-border coordination and collaboration.

## 3.4 Overview of the situation – Yaws: Professor André Meheus

Yaws was a public health problem in about 50 countries of the world in the 1950s. It is a disease of the poorest of the poor, and primarily affects the skin and bones. The first global disease control programme was for yaws, launched jointly by WHO and UNICEF in 1952 and ongoing until 1964. During this period, 50 million people in 46 countries were treated with injectable long-acting penicillin, which resulted in a 95% decrease in prevalence in just 12 years. Unfortunately, the momentum was not maintained, the successful strong vertical programme was disbanded or diluted in most countries and integrated with the basic health services with little or no support. The disease has been allowed to linger and has resurged in some countries.

In SEAR, yaws is limited to three countries – India, Indonesia and Timor-Leste, with about 5000 cases reported annually. However, India has not reported any new cases since 2004 and has formally declared elimination of yaws.

Though the disease is highly amenable to eradication, there are some barriers: (a) the belief among policy-makers that it is not a priority, and even ignorance regarding its presence; (b) since it mainly affects children, and the remaining foci are limited to remote rural areas, the economic impact of the disease is not visible; (c) health services in the affected areas are absent or weak; and (d) the disease poses no threat to the industrialized world.

The disease is amenable to eradication because man is the only reservoir, a "magic bullet" is available – a single intramuscular injection of long-acting penicillin, transmission is only by direct skin-to-skin contact, well-validated diagnostic tests are available and no serious antimicrobial resistance has been reported so far.

The main challenges are (a) more precise mapping of affected areas; (b) strengthening of primary health centre (PHC) services including capacity building of health staff; (c) integration with other programmes wherever possible, e.g. leprosy, and (d) strong partnerships and intersectoral coordination.

# 4. Invited presentations

## 4.1 Integrated control of neglected tropical diseases – the way forward Professor David Molyneux, Lymphatic Filariasis Support Centre, Liverpool School of Tropical Medicine, UK

Over 1 billion of the world's poor are infected and at least two billion are at risk for developing NTDs. The combined disease burden in terms of disability-adjusted life years (DALYs) for NTDs as a group is 56.6 million, which is more than that of malaria at 46.5 million and tuberculosis at 34.7 million. Only HIV/AIDS with 84.5 million is higher.

However, several large-scale successes in the control of NTDS have not been recognized such as (a) elimination of LF in China, with 350 million free from the risk of LF; (b) control of onchocerciasis in 10 countries of Africa; (c) elimination of domestic transmission of Chagas diseases in five countries of South America; (d) control of schistosomiasis in China and Egypt, and (e) elimination of leprosy as a public health problem in over 100 countries.

The success and achievements of the above programmes can be attributed to the availability of cost-effective interventions and strong partnerships including drug donations such as (1) MDT for leprosy initially by the Nippon Foundation and now by Novartis; (2) mectizan for onchocerciasis and LF by Merck; (3) albendazole for LF by GlaxoSmithKline (assured till 2020); (4) azithromycin for trachoma by Pfizer, and (5) mebendazole for intestinal worms by Johnson & Johnson. International partnerships between the Ministries of Health, bilateral/multilateral agencies, UN agencies, NGOs and the private sector are becoming increasingly stronger and provide an opportunity to intensify efforts to tackle communicable diseases in general and NTDs in particular.

Recent studies have shown that significant cost savings can be achieved through integration of programmes. Further, such integration not only allows leveraging of the collateral benefits of MDA but also helps to achieve a rapid impact and limits the development of resistance. New initiatives such as the USAID's Neglected Tropical Diseases Control Programme are promoting integrated control of NTDs in five fast-track countries to build capacity, and promote sustainability by working through

local partners. A Global Network for Neglected Tropical Diseases (GNNTD) that has multiple partners, global disease-specific control initiatives, disease control support centres and drug donation programmes has been established to reduce disease burden and improve efficiency.

Professor Molyneux said that success in eliminating NTDs can be achieved by (a) ensuring that countries incorporate and prioritize NTD control policies; (b) securing national commitment following the World Health Assembly or Regional Resolutions; (c) ensuring funding by the USAID NTD Programme to SEAR countries; (d) delivering continued advocacy – best buy, pro-poor and consistent messages for policy-makers and opinion formers; (e) linking with the Global Network for advocacy and resource mobilization (e.g. setting up a DEC Drug Fund; and (f) sustaining links to the Clinton Global Initiative, US Senate, Hollywood, etc.

