

ACTION PROGRAMME FOR THE ELIMINATION OF LEPROSY



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Foreword

As we approach the end of the millennium, leprosy is no longer the dreaded disease that it used to be, and leprosy patients face a far better future than ever before.

This does not mean that all the problems in leprosy have been resolved, nor does it mean that we can afford to slacken our efforts towards the elimination of the disease as a public health problem. In spite of the fact that the profile of the disease is much milder, and in spite of the fact that disability among new patients is quite low, the social image of leprosy has not greatly changed in many parts of the world; this is all too well reflected in the attitude of the community, particularly towards individuals disabled due to the disease.

Today we can be confident that elimination -- reduction of prevalence to less than one case per 10 000 population -- is within our reach. There must be no complacency, for there are still countries where very special efforts will be needed to reach that goal. And there are even more areas of the world where, long after the country has attained elimination, continuing and sustained efforts will be required to reach the target at provincial and district level. So the year 2000 will in no sense see an end to mankind's battle against leprosy. Quite apart from the need to detect every last case in every last community and provide that person with MDT, there will be a continuing need to care for those patients for whom dapsone and MDT came too late, and who accordingly will live out their lives with grievous disabilities.

The goal of elimination of leprosy as a public health problem is only the first and most important step before being able to foresee a world totally free from leprosy. This means that, even after the elimination goal is attained, there will be a need to maintain a certain level of activities to ensure that the remaining tasks are accomplished through strategies adjusted to specific needs. WHO will continue to address the residual problems through constant monitoring of the situation, development of technologies and strategies, and technical cooperation with countries to ensure not

only that elimination is attained in every corner of the world -- and is sustained -- but also that in the fullness of time this will be a totally leprosy-free world. However, the immediate task is to see that we intensify our efforts towards case detection and treatment with MDT in all endemic countries sufficiently to reach the elimination goal in time.

This Status Report 1998 outlines both the progress made during 1997 and the challenges still to be addressed in order to eliminate this disease as a public health problem. It is published in the hope that it will spur further activities by all those concerned in our global effort to bring about a leprosy-free world.

Dr S.K. Noordeen
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Abbreviations and Definitions

AFRO	WHO Regional Office for Africa
AMRO	WHO Regional Office for the Americas
CBH	Capacity Building and Health Systems Research, component of LEP
CBR	Community-based rehabilitation
CSP	Country Support and Special Action Projects, component of LEP
EMRO	WHO Regional Office for the Eastern Mediterranean
EURO	WHO Regional Office for Europe
GIS	Geographical Information Systems
GPS	Global Positioning System
HSR	Health Systems Research
IILEP	International Federation of Antileprosy Associations
IMMYC	Scientific Working Group on the Immunology of Mycobacteria
LEAG	Leprosy Elimination Advisory Group
LEC	Leprosy Elimination Campaigns
LEM	Leprosy Elimination Monitoring
MB	Multibacillary leprosy
MDT	Multidrug Therapy
MEE	Monitoring and Evaluation of the Elimination of Leprosy, component of LEP
NGO	Nongovernmental Organization
PAHO	Pan American Health Organization
PB	Paucibacillary leprosy
POD	Prevention of disabilities
ROM	Rifampicin + ofloxacin + minocycline
SAPEL	Special Action Projects for the Elimination of Leprosy
SEARO	WHO Regional Office for South-East Asia
THEMYC	Scientific Working Group on Chemotherapy of Mycobacterial Diseases
UNDP	United Nations Development Programme
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific

Definitions

Some terms related to leprosy elimination used in this report reflect concepts or scientific definitions as generally admitted by the scientific community.

Backlog case: A case of leprosy who has remained undiagnosed and untreated for more than one year after the onset of the disease.

Case-detection or Case-finding: A systematic method of finding leprosy patients in need of treatment.

Case-holding: The methods used to assist leprosy patients in taking the prescribed treatment in the right doses and following the correct schedule for the necessary period of time.

Coverage (health coverage): A concept indicating the extent to which a given amount of health services is provided to a specified population.

Disability grading: A method of grouping the degree of disability into a number of grades according to certain defined criteria. The Seventh WHO Expert Committee on Leprosy (1997) endorsed a proposal to simplify the disability grading process into a three-grade (0, 1 and 2) system of classification, primarily for the collection of general data regarding disabilities and/or impairments but also as an indicator for assessing the performance of the elimination programme.

Disability prevention: This component of leprosy control aims at the prevention of disability, e.g. early recognition and management of nerve function impairment and complications, provision of health education to the patient, supply of protective gloves and footwear, etc.

District: The most peripheral geographical and administrative area of government which has full powers and responsibilities for the major ministries concerned with local affairs, e.g. health, agriculture, education. A typical district has a population of between 100 000 and 300 000

people and an area of between 5 000 and 50 000 sq. kms. Different terms are used in various countries for such an area.

Elimination of leprosy as a public health problem: Elimination of leprosy as a public health problem refers to a level of prevalence of less than one case per 10 000 population.

Integrated health services: The services necessary for the health protection of a given area and organized either under a single administration or under several agencies, with proper provision for the coordination of their services. An integrated health system is a system which is organized as a whole, i.e. one in which the various elements are disposed, organized and coordinated with reference to a common objective: the acceptance of responsibility for the health of a population.

