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The Dangers of Misinterpretation of the Elimination Campaign

It seems tendentious to offer any criticism of a program that has the laudable aim of the elimination of a serious public health problem, especially when that program has been demonstrably successful over the past 7 years, and even more so since it was largely based on the foundation of a prior 10 years of world-wide experience using the same basic technology. The task of criticism is made more difficult by an editorial that frankly recognizes some of the weaknesses in the program.

One of the difficulties we face is that the rules appear to have been changed in the middle of the game. As a result, the experiences of the past 7 years may no longer be a sound guide to the future. In particular, treatment with multidrug therapy (MDT) has been progressively shortened from "until smear negativity" (which usually meant 5 years or so) to "2 years" and now to "1 year" only. We already know [reference Jamet, P., Ji, B. and the Marchoux Chemotherapy Study Group. Relapse after long-term follow up of multibacillary patients treated by WHO multidrug regimen. Int. J. Lepr. **63** (1995) 195–201] that some cases with high smear positivity at the outset are at serious risk of relapse after the 2 years of therapy, and it should be noted that the mean time lapse between the end of MDT and relapse was 62.7 ± 18.7 months. It seems a fair assumption that when the duration of treatment is reduced to 1 year many more cases will relapse. This change is certainly attractive for program managers and convenient and safe for the majority of the patients who will probably be cured in 1 year. However, we appear to have embarked on an uncontrolled clinical trial on a global scale. This means that a significant proportion of patients, who have trusted the program with their lives and livelihoods, will relapse and thus be exposed to the risk of serious and permanent disability. Most of these relapses will occur after the target date for "elimination."

The most optimistic evidence we have "in selected programs and special projects, where it has been possible to measure incidence through repeated total population examinations (is that) the reduction in incidence after the first 5 years of MDT implementation has been found to be about 10% per year." This experience has not been published so far as I know, but if it holds good generally and is maintained for 10 years or so, it will indeed lead to significant and very welcome reductions in incidence. It should be noted that the reduction in incidence did not begin until 5 years after the initiation of the programs. However, "WHO is strongly promoting, for the remaining years [3 at the most], a three-pronged strategy of: a) leprosy elimination campaigns (LEC) to reach hidden cases and bring them under treatment; b) special action projects for the elimination of leprosy (SAPEL) in order to reach patients in inaccessible areas; and c) making MDT available in every general health facility so as to make leprosy treatment universally accessible."

The SAPEL programs are scheduled to operate over a very short time span, and unless they are merely a prelude to a sustained campaign, which we all know involves a great deal more than simply making "leprosy treatment universally accessible," the results will be illusory since new cases occur to replace those fortunate enough to have been identified and treated.

Those in the know understand that the World Health Organization has assigned a special meaning to the word "elimination" and that it does not mean eradication. It is indeed "a more modest goal than eradication." Few seem to understand this and most read the word "elimination" in its ordinary, dictionary sense, which is very much like eradication, and there is a danger that government support for leprosy, as well as public support for leprosy programs, will be seriously reduced once "the target figure of prevalence of less than 1 in 10,000 at the national level and the target date of the end of the year 2000" has been reached. I am told that the Sasakawa Memorial Health Foundation, a major supporter of the pro-

gram, has already declared its intention of ceasing to support leprosy work after the year 2000.

It is claimed "that there is every indication that the majority of cases currently detected are from the backlog component." It is certainly "clear that (case detection figures) are influenced by many factors." We can also agree that "it is not possible to measure incidence from routine information systems." This being the case it would surely be safer to assume that case detection figures provide an underestimate of incidence rather than an overestimate. This has certainly been the assumption in the literature the past many years. Only very recently has this assumption been challenged.

If the future proves that current case detection overestimates incidence and efforts to find and treat leprosy patients have continued at their present scale, we have lost nothing. In fact we have accelerated the eradication of the disease. On the contrary, if the assumption that current case detection overestimates incidence is used as a basis for planning and we allow efforts to detect and treat leprosy to be decreased, we could soon be faced with a catastrophic rise in prevalence and it is this eventuality that must be avoided.

Finally, there is no question that MDT has given us "an opportunity to bring about a mighty impact on the global leprosy situation." We should seize this opportunity! But we shall miss it if we allow leprosy programs to be eliminated before the job is done.

—W. Felton Ross, M.B.B.S.

Medical Consultant
American Leprosy Missions
One ALM Way
Greenville, South Carolina 29601, U.S.A.