## 4.2 Human rights and empowerment of the leprosy affected – Dr P.K. Gopal

For several centuries, people affected by leprosy were segregated and isolated and the disease took away the identity and dignity of the affected people. This continued even after an effective cure was available in the form of the oral drug dapsone since 1948 and, to some extent, even after the introduction of multidrug therapy (MDT) in the early 1980s.

In due course, the success of MDT resulted in greater attention being paid to improving the quality of life of the affected people, and fighting against stigma and discrimination.

In countries such as Brazil, Korea and Japan, leprosy-affected people joined forces to fight for their rights but what was lacking was a "networking" among these groups. This need was fulfilled in 1994 when the organization Integration, Dignity and Economic Advancement (IDEA) was established. IDEA now functions in 16 countries and facilitates networking of the leprosy-affected people in all these countries.

In 2005, IDEA-India conducted a survey of leprosy colonies in India and identified about 650 leprosy colonies managed by the affected persons themselves. IDEA also conducted socioeconomic empowerment workshops in various states which helped identify state-wise leaders who in turn

organized state-wise groups. Two national conferences on "Integration and empowerment of the leprosy-affected people" were held in 2005 and 2006 in New Delhi. These conferences received wide media coverage.

Such movement and networking among leprosy-affected persons in different countries need to be promoted and strengthened so that their voices for equal rights could be heard, their honour and dignity restored and they become productive members of the community. This model could be replicated for those affected by NTDs.

## 4.3 Lymphatic filariasis: a poverty trap – Dr Myrtle Perera and Professor David Molyneux

The results of an assessment on "Impact of LF on patients and households" in Sri Lanka conducted by the Marga Institute in Colombo were presented.

LF had a significant impact on patients and their households, and not only affected poor people but also pushed people who were not poor into poverty. The disease dragged both patients and their households into a poverty trap and kept them in continued poverty. In addition, it prevented the steady progress of their economies and imposed fluctuations.

The study identified differentials at various levels such as the stage of infection, adopting preventative measures, ability to follow treatment schedules, time of diagnosis and management of complications.

The clinical manifestations of LF such as lymphoedema, hydrocele and elephantiasis resulted in extreme debilitation over long periods, which was further aggravated by stigma leading to social isolation, delayed diagnosis and advancement of disease beyond treatment. Diagnosis and treatment behaviour were delayed in poorer groups and had more severe consequences for the most disadvantaged. Whole households became enmeshed in the consequences as the condition impacts on living conditions, work, and social and educational opportunities. Simple measures such as washing programmes and hydrocelectomy provided significant relief from pain and discomfort, increased self-esteem and improved economic opportunities.

The findings have important implications for the LF elimination programme. It prompts a re-examination of the DALY burden attributed to LF. Previous studies underestimated the economic costs as they did not take into account the impact on the family and the indirect financial, emotional and social costs.

The study provides evidence that LF is not just a disease of the poor but can plunge non-poor households into poverty and poor households into absolute poverty. Thus, an LF patient can drag the household down into poverty or keep the household in perpetual poverty and be a hindrance to family progress.

# 5. Statements by participating agencies

## 5.1 Representatives from partners

***Sasakawa Memorial Health Foundation: Mr Genji Matsumoto, Executive Secretary***

The Saskawa Memorial Health Foundation (SMHF) has focused on leprosy for more than thirty years. SMHF continues to work towards reducing the number of leprosy cases, educating the public to eliminate stigma and discrimination, and empowering leprosy-affected people so that they can live a dignified life in society. SMHF will continue this work in collaboration with their partners working for the elimination of yaws, LF, kala-azar and other diseases. SMHF welcomed the presence of senior-level government officials from SEAR countries, which reconfirmed that countries are placing the targeted diseases high on the political agenda.

***Federal Ministry of Economic Cooperation and Development, Germany (BMZ/GTZ) – Ms Marianne Weinbach, Embassy of Germany, Jakarta***

The Federal Republic of Germany is firmly committed to playing an active part in the global efforts to achieve the MDGs, and specifically to building partnerships for the commitment to eliminate diseases. In 2003 and 2005, the German Government hosted two WHO strategic and technical meetings on intensified control of NTDs that set the stage for global, regional and country strategies. The German Government participated in

the first partners' meeting on tropical diseases in Bangalore in November 2005 and was pleased to be a co-sponsor of this meeting. They would also be supporting the meeting to be organized by the Special Programme for Research and Training in Tropical Diseases (TDR)/WHO in Varanasi, India in 2007. There have been some very encouraging results in integrating tropical infectious disease control programmes with health sector strengthening programmes.

The Bangalore Declaration on the intensive control/elimination of NTDs was a major milestone. Building on this consensus must continue for joint planning and concrete action, which would have significant results for the poor.

