Leprosy in the South Pacific

Stephen T Chambers

The letter in this issue of the Journal from Colin Crawford gives some welcome attention to the ongoing problem of leprosy transmission in the Pacific region. While leprosy is no longer the scourge that it once was, it is comparatively recently that in 1991 the World Health Organization (WHO) Assembly took an important initiative and passed a resolution to “eliminate leprosy as a public health problem” by 2000. This was defined as a global prevalence to less than 1 case per 10,000 population, which is equivalent to fewer than 600,000 cases worldwide.

By 2005 the disease burden had fallen around 250,000 cases annually thanks in large part to the resounding success of the multidrug therapy programme. Unfortunately the decline has since stalled and the number of cases has remained fairly static since then. The current situation in the Pacific region is little different from that found elsewhere in the world. Some regions are reporting a reduction in cases but there are foci of transmission in the Pacific as well as in Africa (including Nigeria), the America and Asia.

Because of the success in achieving the WHO benchmark of ‘elimination of leprosy as a public health problem’ there has been the temptation for policy makers around the globe to pay much less attention to the quality of the leprosy programme. This has occurred whether or not the country has achieved elimination targets in part because of limited resources and the rising tide of other health issue demanding attention and resources. These include tuberculosis, obesity and diabetes.

Skill levels for leprosy control programmes are also very difficult to maintain in integrated services as there are a low number of cases, loss of awareness, high turnover of staff, and often a loss of focus on maintaining the quality of the service. Nevertheless, it is obvious that the long-term goal should be complete eradication of leprosy as has occurred in Europe, except perhaps from places such as the Southern United States where infected armadillos survive and are the source of sporadic cases.

These considerations have led to a recent reconsideration of how the strategy for the next phase of leprosy eradication should be undertaken. The key element of the strategy is to respond to the current epidemiological situation. The main risk of leprosy is in close contacts of new untreated cases whereas the risk in the general community is low.

Contacts need to be examined for signs of leprosy by competent staff, educated on the signs of early leprosy and to report suspicious lesions when they occur. Anecdotal evidence suggests some of the best informed people are those who have suffered from leprosy and they represent a pool of expertise who can alert others to the possible occurrence of disease.

Trial evidence demonstrate that a single dose of rifampicin (600mg) reduces development of disease by about 50% but contacts need to be reviewed as disease...
may still occur.\textsuperscript{8} This will require initiatives to ensure relevant record keeping and epidemiological mapping is maintained over prolonged periods.

What then is the role of non-governmental organisations (NGOs) such as the Pacific Leprosy Foundation (PLF)?

Firstly NGOs are guests in sovereign states and need to operate as such. They have a support role, and although providing assistance, are not responsible for activities such as national reporting to WHO or instituting policy at the national or operations level that is inconsistent with government policy.

Secondly NGOs must be true to their mission. The mission statement of the PLF is “The eradication of leprosy and the continued care of patients and their families with disability, or social and economic disadvantage due to leprosy in New Zealand and the Pacific.”

This is platform from which is solicits financial support from the public. There is plenty of evidence that this is what it is doing. Indeed the WHO awarded the PLF the Lee Jong-Wook Memorial Prize for Excellence in Public Health in 2012.

The primary goal is and remains eradication of the disease and to this end it supports field workers in Kiribati, the Solomon Islands, Samoa, Vanuatu, Fiji as well as the Twomey Leprosy Hospital in Fiji. The PLF also funds visits of WHO accredited leprologists over several weeks twice a year to high prevalence counties to provide expert clinical care, education, advocacy to governments and review of infrastructure. Engagement with policy to provide sustainable leprosy services as has also been well documented.\textsuperscript{9}

Thirdly, NGOs can have an important role in providing leadership in developing best practice as it changes. The PLF and other such organisations are aware of new policy initiatives, such as those advocated recently by ILEP and others, and actively promote local appropriate regional responses to these.\textsuperscript{6,7}

It is worth pointing out that NGOs have limited budgets and seek to provide ongoing service to areas where it can be sustained. This inevitably means negotiations to provide the best solution for each locality bearing in mind the resources and expertise available at each site.

The PLF is engaged with Kiribati, but not with the Federated States of Micronesia or the Marshall Islands, although it collaborates with other countries to develop relevant policy.

Leprosy programmes in the latter two countries are supported by directly by WHO. All these three countries have vast areas of ocean separating islands (e.g. Kiribati is spread over more than 100,000 square miles) and the logistics for providing services are very challenging. These countries consist mainly of atolls and the population is at risk from rising seas.

Many inhabitants may well migrate both for work and potentially as a refugees, carrying leprosy with them and risking reintroducing this organism to New Zealand. Government aid funding could be well spent in averting this problem by supporting leprosy and other infectious diseases programmes in these countries.
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Author information: Stephen T Chambers, Infectious Diseases Physician, Department of Infectious Diseases, Christchurch Hospital, Christchurch

Correspondence: Dr ST Chambers, Department of Infectious Diseases, Christchurch Hospital, PO Box 4345, Christchurch, New Zealand. Fax: +64 (0)3 3640952; email: Steve.Chambers@cdhb.health.nz

References: