WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR SOUTH - EAST ASIA

REGIONAL COMMITTEE

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Provisional Agenda item 16

SEA/RC45/19

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LEPROSY ELIMINATION

CONTENTS

1. INTRODUCTION

Despite the significant progress made during the past decade, leprosy continues to be a major public health problem in the world.

The estimated number of leprosy cases worldwide has recently been revised. The revised global estimates for 1990-1991 is 5 511 000 cases, as compared to 10-12 million cases estimated earlier. The WHO South-East Asia Region, with an estimated case load of 3 750 000, contributes over 60 per cent of the total estimated cases in the world.

Since the introduction of multidrug therapy (MDT) in the early 1980s, the South-East Asia Region has witnessed a steep decline in the number of registered cases - from 3.7 million in 1985 to 2.2 million in February 1992. This dramatic decline in the number of cases can be attributed, to a large extent, to the high efficacy as well as acceptability of the WHO-recommended MDT regimen. In the South-East Asia Region, over 2.6 million patients have successfully completed MDT and have been released from treatment since the start of implementation of this treatment regimen about a decade ago.

2. LEPROSY SITUATION IN THE SOUTH-EAST ASIA REGION

Leprosy is endemic in nine out of 11 Member Countries of the South-East Asia Region. The maximum number of estimated as well as registered cases are in India (3.0 million and 1.9 million cases respectively) followed by Indonesia (200 000 and 81 000 cases respectively). As compared to Indonesia, Myanmar has a larger number of estimated cases (240 000) but registered cases are less (79 000). Bangladesh accounts for 150 000 estimated cases while registered cases are only 24 000. It is estimated that Nepal has 100 000 estimated cases while the number of registered cases is 30 000. In Thailand, the estimated number of cases is 12 000 and the number of registered cases is only 8 000. In the remaining countries, the numbers of both estimated and registered cases are rather low, as shown in the Table on p.2.

Following the introduction of MDT after the WHO Study Group Report in 1982, and the Regional Committee resolution SEA/RC35/R6, all endemic countries have introduced and expanded MDT coverage. Compared to dapsone monotherapy, which required prolonged treatment and which often had to be continued for life and administered under strict supervision, MDT, with its short duration (6-24 months) and relative ease of administration, turned out to be a most welcome development for the programme managers as well as the patients.

The actual MDT coverage varies from country to country and from time to time, depending on a number of factors. It is therefore very difficult to use coverage as an accurate indicator of the success of a programme, though the degree of accuracy may be good if the methodology of estimate and data back are good.

TABLE. Leprosy situation and MDT coverage in SEAR countries

	BAN	BHU	IND	INO	MAV	MNR	NEP	SRL	THA
Leprosy situation									
Estimated cases (thousands)	150	0.5	3 000	200	0.4	240	100	4	12
Estimated prevalence 1/10000	1.3	3.2	34.4	10.7	18.1	56.4	51.0	2.3	2.1
Registered cases (thousands)	24	0.2	1 965	81	0.2	79	30	3	8
Registered preva-lence 1/10000	2.0	1.6	22.6	4.3	10.0	18.4	15.4	1.4	1.5
New cases in 1991 (thousands)	5.3	0.06	468	9.0	0.06	6.2	6.0	0.06	1.4
MB proportion (%)	25.0	...	...	55.2	...	...	71.9	...	70.0
Deformity rate (%)	16.0	...	12.0	18.0	...	17.0	15.0	...	26.0
MDT implementation									
Cases currently on MDT	15 576	235	900 000	42 347	203	24 783	18 360	2 515	7 996
Current MDT coverage (%) (Based on registered cases)	65.0	94.0	45.8	52.0	91.9	31.6	60.7	100.0	97.7
Current MDT coverage (%) (Based on estimated cases)	10.4	47	30	21.2	50.8	10.3	18.4	62.9	66.7
Cases completed MDT	6 230	2 507	2 450 000	53 337	988	63 316	16 831	15 389	31 520
Cumulative MDT coverage (%) of registered cases	72.2	99.5	75.9	71.0	98.5	62.1	74.7	100.0	99.5

Note: ... = Data not available

(Source: Leprosy Unit, WHO/HQ, Geneva)

Cumulative MDT coverage, on the other hand, is beginning to be accepted as a more reliable indicator, especially if taken in combination with MDT coverage. As shown in the Table above, four of the nine endemic countries have attained a cumulative MDT coverage of over 98 per cent while the rest of the countries have achieved over 62 per cent coverage. This has resulted in the release of over 2.6 million patients after completing treatment. The governments of all the endemic countries of the Region have accorded a high priority to leprosy control, especially following practical demonstration by the respective programmes that with the new technology available in the form of MDT, leprosy control programmes can show tangible results within a relatively short period of time.

WHO has been working in true partnership with Member Countries in this important area with generous financial support from a number of nongovernmental organizations as well as bilateral sources. WHO is also supporting research activities in its endeavours to find an efficacious vaccine and an even more effective treatment regimen than the one currently available. While

conclusive results of the vaccine trials conducted in India and elsewhere may not be available for another 5-6 years, trials with a new treatment regimen consisting of a relatively new drug, Ofloxaccine, and rifampicin, a component in the MDT regimen, are under way. These are the two most powerful antibacterial drugs available today. Preliminary results are very promising and, if found successful, this combination is expected to shorten the duration of therapy to just one month. A number of countries in the Region are expected to participate in these trials.

