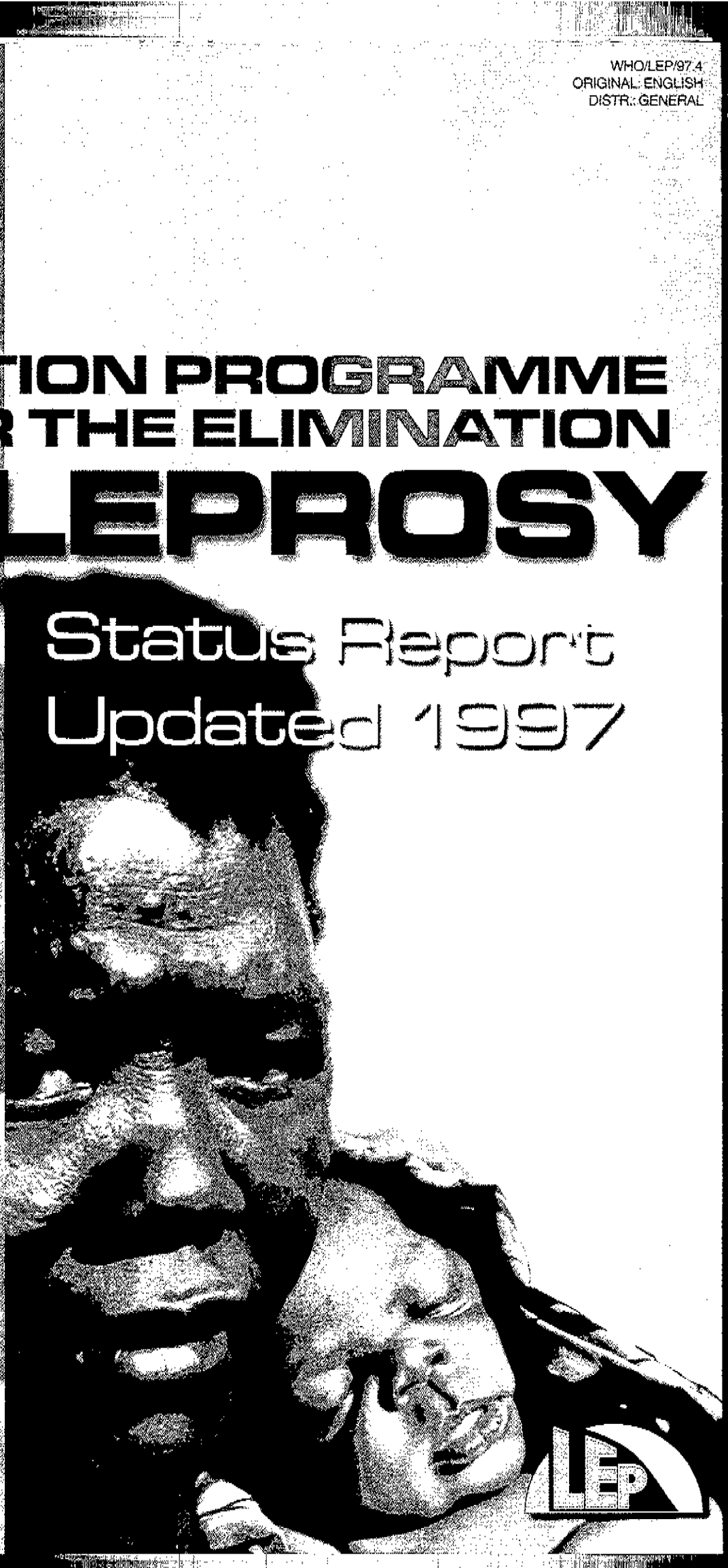
WHO/LEP/97.4
ORIGINAL: ENGLISH
DISTR.: GENERAL

ACTION PROGRAMME FOR THE ELIMINATION OF LEPROSY

Status Report Updated 1997



WORLD HEALTH ORGANIZATION

WHO/LEP/97.4
ORIGINAL: ENGLISH
DISTR.: GENERAL

ACTION PROGRAMME FOR THE ELIMINATION OF LEPROSY

STATUS REPORT : UPDATE 1997

This document updates the Status Report 1996, WHO/LEP/96.5, published by the Action Programme for the Elimination of Leprosy (LEP), which should be consulted for all further information on the work of the Action Programme.

