

## Global W.H.O. Strategy

### Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy (Plan Period: 2011-2015)

The main principles of leprosy control, based on timely detection of new cases and their treatment with effective chemotherapy in the form of multidrug therapy (MDT), will not change over the coming years. The emphasis will remain on sustaining the provisions for quality patient care that are equitably distributed, affordable and easily accessible.

Though there has been an enormous reduction in the number of patients registered for treatment, new cases of leprosy will continue to appear for many years or even decades. Therefore, health services must sustain the key provision of quality services at all levels in the foreseeable future. The principles of integration, quality, equity and sustainability have been accorded primacy in the formulation of this Enhanced Global Strategy.

The current framework for leprosy control is characterized by an integrated delivery of basic leprosy services provided at the peripheral level. These are supported by specialized units with leprosy expertise at the intermediate levels which provide the necessary technical guidance, and a central unit for the formulation of policies and for monitoring and evaluation. The key approach is to integrate all the essential components of leprosy control activities into the primary health-care system. It includes the utilization and strengthening of integrated referral facilities to deal with leprosy related acute (e.g. reactions) and chronic (e.g. trophic ulcers) complications. Such a strategy needs careful planning and different approaches at the national and sub-national levels within the same country, depending upon the local leprosy burden, the availability of an appropriate health infrastructure, and the level of support from the local government authority.

A set of approaches is being proposed to deal with areas with low as well as high disease burden due to leprosy, i.e. to improve the quality of clinical services, to make the distribution of MDT more efficient, to implement innovative approaches to reach underserved populations, to improve supervision at the primary health-care level, and carry out effective surveillance for drug resistance.

Unified efforts are required to promote increased awareness about leprosy and reduce stigma and discrimination, so as to sustain the interest of policy-makers and encourage the involvement of general health services in leprosy control. It is important to address the problem of leprosy and its wider ramifications through careful implementation of evidence-based strategies. It is necessary to use every available opportunity to expand the vision and enhance all efforts to achieve the goal.

The burden of leprosy can be measured in terms of occurrence of reported new cases, or of the number of cases registered for treatment, or the number of cases with disabilities. While the number of cases registered for treatment (registered prevalence) has shown a considerable decline, the reduction in occurrence of reported new cases has not been as dramatic. While the disability burden, in terms of new cases with disabilities, has shown a steady decline, it is difficult to comment on the disability burden in terms of its prevalence because of the lack of updated data.

The objective of leprosy control is to reduce the burden caused by leprosy. Indicators are tools for measuring the magnitude of the leprosy problem and the progress made towards achieving the objectives of the programme. They can be used to set quality targets for the programme. As to which indicator or group of indicators should be used for measuring the reduction depends on the influence of operational factors, ease of measurement and validity. Reliable and comparable information about the disease burden due to leprosy in populations, and how this is changing over time, is extremely important to highlight leprosy among diverse priorities and interests and to decide on priorities within the leprosy control service.

W.H.O. has been regularly collecting data on several indicators from various WHO regions and Member States. These include the absolute number of cases registered for treatment at the end of a full year, and new cases detected during a full year. Among new cases the indicators are: numbers with grade-2 disabilities, classified as multibacillary (MB), children and female. In addition, in recent years data has been collected on cure/treatment completion rates on cohorts of paucibacillary (PB) and MB cases. W.H.O. is requesting countries to provide information on the absolute number of relapses reported during the year as a proxy indicator to monitor the effectiveness of multidrug therapy.

## Indicators proposed by WHO for the Plan Period: 2011-2015

### 1. Main indicators for monitoring progress

- 1.1. The number and rate of new cases detected per 100 000 members of the population per year.
- 1.2. Rate of new cases with grade-2 disabilities per 100 000 members of the population per year.
- 1.3. Treatment completion/cure rate.

#### 1.1 Number and rate of new cases detected per 100 000 members of the population per year

All national programs should collect and report this information, distinguishing paucibacillary (PB) and multibacillary (MB) leprosy and child/adult patients, which are important for the calculation of MDT drug requirements.

The nature (e.g. type, grade of disability, etc.) and number of new cases detected in a given area are mainly influenced by five factors:

- Effectiveness of information, education and communication (IEC) activities in promoting awareness and self-reporting.
- Health workers' competence in making an accurate and timely diagnosis.
- Contact examinations and counseling patient's families.
- Quality of monitoring and supervision by programme managers.
- Completeness of programme coverage, ensuring that all inhabitants are reached.

#### 1.2 Rate of new cases with grade-2 disabilities per 100 000 members of the population per year

When reviewed together with other indicators, these can be used to:

- (1) estimate under-detection;
- (2) measure the need for physical and social rehabilitation;
- (3) advocate activities for the prevention of disabilities; and
- (4) promote collaboration with other sectors.

#### 1.3. Treatment completion/cure rate.

A satisfactory treatment completion rate is indicative of efficient case-holding, counseling and the degree of patient satisfaction with the services. Completion of treatment means that a PB patient completes six monthly doses of PB-MDT within nine months and a MB patient completes 12 monthly doses of MB-MDT within 18 months. All national programs should

undertake cohort analysis of treatment completion rates for both PB and MB leprosy at least on a sample basis. A reported unsatisfactory treatment completion rate indicates that the programme manager/supervisor should find more detailed information on the treatment outcome of the reporting clinic/district in order to identify appropriate corrective action.

## **2. Main indicators for evaluating case detection**

The following indicators should be collected to evaluate the case detection activities and to calculate MDT drug requirements:

- 2.1. Proportion of new cases presenting grade-2 disabilities/impairments.
- 2.2. Proportion of child cases among new cases.
- 2.3. Proportion of female patients among new cases.
- 2.4. Proportion of multibacillary cases among new cases.

## **3. Main indicators for assessing the quality of services**

The following indicators for quality of care and patient management may be collected, usually on a representative sample basis, as part of an integrated supervision process.

*3.1. The proportion of new cases correctly diagnosed.* The accuracy of diagnosis should be assessed through regular technical supervision. If there is any suggestion of significant over-diagnosis, a sample of new cases should be reviewed within three months of the diagnosis being made.

*3.2. The proportion of treatment defaulters.*

*3.3. The number of relapses reported during the year.* Relapse cases occur sporadically and are generally not part of any defined cohort, so these figures are difficult to analyze. If high numbers are reported from any particular area, further investigations must be carried out.

*3.4. The proportion of patients who develop new or additional disability during MDT (and after release from treatment).* There are two ways in which information may be gathered in the clinic in order to calculate this indicator, the eye-hand-foot (EHF) score and the Impairment Summary Form (ISF). Both scoring systems can also be used after completion of treatment to monitor prevention of disabilities (POD) activities. A problem with disability as an indicator is that it may not be measured consistently by health staff, and this appears to affect the reliability and completeness of current data on impairment and disability. The

W.H.O. disability Grade, and the related EHF-score, are however, rather simple and can be applied by anyone with the appropriate orientation. Although routinely reported for cases at diagnosis, not many programs are reporting the disability of all cases at the end of treatment, which is necessary in order to calculate this indicator.