***Global Alliance for Elimination of Lymphatic Filariasis – Professor David Molyneux***

Dr Molyneux spoke on behalf of the Global Alliance for Elimination of Lymphatic Filariasis (GAELF) and the Liverpool Lymphatic Filariasis Support Centre. GAELF is committed to scaling up LF programmes, maintaining their momentum, increasing the resources available for LF programmes and continuing collaboration with WHO. The Department for International Development (DFID)-funded Liverpool LF support centre is now working on the integration of neglected disease control programmes. The Alliance is committed to continued support to various partners, including Bangladesh and Sri Lanka. DFID support to the Centre will continue until 2010.

***USAID Regional Development Mission Asia – Dr Molly Brady, Infectious Diseases Advisor***

USAID manages activities in NTDs at three levels – global, regional and country. The USAID Regional Development Mission in Bangkok manages regional and cross-border issues, as well as countries with no USAID Mission presence. At country level, USAID Missions manage bilateral programmes. USAID's infectious diseases strategy focuses on diseases of major public health importance which are not covered by other USAID programmes. The infectious diseases strategy has four main areas of work: development of an information base, a focus on the poor and underserved, increased access to good and affordable medicines, and regional sharing

and scaling up. This year, USAID's Global Neglected Tropical Diseases Programme has granted US$ 100 million to the Research Triangle Institute (RTI) for the control of NTDs. This Programme consists of five focus countries in Africa for integrated mass treatment, and a global request for applications (RFA). Only countries with three of the targeted diseases apply for these grants, and there will be a focus on small grants to fill critical gaps and for disease mapping. The RFA will be posted soon, and programmes are expected to start by July. For the Regional Development Mission, the NTD Programme focuses on dengue and kala-azar (for kala-azar this includes strengthening surveillance, PKDL and risk factors for development of PKDL). USAID will continue collaboration with WHO, particularly for activities that span the SEA and Western Pacific Regions.

***US Centers for Disease Control and Prevention (CDC), Jakarta – Dr William Hawley (also representing UNICEF)***

In Indonesia, CDC provides technical assistance to the Ministry of Health and other partners, carries out both operational research and monitoring and evaluation. Disease elimination programmes are a priority for CDC, in particular guinea-worm disease, onchocerciasis and LF. CDC is looking at the possibility of integrating programmes, particularly malaria and LF. There are many opportunities for synergy, such as the distribution of insecticide-treated bednets, indoor residual spraying, soil transmitted helminths (STH), measles vaccinations, vitamin A distribution.

***International Federation of Anti-leprosy Associations (ILEP) – Mr Douglas Soutar, Secretary General***

ILEP's mission is to work for a world without leprosy and to this end it recognizes the need to move beyond the goal of elimination. ILEP endorses the WHO Global Strategy for further reducing the burden of leprosy and sustaining leprosy activities from 2006 to 2010, and the ILEP strategy builds on the achievements of the elimination strategy based on sustainability, quality assurance, equity and social justice.

ILEP expends around €65 million on leprosy work each year including €2.7 million on research and scientific support. This includes the promotion of the WHO Global Strategy 2006–2010 and operational guidelines and continuing support for national programmes.

ILEP members have planned a number of key changes from 2006 to 2010. These include shifts in focus from campaign-oriented elimination to sustainable control; from prevalence to new case detection and treatment completion; from numerical targets to an emphasis on quality targets, which can reflect the timeliness of diagnosis and quality of treatment; from unbalanced partnership to equal partnership; and according greater priority to prevention of disability, reducing stigma and rehabilitation.

In the interest of all those who will continue to be affected by leprosy, ILEP believes that political commitment must be reconfirmed and effective partnerships forged, as these are prerequisites for sustaining effective and quality leprosy work.

### *Netherlands Leprosy Relief – Mr Dan Ponsteen*

Netherlands Leprosy Relief is a Dutch nongovernmental organization (NGO) with a budget of around €10 million, and works mostly with governments. In Indonesia the most urgent issues are treatment and disability. The organization is working towards the integration of leprosy treatment into the health services. In Mozambique leprosy and TB have been integrated via GFATM funding.

### *International Relief and Development – Dr Estrella Serrano, Health Manager*

IRD is strongly committed to the control of NTDs and looks forward to opportunities to participate in the control, elimination and eradication of these diseases.

### *Asian Development Bank – Mr James Darmann Jungeono, Consultant*

Funding by the Asian Development Bank (ADB), both through loans and grants, is generally not directed to disease elimination or eradication activities, but is aimed at investment activities such as capacity building, procurement of equipment and civil works.

