Commentary on the Global Leprosy update 2017, published by WHO on Aug 31st, 2018.

By Paul Saunderson, ITC Chair

At the end of August, the World Health Organisation published its annual statistics on world leprosy. These provide data about the current state of leprosy from 150 countries – more than ever before.

Statistics concerning leprosy in 2017 were received from 150 countries and this is the second year in which some data have been submitted electronically, using the DHIS2 software. It is hoped that this will gradually improve the quality and completeness of the data that we see. The new case data can now be directly linked to the MDT drug supply through this software. The DHIS2 system also allows more data to be shown, for example the disability rates among new child cases, or the number of cases treated for reactions. ILEP members' help in gathering and submitting data to WHO is acknowledged.

The information about new case detection shows a small increase in all regions other than SEARO – while it would be nice to think that increasing contact examination could be the cause of this, the change is actually quite small and most likely due to more complete reporting (7 more countries than in 2016). One exception may be Somalia, where new case detection more than doubled from 635 cases in 2016 to 1,576 in 2017 – presumably due to better security and thus better access to the health services. Maybe this will allow Somalia to join the other 22 high priority countries! There is a Table showing foreign-born new cases, and the situation is generally as expected; Nepal has by far the largest number, with 600 foreign-born cases, as many routinely cross from India into southern Nepal to access health care.

Targets relating to Grade 2 Disability (G2D) at diagnosis are important in the current Global Strategy, reflecting as they do any effect of interventions to find cases early. One such target is to have "Zero new child cases with G2D". This indicator was reported by 120 countries, of which 88 reported 0 cases, and 27 reported 1–10. Five countries reported more cases: Ethiopia (19), Mozambique (28), the Democratic Republic of the Congo (30), Indonesia (48) and Brazil (54); in total, 238 child cases with G2D were reported. The figure given for India is '0', but this should presumably be 'NR'. Several countries reported new cases with G2D but did not provide disaggregated data for adults and children. The second target is to reduce the G2D rate in new cases to below 1 case per million population. This figure declined from 2.5 per million in 2015, to 1.8 in 2016 and 1.6 in 2017, having previously been very static at around 2.5 per million. It is difficult to call this a significant trend yet – almost all the reduction occurred in India and Indonesia – but we will watch with interest.

Last year, the Table with data from each country was expanded to include an additional column for children with G2D, and also relapses and retreatment cases were divided into two columns. This year,

because of its size, the Table is now in a separate PDF file that can be downloaded from the GLP website. Another noticeable change is that many cells under the relapse and retreatment columns which last year had 'NR' for not reported, now have '0', which in most low endemic countries will be correct.

For the first time in this context, routine reports of testing for drug resistance are presented: 711 new cases and 347 retreatment cases were tested, in 81 countries, with 9 cases of rifampicin resistance in each group (1.3% and 2.6% of cases, respectively; this compares favourably with the figures of 2.0% and 5.1% of cases in the recent report covering 6 years of surveillance (Cambau et al, 2018). It is difficult to know how accurate the reports of treatment completion are. Many countries do not report figures at all, while of those that do, it is not known how many do a proper cohort analysis.

Reactions were also reported on: 7,332 cases had Type 1 reactions and 5,370 cases had Type 2 reactions. The only further detail given is the regional breakdown of cases. In the Americas, 5,045 reactions were reported, while South East Asia reported 6,414 and Africa only 729. While there may be some true differences in reaction rates between different regions, the number in Africa seems especially low, most likely due to both under-diagnosis and under-reporting. Raising awareness by making these data known is a first step towards improved reporting.

Discriminatory laws were reported to still exist in 6 countries, while 47 countries reported at least one instance of discrimination. While this latter figure may suggest gross under-reporting, simply presenting the data raises awareness; it is clear that reliably documenting and reporting such occurrences is extremely difficult, but seeing a report like this can encourage people's organizations to monitor discriminatory behaviour more closely.

In summary, the biggest development in data reporting over the last two years is the use of DHIS2 software, which allows more indicators to be reported and may be expected to lead to a gradual improvement in the quality and completeness of the data that is presented each year. While there is very little change in the standard indicators since last year, new data on drug resistance, reactions and instances of discrimination is very important. These new data don't yet tell the full story, but hold promise for the future by raising awareness about these issues, encouraging improved reporting in future years and then allowing trends over time to be identified.