World Health Organization
Geneva, 1997

ACTION PROGRAMME FOR THE ELIMINATION OF LEPROSY

1. Introduction

The greater part of the text which appeared in the Status Report 1996 still stands and can be regarded as valid. However, because of the striking progress being made in the campaign to eliminate leprosy as a public health problem, many of the figures adduced in that Report have clearly been overtaken. The present text therefore seeks to revise the more significant figures and update the more important tables so as to better reflect the current position of leprosy in the world.

The weapon that has been deployed against the disease since the early 1980s -- multidrug therapy or MDT -- is proving both reliable and flexible. The reliability is reflected in the steadily increasing numbers of registered cases who have been cured, totally, after the appropriate course of MDT drugs. The flexibility has made it possible to simplify the standard regimens for treating patients. The 7th WHO Expert Committee, which met in Geneva from 26 May to 3 June, concluded that MDT is now proving so effective that the course of treatment for multibacillary (MB) leprosy may be shortened from 24 months to 12 months without significantly compromising its efficacy. The Expert Committee took into account recent changes in the definition of MB, the low relapse rates (even under field conditions) and the fact that no drug resistance has been observed. Furthermore, it considered that, for paucibacillary (PB) patients with only one skin lesion, a single dose of three antileprosy drugs in combination will be sufficient to bring about a cure.

Because of the poor coverage of the health services in most of the leprosy-endemic countries, supervision of the monthly administered drugs by health workers may not always be possible. In that case, the Expert Committee felt able to suggest that more than a month's supply of MDT blister packs may be provided to the patient.

These measures are aimed at making MDT delivery more flexible and more patient-friendly, since this therapy has proved to be a robust regimen, maintaining its efficacy even if not taken regularly and for significantly less than the originally recommended durations. The conclusions and recommendations of the Expert Committee, particularly as regards simplifying the chemotherapy, will bring tremendous benefits to the patients, and to the health services which are currently burdened with treating patients over long periods. The simplified treatment is expected to be introduced in the countries concerned according to the capacity and needs of the national leprosy programmes.

In fact, MDT has successfully cured more than 8.4 million people of leprosy since 1981, and the number of countries showing prevalence rates above 1 case per 10 000 population has been reduced from 122 in 1985 to only 55 at the beginning of 1997.

In a majority of those remaining endemic countries, there is now little doubt that the target set by WHO's Member States in 1991 of eliminating leprosy as a public health problem by the year 2000, that is, of reducing the prevalence below 1 per 10 000, will indeed be reached. However, it has to be recognized that in a limited number of countries or areas where levels of endemicity are still very high, or where it will be operationally difficult to increase the geographical coverage, there are considerable challenges to achieving the elimination target on time. Even where countries achieve the goal, there may be whole provinces or districts where the prevalence well exceeds 1 per 10 000, so there can be no let-up in the drive to detect cases, ensure that each one receives MDT, and thus guarantee a total cure.

2. Global and regional leprosy situation in 1997

Prevalence

At the beginning of 1997, it was estimated that there were about 1 150 000 leprosy cases in the world, out of whom 888 340 were registered for treatment.

The distribution of estimated and registered prevalence by WHO Regions is shown in *Table 1*. Only a modest reduction in the number of registered cases has been noted between 1996 and 1997. The global prevalence rate of registered cases, which was constantly decreasing over the last 10 years, is still about 1.6 per 10 000. More importantly, in the sixteen major endemic countries which represent 91% of the global leprosy problem, the prevalence rate is still 4.3 per 10 000, indicating that additional efforts will be required to achieve elimination of leprosy as a public health problem. It is possible that some of these countries might need to continue and intensify activities beyond the year 2000 to reach their leprosy elimination targets.

Table 1 **Number of estimated and registered cases of leprosy by WHO Region, and percentage change between 1996 and 1997**

WHO Region	Estimated number of cases (rate per 10 000)	Number of registered cases (rate per 10 000)		Percentage change
	1997	1996	1997	
Africa	140 000 (2.4)	95 901 (1.77)	82 758 (1.39)	(-) 14
Americas	140 000 (1.7)	123 537 (1.64)	127 866 (1.63)	(+) 4
South-East Asia	800 000 (5.7)	651 562 (4.72)	637 413 (4.50)	(-) 2
East. Mediterranean	30 000 (0.6)	23 005 (0.54)	13 038 (0.28)	(-) 42
Western Pacific	40 000 (0.2)	32 254 (0.20)	26 533 (0.16)	(-) 17
Europe	less than 1000	less than 1000	732 (0.01)	-
Total	**1 150 000 (2.0)**	**926 259 (1.67)**	**888 340 (1.54)**	**(-) 4**

The number of cases detected in 1996 by WHO Regions is shown in *Table 2*. About 566 000 cases were detected during 1996 (9.8 per 100 000 population). About 535 000 cases (95%) were detected in the 16 major endemic countries, and 73 % of the newly detected cases were living in India alone. Among newly detected cases more than 85 000 (15%) were children, about 170 000 (30%) were multibacillary cases and about 30 000 (5.3%) were showing severe disabilities at the time of diagnosis.

