

Letter to the Editor

THE FINAL PUSH STRATEGY TO ELIMINATE LEPROSY AS A PUBLIC HEALTH PROBLEM: QUESTIONS AND ANSWERS

Editor,

The World Health Organisation (WHO) recently issued a well-produced document entitled *The Final Push Strategy to Eliminate Leprosy as a Public Health Problem: Questions and Answers*. Although WHO's motives for producing the document are laudable, it contains some statements that are gross oversimplifications and others that are either half-truths or wholly untrue. It also makes certain assumptions without evidence to support them. Furthermore, some of the conclusions and recommendations arising from the third meeting of the WHO Technical Advisory Group are similarly controversial.

These same issues were debated at length in the Technical Forum convened by the International Leprosy Association in February 2002. In preparation for that Forum, a comprehensive review of published and 'grey' literature from 1966 onwards was carried out, enabling conclusions to be reached and recommendations to be made that are based on evidence. Where evidence is lacking, recommendations for best practice were made. Matters requiring further research were also identified.

In this paper, the ILEP Medico-Social Commission comments on the important points made in the WHO documents (in the interests of conciseness, remarks on the more peripheral issues have been omitted). In addition, the conclusions of the ILA Technical Forum are cited throughout.

The impact of MDT

It is true that MDT rapidly reduces the infectivity of patients, but it does not seem to prevent new cases occurring in the community; perhaps patients are detected too late for MDT to have a significantly greater effect than dapsone monotherapy. The ILA Technical Forum concluded: 'There is no consistent evidence that the introduction of MDT has accelerated the decline of the incidence of leprosy,' adding that 'there is no evidence that, once a predefined level of prevalence rate is reached, leprosy will necessarily die out'.

'Reduction of 90% in global prevalence over the past 15 years.' This figure refers solely to the prevalence of patients registered for treatment, and is the result of a range of factors, including changes in the definition of a leprosy case, reductions in the duration of treatment, and the cleaning of registers. The actual prevalence is undoubtedly higher than the prevalence of registered cases, and may well be more than 1 per 10,000; it is significant that the global rate of detection of new cases, a much more significant statistic than the prevalence rate, exceeds 1 per 10,000. Thus it is premature to claim that leprosy has been 'eliminated' across the world.

'Some 4 million people have been protected from developing deformities.' There is insufficient evidence for such an assertion: many patients are detected too late and already have disabilities by the time they begin treatment. Many others develop disabilities during or after MDT.

The main problems facing the elimination strategy

WHO's claim that 'the main problems are operational in nature, rather than technical' is only partially true. Certainly, there are some operational problems, such as the appropriate training of general staff or the integration of activities in the general health structures, which need to be solved. But a number of major technical obstacles limit the effect that programmes may have on the transmission of the disease: for instance, we have as yet no way of detecting infectious cases very early on, and therefore, by the time patients are detected, it is often too late to avoid the transmission of infection. Also, we need better methods for preventing the impairment of nerve function.

Diagnosis

'*Discontinuation of skin smears for diagnosis.*' Most cases of leprosy could, it is true, be diagnosed on the basis of clinical signs alone, yet clinical examination should not be restricted to searching for patches with sensory loss, skin smears are still a useful way of diagnosing true MB cases, and particularly for confirming early lepromatous leprosy. The ILA Technical Forum noted: 'Approximately 70% of leprosy patients can be diagnosed by the single sign of skin patches with sensory loss, and this sign of leprosy should be taught as widely as possible. However, 30% of patients, including many multibacillary (MB) patients, do not present with this sign. Enlargement of one or more nerves is an important additional sign, to be supplemented by skin smears, if these are available and of assured quality.'

Treatment

The recommendation that the full course of MDT should be handed over at diagnosis to all or most patients is irresponsible and unethical. The ILA Technical Forum comments: 'The system for delivery of MDT should be patient-friendly. Flexibility is important, but regular contact between the patient and the health worker should be maintained. Only in exceptional cases, in which the patients cannot be seen monthly, should more than a 1-month supply of MDT blister packs be provided.' The main reason for recommending frequent contact between the patient and the health staff is to reduce the likelihood of complications developing, rather than simply to check on the patient's compliance. It is a mistake to assume that accompanied MDT will give staff more time for patient counselling and disability prevention: in practice, most patients will be seen only once and no POD activities will take place during treatment. Any increase in patient compliance with treatment is likely to be on paper only.

The recommendation made by the WHO Technical Advisory Group of a 6-month multibacillary MDT regimen for all leprosy patients, both PB and MB, also raises concern. Since 1998 almost all MB patients have been treated with a 12-month MDT regimen, but we still do not know the relapse rate after treatment. The duration of treatment for MB patients should not be reduced until controlled studies can show that such a reduction will not lead to unacceptably high relapse rates. The appropriateness of adding clofazimine to the regimen for PB patients may also be questioned. The ILA Technical Forum concludes: 'Although a shorter, common regimen for both PB and MB leprosy is desirable, such a regimen must first be studied in controlled trials, with relapse as the outcome, before it can be implemented.'

Reactions

WHO's claim that MDT significantly reduces the frequency and severity of reversal reactions is not proven. In particular, the assertion that fewer than 2% of the patients who start MDT go on to develop

lepra reactions requiring treatment with steroids is simply untrue. Why WHO should attempt to play down the importance of regular patient-health staff contact by providing misleading information of this kind is hard to comprehend. It has been shown in Bangladesh that 16% of MB patients with normal nerve function at diagnosis developed new nerve function impairment (NFI) after the start of treatment. For the MB patients who already had an impaired nerve function at diagnosis, the likelihood of new NFI rose to 65%. For the PB patients, the likelihood of new NFI ranged from 1% to 16%, according to whether they showed nerve function impairment at diagnosis or not.

Early diagnosis and treatment with MDT are effective ways of preventing leprosy related disabilities, but they are not sufficient in themselves.

No one would wish to recommend the uncontrolled use of prednisolone in the field, but patients presenting with neuritis should be allowed to benefit from it. The ILA Technical Forum says: 'Steroids are recommended for the treatment of reactions and NFI of recent onset; the expected recovery rate for nerve function is approximately 60%.' There is, of course, no question of denying prednisolone to non-leprosy patients with serious conditions.

Monitoring: prevalence rate or case detection rate?

The prevalence of registered cases is even more strongly influenced by operational factors than the new case detection rate, since it depends upon the extent of case detection activities and a number of other variables, such as the duration of treatment and the updating of registers.

Leprosy control or leprosy elimination?

WHO is wrong to claim that 'leprosy control is a more limited concept [than leprosy elimination]' and that 'leprosy control services are usually provided by specialized staff rather by general health workers'. Leprosy control aims to cure patients, interrupt transmission and prevent disabilities. The elimination strategy has led to an almost complete neglect of prevention of disability activities in the field (except, of course, on paper). The key elements of the Final Push Strategy are the same as those needed for a leprosy control programme: good geographical coverage is essential. There is no reason why leprosy control services should have to be provided by specialized staff.

To sum up, the Medico-Social Commission feels that *The Final Push Strategy to Eliminate Leprosy as a Public Health Problem* contains a number of misleading statements that need to be corrected. Some of these statements could give national programmes a false sense of security, or, even worse, lead them to abdicate their responsibilities towards people who have leprosy or will develop it in future.

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The ILEP Medico-Social Commission