LEPROSY ELIMINATION AND ROLE OF DERMATOLOGIST IN LOW CASE SCENARIO

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Leprosy control activities started in Nepal since 1960AD with leprosy surveys. In 1966, about 100,000 cases were estimated in the country with a hyper endemicity in western and far western region. A pilot project was started in 1966, based on dapsone mono therapy and gradually extended to more areas under vertical leprosy control program.

The leprosy control services were integrated into general health services in the year 1987 to provide wider coverage. Since, 1982/83 multi drug therapy (MDT) was introduced in few areas and some Hospitals, replacing mono therapy i.e. dapsone and gradually covering all 75 districts of Nepal by 1996. After the introduction of multi drug therapy (MDT) drugs treatment duration was reduced from life long to few years and this therapy has been found to be effective and acceptable to the leprosy patients.

After the introduction of multi drug therapy (MDT), the prevalence rate in the country has declined significantly. At the end of July 1982, registered leprosy cases in the country were 31,537 with PR 21 per 10000 populations that have been reduced to 5899 with PR 2.41 in 10000 populations by mid July 2004 depicting PR by 88.52% deduction. multi drug therapy (MDT) has been proved to be safe, effective in curing disease, reducing the period of treatment, well accepted by leprosy patients, easy to apply in the field, prevents development of drug resistance, reduces the risk of relapse and improves the community attitude towards leprosy patients.

World Health Assembly in 1991, declared the resolution of global elimination of the leprosy by the end of year 2000. Out of 8 endemic countries, Nepal was one of them, which has to achieve leprosy elimination goal, for this target date has been extended to end of year 2005. Nepal is an active member of the global alliance for leprosy elimination as a public health problem.

Nepal has started to implement of an adhoc plan since 1991/ 92 for achieving this national goal of leprosy elimination within the set stipulated time frame. A six years plan was developed in the year 1995 for strengthening the leprosy elimination program in the country.

The first independent evaluation of national leprosy elimination program was also undertaken by experts from His Majesty Government (HMG) / World Health Organization (WHO) & Non Governmental Oganizations (NGOs) from 7th January to 26th January 1996. The evaluation team appreciated the plan activities. In spite of this two round leprosy elimination compaign (LEC) were also implemented, first leprosy elimination compaign (LEC) in the year 1999 & second leprosy elimination compaign (LEC) in the year 2001 for endemic districts which brought most of the backlog and hidden cases from the community for treatment compliance. The information education & communication (IEC) that is electronic and non electronic media has also played a vital role in community awareness as well as reduction in social stigma in the community.

A detailed study of referral centers were carried out in 2002 in coordination with world health organization (WHO) / shool term professional (STP) based on which it was suggested that for timely cure of large number of leprosy patients retained at referral centers & reducing the burden of irregular patients, cooperation from referral centers is almost necessary for changing the disease profile positively.

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To improve accessibilities of services in the 058/059 a decision was taken to transfer out the retained patients from the referral centers to nearby health institutions of respective districts as per issued guidelines by His Majesty Government (HMG) Leprosy Control Division (LCD) to concerned referral centers of respective regions of the country. This guideline was implemented by all concerned referral centers showing good treatment compliance, involvement of peripheral health institutions as well as better coordination & cooperation among the supporting partners. Some operational problems are identified that is over diagnosis, re-registration and delayed treatment compliance in leprosy elimination program, which needs to be tackled effectively through appropriate capacity building of BHS staff responsible for diagnosis of cases & more liberal use of flexible multi drug therapy (MDT) to facilitate prompt treatment completion.

Leprosy continued to decline in Nepal. Number of new cases detected during this current fiscal year 2003/04 is 6958 where as this value was 8046 in the preceding year. New care detection rate (NCDR) has declined from 3.24 to 2.84 per 10000 populations. About 50% of newly detected cases are multi bacillary (MB). In this fiscal year female proportion is 31.8%, child proportion is 6.57% and disability grade II proportion among new cases is 3.48%. Terai regions accounted for 81% of the new cases detected during this FY 2003/04. NCDR has declined in all the regions except far western development region (FWDR). In FWDR, NCDR is slightly increased from 2.5 of preceding year to 2.77 this year. Similarly, point prevalence rate (PR), that is used a yardstick for leprosy elimination, of registered cases is also declined from 3.04 of preceding year to 2.41 per 10000 populations this year. This shows that PR is declined by 20.7%. PR is declined in all development regions of the country except FWDR where it is slightly increased (12%) from 2.5 of preceding year to 2.8 this year. At the end of fiscal year i.e. mid July 2004, 5,849 leprosy cases were under regular treatment.

On comparing the leprosy endemicity, four districts of Nepal viz. Jhapa, Dhanusha, Mahotari & Kailali have PR more than 5. Districts with PR less than 1 are 28. In this fiscal year 2003/04, 8210 leprosy patients completed their course of multi drug therapy (MDT) and released from treatment (RFT). Treatment completion rate has been increased by 6% that is from 84% of preceding year to 89.60% in this fiscal year 2003/04. This rate is satisfactory at the national level.

Figure shows that prevalence rate (PR) and new care detection rate (NCDR) values are continually in decreasing trend. Both are high in fiscal year 2001/02 due to special campaign (LEC) being conducted at highly endemic 17 Terai districts of the country.

ROLE OF DERMATOLOGIST IN LOW CASE (POST ELIMINATION) SCENARIO

Leprosy will not remain as a public health problem in the country at nation level after set time frame of elimination. But there will be still endemic pockets in different region and districts even after reaching the goal at national level. So the leprosy activities should be focused to the remaining high endemic cluster pocket areas.

