Dr. Claire Vellut on declaration of "elimination of leprosy" in India

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Unless we choose to turn a blind eye...

The idea of leprosy elimination is based on the assumption that a prevalence of less than 1 case per ten thousand population will interrupt transmission of the disease. This is a false assumption. It lacks proof. Further, it is contradicted by the reality. The factors influencing the transmission have remained unchanged or worsened, in conditions of extreme poverty. In India, millions live below poverty level (BPL) in overcrowding, unhygienic conditions, malnutrition etc. In this situation, we cannot expect the transmission of chronic infectious diseases to decrease, unless we choose to turn a blind eye to these realities.

In fact, in the world, there has been a slow decrease in the number of new leprosy cases, in the order of 2 to 12 % per year, probably due to a natural decline in the endemicity of the disease and to the positive effects of good MDT campaigns. In India, there has been a decrease up to 25% – 30% per year in the number of new cases. These results call for serious studies.

The lacuna in the elimination strategy is the prevalence rate taken as the criteria instead of the new cases detection rate -NCDR- as done previously. Prevalence rate is much influenced by operational factors. There has been change in the methodology after the "Kathmandu recommendations". The changes such as "all the new cases detected to be registered and given MDT after validation by the authorities in each area", is not practical in rural areas, where the authorities may be far away. Further, how quickly and regularly this was done and by whom? Instructions like "do not register single lesion leprosy (SSL) cases for now" will misguide the leprosy workers. What will be the impact on IEC, when therapy is refused to a patient presenting with a single well defined, anaesthetic skin lesion?

The active case detection has been stopped - the 'self-healing' character of leprosy should not be overlooked as it is almost 50% among the child cases. Therefore, specially, school surveys should be stopped.

After the integration of the vertical leprosy programme with the General Health services, it is being accused for giving incomplete statistics because of lack of supervision and poor recording. This situation may improve with the experience of GH staff and a better monitoring in the long run.

The strategy of leprosy control in the "post elimination" period by LEAP is well presented by A. A. Samy et al. This article underpins the need for the following:

1. Intensive community IEC campaigns, specially in selective pockets with high prevalence.
2. Capacity building of all medical and paramedical personnel and change of curriculum.
3. Availability of referral facility with good bacteriological laboratory for AFB is the only way to diagnose an early infectious case. For the moment, it should also include training for POD and referral for corrective surgery.
4. Creation of a good monitoring and evaluation system. Sample Survey should be restricted to very selective pockets. The Contact Survey of all new cases should be encouraged.

Leprosy elimination tasks are not impossible, but we have a long way to go in the medical field, equity and in the improvement of the quality of life for all.

Dr. Claire Vellut, MD, FAMS,
Senior Leprologist,
Founding Trustee, Damien Foundation India Trust (DFIT)