3. LEPROSY ELIMINATION

Noting the considerable progress that has been made in the control programmes throughout the world since the introduction of MDT, which has resulted in a reduction, by about one-third, of registered leprosy cases worldwide, the Forty-fourth World Health Assembly, in 1991, urged Member Countries to intensify leprosy control activities in order to eliminate leprosy as a public health problem (to reduce prevalence to a level below one per 10 000 population) by the year 2000 (resolution WHA44.9).

Following this historic resolution, national leprosy programme managers from nine leprosy-endemic countries critically reviewed, at their annual intercountry consultation meeting in January 1992, the progress made and the constraints faced by their respective programmes, and came to the conclusion that with technical support from WHO and necessary material support from national as well as external agencies concerned, the target of elimination could be achieved.

Member Countries are currently in the process of formulating national plans of action and strategies with technical support from WHO. The considerable goodwill and the favourable disposition of NGOs and donors concerned towards leprosy is expected to ensure the inflow of required financial resources. WHO will continue to provide technical support and necessary coordination between Member Countries and donors for mobilizing external resources as well as promoting the optimum use of available resources. Governments are expected to continue to give priority to national leprosy control programmes.

The Regional Office is formulating a strategy paper for the elimination of leprosy as a public health problem in South-East Asia which, after technical scrutiny, will be submitted to the Regional Committee.

The goal of elimination of leprosy as a public health problem can be achieved only by interrupting the chain of transmission that is going on in many communities where leprosy is still a major public health problem. This interruption of transmission can be measured by observing a fall in the incidence of leprosy. Since human beings are the only reservoir of infection, elimination of infection from this potential source should lead to interruption of the transmission. Many developed countries that have eliminated leprosy had leprosy as a major health problem at one time in

history. The elimination of leprosy in these countries, which was partly attributed to the rising socioeconomic status of the people, nevertheless shows that the goal of elimination is not impossible to achieve.

The only strategy available now is early case finding and specific treatment with MDT. BCG vaccination under the EPI programme provides only a fringe benefit to leprosy control. A prophylactic vaccine is not expected to be available in the near future.

The strategy of elimination would not aim at eradication of leprosy where the last focus of infection should be removed through active surveillance. Case finding through active surveillance is not cost-effective. It has been well established even for a disease with a short incubation period such as malaria.

The strategy for the elimination of leprosy would accept a small residual case of less than one per 10 000 population with the presumption that the disease at such a low prevalence in the community will not be transmissible and would die out by itself, particularly when public awareness is high and the socioeconomic status has improved. Here, a question may be raised on the possibilities of resurgence from the small residual foci. Present-day knowledge as well as the experience of developed countries, as stated earlier, give strength to this presumption, particularly when man is the only reservoir and no intermediate hosts are involved. However, epidemiologically it is important that these undetected cases remaining in the community be detected at an early stage and be made non-infectious by means of chemotherapy with MDT.

There is wide variation in the distribution pattern of leprosy, health infrastructure and resource inputs among the countries of the Region. In most of the countries, leprosy control activities have been integrated into the basic health services. Though the basic strategy of early case finding and adequate treatment will be the same for all the countries of the Region, yet each country or different regions within the same country will have different approaches for control depending on the health infrastructure, the magnitude of the problem and the resources available for leprosy control activities.

Although the strategy will be the same, i.e. case detection and MDT, the emphasis on each component of the strategy will vary according to the epidemiological situation, health care delivery system, available resources and progress made by the programme. Case detection will be more intensified where the programme has achieved about 50 per cent MDT coverage, but, in the initial phase, both the components will be given equal emphasis.

Based on a number of factors, such as case load, MDT coverage, health infrastructure, current status of existing leprosy control activities, etc., countries would be stratified into several categories or groups. Activities would be identified for each group to be undertaken in a phased manner. A number of indicators would be indentified to monitor progress on a regular basis.

After the adoption of the regional strategy by Member Countries, a detailed regional plan of action for the elimination of leprosy as a public health problem, compatible with the plans of action of individual countries, is envisaged to be formulated at the forthcoming Intercountry Consultative Meeting of National Leprosy Programme Managers, for implementation by Member Countries.

4. CONCLUSIONS

This is the first time in the history of leprosy control that a time-frame is being set globally for the elimination of leprosy as a public health problem. This has been made possible because of the strong commitment from Member Countries, WHO and other concerned agencies. Undoubtedly, the high efficacy of WHO-recommended MDT has also been crucial. The hard work and dedication of numerous leprosy workers the world over has contributed immensely to this. The time has now come when all concerned have to redouble their collective efforts and take a plunge to eliminate leprosy - one of the oldest scourges of mankind - as a public health problem, once and for all.

WORLD HEALTH ORGANIZATION

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REPORT OF THE CCPDM WORKING GROUP ON WHO PROGRAMME MANAGEMENT

Corrigendum

Please make the following change in the document SEA/RC45/20:

Cover page: Last para, fifth line, for "Section 5" read "Section 6".