Even after disease elimination is declared, diagnosis of new

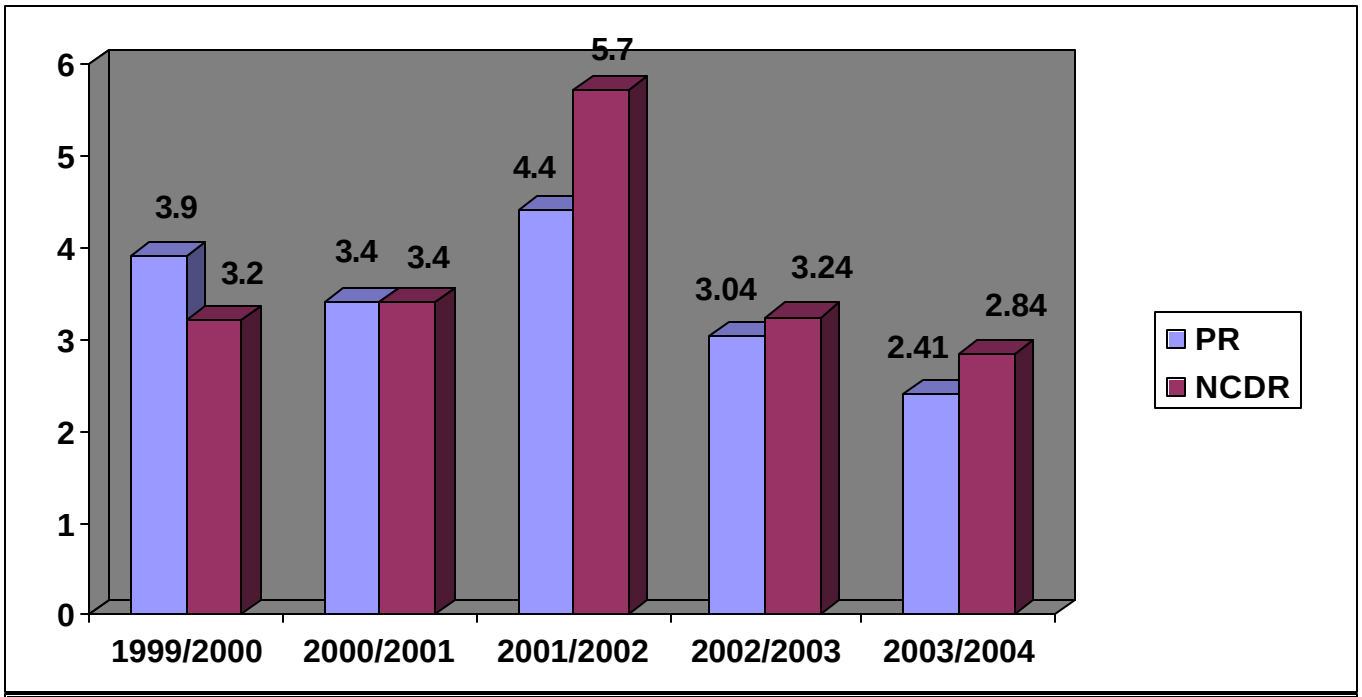

Fig. 1 : Prevalence Rate (PR) & New Care Detection Rate (NCDR) Trend of Nepal

cases, relapsed reporting and complication management will remain the major challenges. This needs to be tackled by basic health servic (BHS) staff, medical officers and dermatologists respectively. In post elimination scenario and in such integrated health service system the role of dermatologists will be more responsible for diagnosis, differential diagnosis, treatment, management of complication as well as capacity building of basic health service (BHS) staff and medical officers. Therefore, department of dermatology should be developed in each regional hospitals and referral centers keeping view of management of complicated cases and rehabilitation part (medical surgical and physical).

It may be that leprosy can be considered as low priority program, some of the donors may withdraw their support from this field and as in existing integrated approach leprosy activities may run as regular activities, but the community aspects and natures of the disease may remain the same. Case diagnosis and putting them in multi drug therapy (MDT) is not a very big problem in the field level, but patients suffering with recurrent leprae reactions, ulcer, neuritis and other complications are entirely different mode of the disease leprosy. There are still certain queries and assumptions in leprosy that, more researches and studies need to be held to get the clear answers. In low case scenario dermatologists and leprosy field workers may have sufficient time to explore best efforts in all these essential fields.

After the introduction of multi drug therapy (MDT) leprosy prevalence has been found continually declining but new case detection rate is about stagnant over the years. In the absence of any standard laboratory test for diagnosis of leprosy, validation studies are useful to assess the accuracy of diagnosis. Dermatologists, as leprosy experts, can play vital role for the conduction of several such studies in low case scenario.

At policy level, strategies need to be focused on to sustain leprosy control activities at all level. Precautions can be taken on roll back of disease burden as well as continue interruption of disease transmission. Since, leprosy is regarded as one of the chronic infectious disease, the disfigurement that leprosy causes & the mystery surrounding its transmission have always given rise to fear, and fear has generated discrimination – not just towards those with the disease, but their families as well. Hence full fledged community awareness rising information education & communication (IEC) activities are always the major issues. Major strategies of supporting agencies need to be diverted towards this line. A strong coordination and commitment of HMGN organizations, dermatologists, supporting partners and others would fortunately the major achievement for the sufferers with Hansen's bacilli!

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