In Indonesia, ADB is presently funding two loan projects, the Decentralized Health Services and the Second Decentralized Health

Services Projects, which cover 17 of the 33 provinces and over 160 districts of the country. ADB supports district health offices to identify and prioritize funding sources for district health needs and develop integrated and comprehensive health plans. In this way, more effective and efficient utilization of available resources may be achieved, resulting in better quality of coverage and delivery of health services, avoidance of overlap of activity among donors and, most importantly, an improved health status.

It may be possible to access funding for activities in the area of control of neglected diseases by making sure that the planned activities are advocated at the district decision-maker level, and are prioritized in the district master plan and annual plans.

***GlaxoSmithKline – Mr Sameer Deb***

As a leading pharmaceutical company, GlaxoSmithKline's responsibility is to operate profitably in a socially responsible way. LF elimination is the flagship community programme, and the GSK commitment is to *"donate albendazole to WHO for every country that needs it until LF is eliminated as a public health problem"* GSK also provides funds for building the GAELF support centres, monitoring and evaluation, workshops, meetings and communications.

Highlights of the work for 2006 include integration grants for NTDs made by USAID and the Gates Foundation. WHO guidelines for integration were produced and several countries completed the fifth round of MDA. In December, all manufacturing of albendazole was transferred to Cape Town, South Africa. GlaxoSmithKline also received the 2006 World Business Award from United Nations Development Programme (UNDP), International Chamber of Commerce (ICC) and the Prince of Wales International Business Leaders Forum (IBLF).

For 2007, GlaxoSmithKline's main focus will be on working with WHO to supply a forecasted 225 million albendazole tablets globally, of which more than half will be delivered to SEAR; supporting the integration of LF with other NTD Programmes; and carrying out post-fifth MDA evaluations in Sri Lanka, Zanzibar, the Pacific Islands and Egypt. GlaxoSmithKline will also work with the Gates grant group to resolve the scientific and technical issues affecting LF elimination and support the GAELF in advocacy and resource mobilization.

### *One World Health – Dr Phillip Desjeux*

One World Health is the first non-profit pharmaceutical company in the USA. The goal is to develop effective, safe and affordable drugs. One World Health endorses and supports the WHO and government commitment to eliminate kala-azar.

One World Health has developed paramomycin for the treatment of kala-azar. The drug is currently undergoing phase three trials with registration in August 2006, and is currently submitted in India for approval for use by the Government of India in the public sector. The safety study will be extended in phase four trials. One World Health will also be working to reduce the gap between illness and treatment-seeking, as the key to reducing transmission is early detection and treatment.

In the future, it is important to move towards combination therapy, as kala-azar is still one of the few diseases being treated by monotherapy.

### *LEPRA, UK – Dr Ranganadha Rao*

LEPRA is a medical charity focusing on leprosy, with a vision of a world without leprosy. The organization supports governments and NGOs, and offers social and economic assistance. In India, LEPRA is also working in the area of TB and disabilities, and will continue to provide disability care in urban settings. The lessons learned from leprosy will form the basis of expansion. LEPRA also plans to enlarge its activities to include disabilities due to other NTDs such as LF and kala-azar. In Orissa, LEPRA has initiated social mobilization campaigns to enhance acceptance of MDA for the elimination of LF and is promoting disability-management programmes through self-care groups. There are similar plans for Andhra Pradesh and seven districts in Bangladesh, where synergies with kala-azar are being explored.

### *School of Public Health and Tropical Medicine, James Cook University, Australia – Professor Peter Leggat*

James Cooke University (JCU) works in the area of NTDs in a number of ways. The LF Support Centre provides technical support, and JCU carries out basic and operational research including baseline surveys, programme

evaluations and new technology research. In the area of training and education, the university provides both short courses and postgraduate training in public health and tropical medicine. The University makes a significant contribution to training the workforce of health managers and field workers from regional and international NGOs and organizations.

### *The Leprosy Mission South-East Asia – Mr Nuah P. Tarigan*

The vision of the Leprosy Mission South-East Asia is a world without leprosy, and its focus is on leprosy until the work is finished. It plans to expand its area of work to support people with disabilities.

### *Zentaris (submitted in writing by Professor Jürgen Engel)*

The cooperation between WHO/TDR) and Zentaris, a small German company, reflects the successful realization of a public–private partnership. The product Impavido with its active ingredient **miltefosine** is the first oral drug for the treatment of visceral leishmaniasis.