New case: Defined as a previously untreated case of leprosy with onset of disease in the year in question (true incidence), and also a case with onset in previous years (backlog prevalence).

Single-dose ROM: A single dose of a drug combination consisting of 600 mg rifampicin, 400 mg ofloxacin and 100 mg of minocycline has proved efficacious as treatment for single-lesion paucibacillary leprosy.

Introduction

The development of multidrug therapy (MDT) during the early 1980s offered the long-dreamt-of solution to the problem of leprosy. Considered for centuries as not only an incurable disease but also as a highly contagious one, leprosy suddenly began to look like “a paper tiger.” MDT, a simple combination of three powerful antileprosy drugs, not only hit the causative agent from three different directions, but it also ensured that the bacillus had no opportunity to develop resistance to any one drug.

First put into widespread use in the mid-1980s, MDT's achievements during the first five to six years of implementation were so impressive that it became possible to envisage eliminating leprosy as a public health problem. It was felt that a strategy based on MDT could reduce the prevalence to such a level that transmission would be interrupted; that level was set at one case per 10 000 population. This apparent breakthrough emboldened the Forty-fourth World Health Assembly, in May 1991, to adopt resolution WHA44.9 which committed Member States to promote the use of all control measures, including multidrug therapy together with case-finding, in order to attain the global elimination of leprosy as a public health problem by the year 2000.

Since that key decision, two International Conferences on the Elimination of Leprosy, organized by WHO in Hanoi, Viet Nam (July 1994) and in New Delhi, India (October 1996), have been milestones marking the progress

towards the goal, at the same time reaffirming political commitment towards that goal by the major endemic countries and by the various participating agencies and NGOs, both national and international. WHO's aim is to provide easy access to good quality MDT drugs, free of charge, for all existing and new patients.

The achievements of MDT can be summed up succinctly: by the beginning of 1998, more than 10.7 million cases had been cured by MDT, and virtually every registered patient is receiving MDT. The number of countries showing prevalence rates above 1 per 10 000 population has fallen from 122 in 1985 to 32 at the beginning of 1998; in other words, in only 32 countries can leprosy still be regarded as a public health problem. At the start of 1998 there remain 828 803 leprosy cases registered for treatment in the world. But while the global prevalence rate of registered cases stands at about 1.39 per 10 000, in the 16 major endemic countries — which represent 92% of the global leprosy problem — the prevalence rate is still 3.9 per 10 000.

It is evident that additional efforts and new strategies will be required to achieve the elimination goal, and that some countries may need to continue and intensify activities beyond the year 2000 to reach their elimination targets. In 1998, with time running out if the target date is to be attained, the problem of hard-to-reach patients has become a priority, and innovative approaches have been introduced to address this. Both Special Action Projects (SAPEL) and

Leprosy Elimination Campaigns (LEC) rely on greater community participation to reach, respectively, neglected population groups living in difficult-to-access areas and cases that remain undetected in the community.

The Seventh Expert Committee on Leprosy, which met in Geneva from 26 May to 3 June 1997, sought ways to further simplify the technology without compromising efficacy, and recommended changes aimed at, inter alia, encouraging greater patient compliance and reducing any unnecessary workload on health service personnel. Among the Committee's major conclusions and recommendations were: "that a single dose of a combination of rifampicin, ofloxacin and minocycline (ROM) is an acceptable and cost-effective alternative regimen for the treatment of single-lesion paucibacillary (PB) leprosy. Furthermore, based on available information, it is possible that the duration of the current MDT regimen for multibacillary (MB) leprosy could be shortened further to 12 months." The Expert Committee also recommended that antileprosy activities should become, and should remain beyond the year 2000, an integral part of general health services everywhere, and should involve the communities to the fullest extent possible. It urged a fresh strategy for undertaking disability prevention and rehabilitation so as to ensure a practical, community-oriented approach aimed at reaching the largest number of persons in need with cost-effective interventions.

Viewed overall, the leprosy situation in the world gives every reason for satisfaction. The political commitment to continuing the drive against the disease is already in place on the part of governments, ministries and decision-makers. WHO's partners, particularly the member associations of the International Federation of Antileprosy Associations (ILEP), are making an invaluable contribution to the war against this disease wherever it exists, and the necessary MDT drugs are made available to patients everywhere, cost-free, thanks to the generous contribution of the Nippon Foundation of Japan. Meanwhile the message that leprosy is curable and is no longer a cause for social ostracism is spreading even into remote areas of endemic countries.

But there is still no room for complacency. There are many parts of the world where progress is sluggish. To the natural hazards of intemperate weather, rugged terrain and impenetrable jungles must be added such manmade constraints as wars, local conflicts, bureaucracy and even corruption, all of which militate against the drive to extend case-finding and treatment "to every patient in every village" where there is need. These constraints and challenges must be overcome, and ways must be found to further simplify the technology. A concerted effort on the part of everyone concerned is called for, with immediate effect, if we are to make certain that leprosy is indeed eliminated as a public health problem by the year 2000. ■