As every year, WHO has recently published the latest Leprosy Global Statistics.\(^1\) Huge efforts have been made for the 2009 data to be as complete as possible. A total of 141 countries or territories reported figures, i.e. 20 countries more than for 2008. Of these, 23 countries or territories reported no new leprosy cases in 2009. A further 28 sent no report to WHO. However, in most of these countries, the leprosy problem is either non-existent, or extremely limited. It is estimated that these countries contribute up to only 150 additional new cases, i.e. less than 0·1\(\%\), to the global figures.

As written in a previous editorial,\(^2\) caution is mandatory when one tries to analyse and interpret global data. One should always keep in mind a number of limitations or possible pitfalls such as:

- These are not prevalence or incidence figures, but data on patients registered for treatment and on newly detected cases only.
- Trends at global level are primarily influenced by countries reporting large numbers of patients: India first, which reports 55\% of the new patients detected globally, followed by Brazil (15\%) and Indonesia (7\%). The influence of the other countries on global figures is extremely limited.
- It is difficult, and possibly misleading, to try and analyse trends without an in-depth knowledge of all the operational factors that might have affected the situation in each country. For that reason also, inter-country comparisons should be avoided.
- No information is available on the completeness and reliability of the data reported by countries. Indeed, it is not the role of WHO to judge on the reliability of data before publishing them, but that of Ministries of Health.

Bearing these limitations in mind the comments below will be limited to a few general observations.
Case detection figures seem to be leveling off at global level: there was only a 1.7% reduction in the number of newly detected patients in 2009, compared to 2008. Sixteen countries reported more than 1,000 new cases. Angola, with 937 newly detected cases in 2009 only, disappeared from the list. Those 16 countries are responsible for 93.1% of the global detection figures. Absolute numbers of new cases are decreasing in most of these countries, compared to 2008. In Bangladesh, China and India, they are almost similar to those of last year, and in Ethiopia and Sudan, they are increasing. Looking at trends over the last few years, a plateau seems to have been reached in Bangladesh, China, Ethiopia, India, Indonesia, Madagascar and Nepal.

Using the 2009 estimated national populations from the 2006 revision of the World Population Prospects (New-York, UN Population Division), it is Brazil which has the highest case detection rate, followed by Nepal and India. Case detection rates have decreased in all 16 countries, except in Sudan, where it is increasing. Some other countries or territories have also high case detection rates but, because of their relatively small population, they do not appear in the list of countries with more than 1,000 newly detected cases.

The rate of new patients with Grade 2 disabilities per 100,000 population (the new indicator adopted by WHO in its strategic plan for the period 2011–2015) decreased in nine countries, but increased in six of them. No significant change is seen in China, due to the very small number of patients compared to the size of the country population.

The proportion of newly detected patients presenting with disabilities is more than 10%, in 10 of the 16 countries, which is a sign of late detection. It is smallest in India where it has, however, been increasing constantly for the last 5 years, coming from 1.6% in 2004. It is on the rise in nine of the most endemic countries. This observation is particularly worrying when accent of the new Global Strategy is put on quality of services and it is known that the most effective way to prevent disabilities is through early detection of new cases.

The MB proportion among new cases is stable everywhere except the Philippines, where it went from 61.3% in 2007 to 90.3% in 2008 and 95.0% in 2009. The underlying reason for this dramatic change is not known, but very unlikely to be due to epidemiologic factors. Smaller rises are seen in Brazil, Mozambique and Tanzania.

A high proportion of children among the new cases is a sign of active and recent transmission. It is however very much dependent on detection strategies. It will usually be higher when household contacts of leprosy patients are systematically and actively examined. It reaches 10% or more in three of the 16 most endemic countries: DR Congo, India and Indonesia. At global level, this proportion has been around 9% for the last 5 years.

Leprosy is more prevalent among males than females, but nobody knows what proportion to expect, and actual geographical variations occur. A very low percentage of females being diagnosed is likely to be the consequence of low awareness among the female population, and/or their lesser accessibility to health services, possibly due to cultural factors. The increasing proportion of females at global level might thus be seen as a positive sign. No data on the female proportion are available from Mozambique. The proportion of females is extremely low in Ethiopia: only 6.5% in 2009, while it was 29.4% in 2008. Even for this seemingly unambiguous information, there might thus be a problem of reliability of the data collected and/or reported.

No report on treatment completion rate is available, from any African country, nor from China and Sri Lanka.
CONCLUSION

A reliable information system is part of quality services. It is essential for decision making at country or local level, even more than at global level. All leprosy programme managers should strive to collect and analyse the information which will permit them to monitor progress and to adopt appropriate control measures.

References