Studies have now established that miltefosine is safe and effective. By now, more than 18 000 patients have been treated all over the world with miltefosine and the product is registered in Germany, India, Bangladesh, Nepal and Pakistan as well as in many countries of Latin America. It has the designation of an orphan drug in Europe and the US.

Zentaris is supporting a phase IV study in Bangladesh and clinical studies in combination with other antileishmanial drugs. Based on encouraging clinical data on PKDL, the drug will be supplied and data management done for a study in India.

Zentaris has already signed an agreement with WHO to supply miltefosine at a preferential price in the range of €50 per treatment for use in elimination programmes. Zentaris appealed to the participants at the Jakarta Meeting to take all necessary steps to start similar programmes as soon as possible in the three countries of the Indian subcontinent to take this chance of saving lives and eliminating this devastating disease forever.

***World Health Organization – Dr Derek Lobo***

Dr Lobo reiterated WHO's commitment to assist and support Member States of SEAR in their efforts towards elimination of leprosy, LF and kala-azar, and eradication of yaws. He stressed the importance of effective implementation of strategies, based on the respective regional strategic plans.

The immediate focus will be on (a) early implementation of the kala-azar programme in Bangladesh, India and Nepal; (b) rapid scale-up of MDA for elimination of LF in all countries; (c) intensification of the yaws eradication programme in Indonesia and Timor-Leste; (d) sustaining leprosy elimination and further reducing the burden of leprosy, as well as addressing issues related to disability prevention, care, rehabilitation, stigma and discrimination; (e) strengthening partnerships; (g) advocating for and assisting countries in resource mobilization.

## 5.2 Representatives from Ministries of Health

***Bangladesh – Dr A.N. Maksuda***

Bangladesh is committed to reducing the disease burden in both communicable and noncommunicable diseases. With regard to NTDs, a strategic plan has been prepared under the Health, Nutrition and Population Sector Programme (HNPSP). Recognizing that diseases such as leprosy, LF and leishmaniasis cause disability/deformity and impose an enormous socioeconomic burden on endemic communities the Plan envisages (a) integration of diagnosis/treatment/management of complications with the general health system (GHS) to make them cost-effective; (b) assured drug availability; (c) enhanced IEC activity, and increased community awareness by using the mass media; (d) strong political commitment; and (e) increased private–public partnerships to combat diseases.

The disease burden due to leprosy has reduced considerably and the disease is now confined to a few endemic areas. Stigma has also reduced. However, rehabilitation of affected persons remains to be taken up.

In the LF elimination programme, 12 of the 32 LF-endemic districts have been covered and 17.2 million people (with 83% coverage) were

administered MDT in 2005. Sixty million people in 45 out of 64 districts are yet to be covered.

The leprosy and LF programmes are supported by many partners such as the World Bank, DFID, Japan International Cooperation Agency (JICA), ILEP, WHO and many local NGOs. WHO played a vital role in procuring drugs for these programmes.

***Indonesia – Dr Nyoman Kandun***

The Government of Indonesia is committed to improving the quality of life of its citizens, but natural disasters, continued poverty and socioeconomic conditions interfere with the progress in implementation of health programmes.

LF, leprosy and yaws still remain major public health problems. The disease burden in terms of prevalence, new cases, disability and population at risk is significant. The Government is committed to eradicating yaws by 2012 and eliminating filariasis by 2020. Though the country achieved the goal of elimination of leprosy in 2000, the leprosy burden needs to be reduced further to interrupt disease transmission and there is a pressing need for appropriate rehabilitation programmes for disabled people. Further, issues related to human rights require to be addressed.

The strategies adopted by Indonesia with respect to NTDs include intensified case finding and treatment of cases and their contacts for yaws eradication, scaling up of MDA in phases to cover 150 million people at risk for LF within the next four to five years and sustaining quality leprosy services. The strategy to integrate programmes and activities related to NTDs will be a priority.

There is need to enhance resource mobilization to meet the funding gap and enlist more partners to bridge the gap and form a national forum of partners. It is proposed to initiate public–private partnerships to combat these diseases.

***Myanmar – Dr Kyaw Nyunt Sein***

Strong partnerships with national and international partners have helped Myanmar eliminate leprosy at all administrative levels. The country is

continuing its efforts to sustain leprosy services in order to further reduce the burden of leprosy.

Some of those affected by leprosy and their families face stigma and discrimination. Measures for prevention/care of disability and rehabilitation programmes are in place, in association with local organizations and international partners. Partnerships should extend to prevention of disability (POD), rehabilitation, basic and operational research, surveillance and sustaining of leprosy services. A Leprosy Elimination Coordination Committee (LECC) has been established to coordinate the activities of all national and international partners.

