# Editorial

## THE WIND OF CHANGE

The Clayton Memorial Lecture was founded by LEPRA in 1974 to honour the memory of the Rev. T. B. Clayton, founder of Toc H, who in the 1930's committed that self-sacrificing organization to the fight against leprosy in Africa, and in co-operation with BELRA was responsible for sending a succession of dedicated laymen to engage in field work, usually in pioneering conditions. The 1976 lecture was given recently by Dr T. W. Meade, an epidemiologist of international reputation, who has also personally been engaged in a major leprosy control project in India, and so knows our problems from the inside as it were. The material of his lecture on the question, "How effective is the treatment of leprosy?" appears by invitation in this issue of *Leprosy Review,* and some readers may well liken it to a gust of cold air shattering their illusions and challenging their complacency.

For over 20 years now it has been the accepted doctrine that in dapsone we have the means to bring leprosy under control, and applying it on a sufficiently large scale we can look forward to the eradication of the disease. Though doubts and questions have arisen in recent years this doctrine is still being put forward in the official publications of some leading anti-leprosy organizations. Dr Meade draws attention to the great fallacy in it, namely the "application gap" between, on the one side, what the planners hope will happen, and on the other side, the actual response of the patients and potential patients who are the expected recipients of their ministrations.

It has been assumed in far too facile a way that, offered dapsone, patients would want to take it and go on taking it for long periods. We now know that many of them do not, sometimes because dapsone is not offered to them in an appropriate way, but more fundamentally because we have not taken the measure of the social, religious and economic factors which are of unique importance in relation to leprosy, a point that has repeatedly been made in this Journal in recent years.

The writer was one of those optimists who lived through the heady exciting years of the first application of dapsone on a large scale, and witnessed the transformation it effected in Nigeria not only on patients but also on public opinion. More recent experience of trying to apply the same methods in central India proved a powerful corrective to optimism. Here, although many patients knew that dapsone was the best medicine available, and that they needed to take it, they were so much the victims of the circumstances which prevailed where they lived, that the kind of co-operation necessary was always difficult for them and sometimes impossible. It is now clear that similar factors operate in many places, and added to the intrinsic depressing effect of leprosy itself, have a direct

bearing on the frequency and severity of reactions, disappointing physiotherapeutic progress and the development of drug resistance.

An understanding of the force of these circumstances is only given to those who come close to the people, and who then appreciate that our patients have to be seen as *people to whom the environment has become hostile.* There can be no question of removing them from that environment. It is the hostility that needs to be removed. Unless leprosy control policy is related to the study of inhibiting environmental factors, and is adapted to overcome them, we are at worst simply beating the air, and at best condemning ourselves to the frustrations of a very long haul indeed.

We now face the ominous situation where, with the appearance of sulphone resistance in many places, the transmission of sulphone-resistant *M. leprae* is inevitable. This prospect must invite a very careful reappraisal of the standard approach to leprosy control.

Leprosy workers everywhere look to the World Health Organisation for guidance and leadership. We welcome the realistic and humane approach now being made by WHO, and in particular the creation of IMMLEP and THELEP. At the same time it is extremely unlikely that the replacement of one form of long term therapy by another will, on its own, materially influence the course of leprosy in the world. Highly effective short term therapy would be another matter, but therapy in itself does not strike at the root of the anxieties and prejudice which bedevil our hopes. From this angle the objectives of IMMLEP are more promising. Provided that any vaccine produced is administered in conjunction with others, and not on its own, leprosy hostility could effectively be bypassed.

One thing becomes clear, namely that leprosy control policy cannot be left to a committee of leprologists working in isolation. Future policy needs to be synthesized by a co-ordinating committee where clinicians, bacteriologists and epidemiologists sit together with social scientists and experts in health education who have made a special study of leprosy and its problems, and the group as a whole consider the control programme suitable for any given country. Only in this manner will adequate respect be paid to the non-medical factors which are so important.

It was concern for children at risk that prompted leprologists of the writer's generation to initiate domiciliary control programmes well before the days of sulphone therapy. That concern must always be before our eyes, but with it must go the degree of emancipation from rigid professional attitudes which will enable us to see the patient in his wholeness and the breaking down of hostility to him as a paramount concern.

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