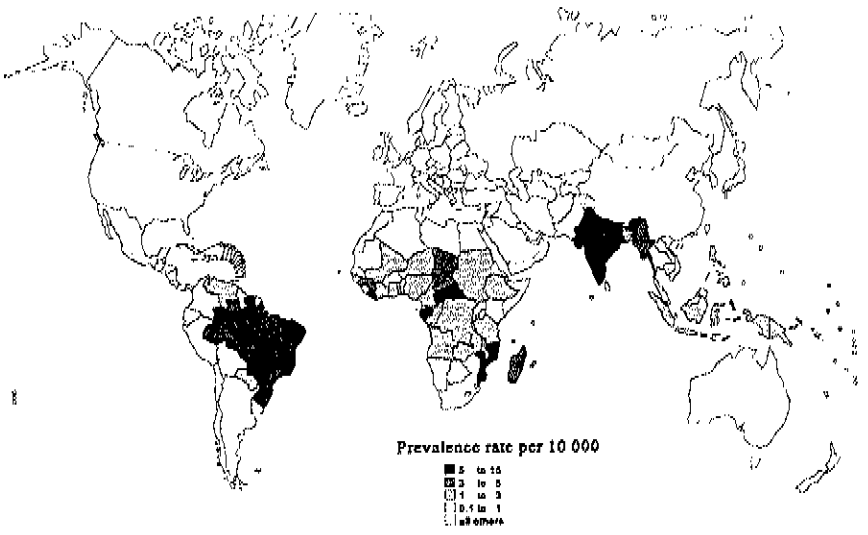
Table 2 **Detection of leprosy, by WHO Region, 1996**[a]

WHO Region	**Number of new cases notified**	**Detection rate per 100 000**
Africa	46 489	7.80
Americas	43 783	5.59
South-East Asia	457 921	32.36
Eastern Mediterranean	5 761	1.25
Western Pacific	12 613	0.77
Europe	37	-
Total	**566 604**	**9.84**

(a) or latest available information

The increase in detection that is observed in many endemic countries reflects an increase in case-finding activities and geographic coverage of leprosy elimination programmes rather than changes in the incidence of the disease. Although the situation varies from one WHO Region to the other, and from one country to another within the same region, the global detection trend has remained stable over the last 12 years. The geographic distribution of leprosy as well as its clinical profile have changed dramatically, and the disease is now shrinking to a limited number of countries, or of districts within countries.

Prevalence of leprosy in the world, 1997



3. Detection trends in 28 endemic countries

Since dependable tools for measuring infection and for monitoring *incidence* trends in leprosy are still not available, the overall elimination strategy relies on monitoring *prevalence*, together with timely case-detection, cure of all diagnosed cases with fixed duration MDT, simplified case-management, and monitoring progress through appropriate information systems. So far, this concept has proved to be valid and the prevalence pool has been reduced by more than 85% in a span of 15 years. The question that now arises is how to demonstrate whether or not this reduction in prevalence has had an impact on the transmission of the disease.

An analysis of trends in leprosy over the last 12 years in 28 endemic countries, of changes in the detection rates and of the shifting profile of newly detected cases makes it possible to assess changes in the transmission of the disease. In theory, if all cases were given early MDT treatment, the impact on transmission should have been visible within a few years. In practice, the detection of leprosy globally has remained unchanged over the last 12 years. What is not clear is the extent to which this can be attributed to a higher level of transmission, improved case-finding, expansion of health services, changes in case definition, an increased population at risk, or a combination of these factors.

During the early years after the introduction of MDT, the problem was mainly the burden of cumulative prevalence (10-12 million estimated cases and 5.4 million registered cases in 1985), and the main objective was to treat, and cure, the large number of already registered patients. At that time, it could be estimated that the average duration of the disease (from diagnosis to cure) ranged between 15 and 20 years. The gap between registered and estimated cases was enormous and was most probably overestimated. Before introduction of MDT, information on the number of new cases detected each year was rather scanty, but the figure was estimated at between 250 000 and 300 000 globally.

Assuming that the introduction of MDT was successful in 'clearing' the accumulated backlog of prevalence, i.e. curing most of the already known cases, we are now facing a new