Efforts to eliminate LF are not progressing as well as leprosy. The LF elimination programme could cover only 50% of the population at risk after six years, though the cost of MDA is minimal at US$ 0.02 per person In urban areas, vector control for LF has already been integrated that for dengue haemorrhagic fever (DHF), and integration of vector control for LF with that for malaria is planned.

According to a limited survey, there are some seropositive imported cases of kala-azar at the Myanmar–Bangladesh border. Proper planning is needed to handle such cross-border issues. The first round of the National Health Plan (NHP 2003–2011) aims to create awareness, build capacity, improve surveillance and reporting systems, and conduct surveys for locally endemic diseases.

Access to services and medicines is important. The availability of free MDT was one of the main factors responsible for the success in eliminating leprosy. Similarly, the efforts of GlaxoSmithKline and other donor agencies are helpful in combating NTDs.

***Nepal – Dr Shanker Shrestha***

Nepal has made significant progress in eliminating LF. Mapping for endemicity has been completed – 38 of the 75 districts are endemic. In 2006, three districts with a population of 2.19 million were administered MDA and it is planned to scale up MDA to cover 21 districts in 2007.

Local NGOs, clubs and medical schools participate in the programme at the community level. The partners supporting the LF programme include the World Bank, DFID, WHO and GlaxoSmithKline.

Nepal, like Bangladesh and India, has targeted kala-azar for elimination as a public health problem by the year 2015 and is working closely with Bangladesh and India to achieve this goal. However, the country lacks the resources required to pilot and scale up activities for elimination of kala-azar.

The country is yet to achieve the goal of leprosy elimination but is making concerted efforts to attain the goal within 2007. The prevalence rate as of July 2006 was 1.6/10 000 population. Case holding has been excellent (>90% total cases reported [TCR]) and the country has a vast pool of trained manpower and a wide network of referral centres. Several partners and WHO have contributed to the success of the programme. Other partners such as professional bodies, medical colleges, paramedical training facilities, hospitals, social welfare departments and communities have played less active roles.

### *Sri Lanka – Dr P.G. Maheepala*

Partnerships have played a crucial role in reaching the target of eliminating LF and leprosy. In response to the World Health Assembly resolutions pertaining to elimination of these tropical diseases and recognizing the cost-effectiveness of the interventions used, the Government of Sri Lanka initiated elimination programmes targeting these diseases.

LF is endemic in a few provinces in the country with a population of about 9.8 million at risk. Sri Lanka initiated an LF elimination campaign in 2000. By 2006, 100% geographical coverage had been achieved, 90% of the population had taken the drugs and the mf rate had been brought down to 0.03% in the course of the year. Sri Lanka solicited and received support for the national elimination programme from GlaxoSmithKline (provision of drugs), WHO (technical guidance) and the Federation for International Football Association (for disability alleviation).

*Leprosy:* MDT was introduced in 1983, the same year that WHO recommended it, and achieved 100% coverage in the same year. MDT was provided by the Swiss Emmaus until 1995 and thereafter by WHO. In 1990, an extensive social marketing campaign was introduced, probably for the first time in history, to raise awareness among the population about the early signs of the disease and to reduce stigma. As a result, the number of self-reported cases went up and social stigma was reduced. In 1995, the target of elimination was reached and in 2002 leprosy activities were integrated with

the provision of routine health care. The main reasons for this high level of performance and success are the very high level of political commitment, excellent collaboration extended by WHO in technical guidance and other partners such as Novartis and Swiss Emmaus, availability of adequate infrastructure and human resources, and resource mobilization.

The Government of Sri Lanka solicits ongoing support from WHO and the other partners mentioned above for further consolidation of the programmes.

### *Thailand – Dr Suwich Thammapalo*

Thailand has been successful in controlling both leprosy and filariasis. The prevalence rate of leprosy declined from 3/10 000 in 1989 to 0.21/10 000 in 2006, while the detection rate fell from 0.29 to 0.10 /10 000 during the same period. Similarly, the prevalence of LF decreased from 11.16/100 000 in 1992 to 0.35/100 000 in 2006.

Local partnerships were built by the health department with local authorities, temples, schools and voluntary organizations. National partnerships such as the Raj Pracha Samasai Foundation (under royal patronage) and the Thai Leprosy Relief Foundation provide grants for socioeconomic rehabilitation. Similar support for LF patients is provided by the Au-atorn Foundation.

International grants and technical support for the leprosy elimination programme were provided by the Sasakawa Memorial Foundation since 1959, Netherlands Leprosy Relief (NLR) since 1985, German Leprosy Relief Association (GLRA) and WHO SEARO and WHO Thailand.

The LF elimination programme received drugs from GlaxoSmithKline (albendazole) and technical support from WHO. The national programme collaborates with neighbouring countries to control border diseases.

### *Timor-Leste – Dr Alex Andjaparidze*

This country, which gained independence in 2002, has a population of approximately one million. The country has very limited infrastructure in its 13 districts and primary health-care services are limited.

LF is endemic in all districts and in 2003 the prevalence ranged between 5% and 26%. Before 1975, the prevalence was estimated at between 5% and 6% in all districts. Mf have also been detected among expatriates living in Timor-Leste for more than six months.

Although there are limited population data regarding intestinal parasites in Timor-Leste, *Ascaris lumbricoides*, *Hymenolepis nana* and *Entamoeba histolytica/dispar* are the commonest intestinal parasites.

The country has adopted an integrated control and elimination programme that includes everyone in Timor-Leste. It involves once-yearly administration of two "single-dose" drugs given together (DEC and albendazole). Additionally, children aged 2–16 years receive another dose of albendazole after six months while children aged 6 months to 2 years receive a single dose of pyrantel every six months. Active case-finding for TB and leprosy is in progress. Two hundred six facilitators have been identified and 3416 distributors have been trained.

The programme is unique for a number of reasons: (a) the integrated approach; (b) incorporating active case-finding for TB and leprosy; (c) involving non-health trained distributors and facilitators; (d) scope to incorporate other initiatives.

By 2006, 137 suspected cases of leprosy and 277 suspected cases of TB were identified during administration of MDA for LF and were referred for confirmation of diagnoses.

The supportive and encouraging statements made by the participating agencies were further elaborated during the **Round Table Discussion** on "The way forward". The Round Table Discussion identified priority areas and helped formulate the recommendations that were made.

# 6. Media advocacy

The press conference held on the first day of the meeting was attended by a large number of journalists from the national and international press. Speakers at the press conference were I. Nyoman Kandun, Director General Communicable Diseases at the Ministry of Health; Mr Yohei Sasakawa, WHO Goodwill Ambassador for Leprosy; Dr Georg Petersen, WHO Representative for Indonesia; Ms Marianne Wienbach, Third

Secretary of the German Embassy in Jakarta; and Dr Jai Narain, Director, Communicable Diseases, WHO SEARO. .All of them made statements and answered questions from the press.

As a result of the press conference, the issue of tropical diseases targeted for elimination and eradication received considerable coverage in the press, including in 29 Indonesian dailies with photo coverage, three television stations, eight online sources, four radio stations and four international news agencies. In addition, Dr Jai Narain, Director Communicable Diseases, appeared in a live interview on Metro TV and AnTeve filmed interviews with Mr Sasakawa, Dr Narain, Dr Molyneux and a leprosy patient.

# 7. Conclusions and recommendations

The participants conveyed their appreciation to the Regional Director, WHO/SEARO, Dr Samlee Plianbangchang for taking the initiative in organizing the Second Meeting of Partners on Neglected Diseases Targeted for Elimination/Eradication and to the new Director General of WHO – Dr Margaret Chan for according high priority to NTDs.

The participants thanked Mr Yohei Sasakawa, WHO Goodwill Ambassador for Leprosy Elimination for his presence and inspiring keynote address. The participants placed on record their appreciation to the Government of Indonesia and the co-sponsors of the meeting – German Development Cooperation – BMZ/GTZ, GAELF, the Sasakawa Memorial Health Foundation, Japan and WHO.

Representatives from partner agencies renewed their commitment to enhance their support to Member States for intensifying efforts towards elimination/eradication of neglected diseases, namely, leprosy, LF, kala-azar and yaws, and made the following recommendations.

(1) National governments should accord high priority to elimination/eradication of NTDs, substantially increase the in-country allocations for NTDs and advocate for external funding.

(2) WHO should assist national governments in developing national plans for integrated delivery of interventions and activities wherever feasible, such as integrated vector management,

integrated prevention/care of disabilities, integrated training, etc. in order to ensure the cost-effectiveness and sustainability of programmes.

(3) Strong regional/national/local public–private partnerships should be formed to ensure advocacy for political commitment, planning, resource mobilization, coordination and effective implementation of programmes.

(4) WHO and other partners should establish a mechanism for drug security to ensure a free supply of drugs required for the treatment of targeted diseases based on the model of MDT for leprosy and albendazole for LF.

(5) Noting that people suffering from diseases such as leprosy, LF and yaws are prone to stigma and discrimination, it is recommended that dealing with issues related to stigma, discrimination and human rights are incorporated into the national/subnational plans, and brought to the attention of national/international human rights commissions and civil rights activist groups, and adequately addressed.

(6) At the national level, high priority should be given to investment in

(i) national human resources for NTDs

(ii) community involvement and participation in programme planning, implementation, monitoring and evaluation. Such participation is to be ensured also from people affected by the targeted diseases;

(iii) procurement of quality drugs, and effective logistics management to ensure easy accessibility to the drugs by those needing them;

(iv) managerial and financial sustainability;

(v) involvement of academic and research institutes;

(vi) basic and operational research.

(7) Noting that implementation of elimination/eradication programmes are particularly problematic in border areas, WHO should assist countries in developing appropriate strategies and

mechanisms to deal with cross-border issues and effectively implement the programmes in border areas.

National governments and partners should document the "success stories" related to control and elimination/eradication of communicable diseases as learning and advocacy tools.

# 8. Closing session

Dr Jai Narain chaired the closing session and thanked all the co-sponsors, temporary advisors, speakers and participants. He stated that the meeting was, from the WHO perspective, a resounding success. He especially thanked Mr Yohei Sasakawa for his presence and enriching keynote address. He also thanked the Government of Indonesia, particularly the Minister of Health and Dr Nyoman Kandun, DG Health and his staff, for their assistance in organizing the meeting.

## Annex 1

# Programme

**Wednesday, 14 February 2007**

| | |
|---|---|
| 08.30 hrs | Registration |
| 09.30 hrs | ***Session 1.0 – Inauguration*** |

- RD's Inaugural Address (read by *Dr Georg Petersen*, WHO Representative, Indonesia)
- Keynote Address: Neglected tropical diseases – lessons from the Global Leprosy Elimination Programme – *Mr Yohei Sasakawa*, WHO Goodwill Ambassador for Leprosy Elimination and Chairman, The Nippon Foundation, Japan
- Address by Chief Guest – Hon'ble Minister of Health, Indonesia
- Introduction of participants and announcements
- Group photograph followed by tea/coffee

11.00 hrs Chair: *Mr Douglas Soutar*, Secretary-General, ILEP, UK

***Session 1.1 – Tropical diseases targeted for elimination/eradication in South-East Asia Region: global and regional overview***

- Leprosy – Dr S.K. Noordeen, Chair, Regional Technical Advisory Group for Leprosy Elimination
- Discussion
- Lymphatic filariasis – Dr Derek Lobo, Regional Adviser, Leprosy and other diseases targeted for elimination/eradication
- Discussion
- Leishmaniasis (kala-azar) – Dr S.K. Bhattacharya, Additional Director General, Indian Council of Medical Research and Director-in-Charge, National Institute of Cholera and Enteric Diseases, Kolkata, India
- Discussion
- Yaws – Professor André Meheus, Chairman, Department of Epidemiology and Social Medicine, University of Antwerp, Belgium
- Discussion

12.30–14.00 hrs Lunch

14.00–15.00 hrs ***Session 1.2 – Integrated approaches to delivery of interventions***

- Presentation – Integrated approaches – the way forward – *Professor David Molyneux*, Executive Secretary, Global Alliance for Elimination of Lymphatic Filariasis (GAELF), UK
- Discussion

15.00–15.30 hrs Tea/coffee

15.30–17.00 hrs Statements by partners and participating agencies on addressing neglected tropical diseases and future plans

19.00–21.00 hrs Reception followed by dinner (Sasono Mulyo-2 Lobby Level, Le Meridien)

**Thursday, 15 February 2007**

09.00 hrs Chair: *Dr I. Nyoman Kandun*, Director-General of Disease Control and Environmental Health, Ministry of Health, Indonesia

***Session 2.0 – Special presentations***

- Human rights and empowerment of the leprosy affected – *Dr P.K. Gopal*, President, National Forum, India
- Lymphatic filariasis – a poverty trap – *Dr Myrtle Perera*, Marga Institute, Colombo, Sri Lanka and *Professor David Molyneux*, Executive Secretary, Global Alliance for Elimination of Lymphatic Filariasis (GAELF), UK
- Discussion

10.00–10.30 hrs Tea/coffee

10.30–11.30 hrs ***Session 2.1 – Round Table Discussions***

Strengthening partnerships for neglected tropical diseases – the way forward

11.30–12.15 hrs Conclusions and Recommendations

12.15–12.30 hrs Closing session

12.30–14.00 hrs Lunch

## Annex 2

# List of participants

Dr Sri Durjati Boedihardjo
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* Unable to attend