

WHO-EM/CTD/069/E

Summary report on the

# Programme managers' meeting on leprosy elimination

Cairo, Egypt  
4–6 November 2012



World Health  
Organization

Regional Office for the Eastern Mediterranean

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## Contents

1.	Introduction .....	1
2.	Summary of discussions.....	2
3.	Recommendations .....	6



## **1. Introduction**

The WHO Regional Office for the Eastern Mediterranean organized a regional meeting of national programme managers of leprosy control programmes from 4 to 6 November 2012. The meeting was held in Cairo, Egypt. Its objectives were to:

- provide an update on the epidemiological situation of leprosy at global and country levels;
- discuss the progress of implementation of the enhanced global strategy for further reducing the disease burden due to leprosy (plan period: 2011–2015), during 2011 and 2012 and outline the plans for 2013; and
- brief the participants on new issues related to leprosy elimination efforts.

The meeting was attended by participants from Afghanistan, Egypt, Islamic Republic of Iran, Morocco, Oman, Pakistan, Saudi Arabia, South Sudan, Sudan, Tunisia and Yemen. From the partners, German Leprosy and Tuberculosis Relief Association (GLRA) in Sudan, AID to Leprosy Patients in Pakistan, Arkangelo Ali Association in Kenya, International Federation of Anti-Leprosy Associations in Sudan, were represented in the meeting. Experts from the University of Aberdeen, United Kingdom, and German Leprosy and Tuberculosis Relief Association (GLRA) in Yemen supported the meeting technically, along with two former senior staff of the Global Leprosy Programme. Also attending were the Global Leprosy Programme Team Leader and other WHO staff from the Regional Office and country offices in Afghanistan and Somalia.

The meeting was opened by Dr Riadh Ben Ismail, Regional Adviser, Tropical Diseases, WHO Regional Office for the Eastern Mediterranean, who delivered opening remarks on behalf of Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean. He drew attention to the changes in the meeting programme, with the addition of a field visit to a

leprosy centre and the special session for the partners to present their activities in the countries. He thanked the Global Leprosy Programme for supporting the meeting and encouraged the countries to continue progress in implementing the enhanced global strategy 2011–2015.

Dr Sumana Barua, Team Leader, Global Leprosy Programme, welcomed the participants and partners and expressed hope for more successful collaboration in leprosy elimination efforts.

Dr Abdul Rahim Al Samei (Yemen) was elected as Chair and Dr Chris Schmotzer (Aid to Leprosy Patients, Pakistan) was elected as Rapporteur.

## **2. Summary of discussions**

The Eastern Mediterranean Region has eliminated leprosy at the regional level and country level except in South Sudan, where its prevalence is around 3.2 per 10 000 population. There are still districts in some countries which have higher burden and have not achieved elimination at district level. It was noted that leprosy prevalence (i.e. cases registered for treatment) in the Region in 2011 was high, 7368 cases, compared to the number of new cases reported in the same year (4357 cases). Prevalence usually should be less or equal to new cases in the same year. Possible reasons for this anomaly cited were discussed by the participants and included using period prevalence in some countries rather than point prevalence on 31 December of the year, as well as not updating the records (i.e. cases that finish treatment remain in the registers and are not removed). Progress in the Region was presented and recommendations of last year's meeting were reviewed. It was clear that the Regional Office had worked on the three recommendations for WHO.

In terms of the global leprosy situation, the three countries with highest reported new cases are India (127 295 cases), Brazil (33 955 cases) and Indonesia (20 023 cases).

Afghanistan has its leprosy programme partially integrated in the national tuberculosis programme, so that the leprosy network makes use of provincial tuberculosis coordinators. However the disease suffers from neglect and low priority. Egypt implemented a WHO-supported initiative to concentrate on the four governorates (Sohag, Qena, Luxor and Aswan) which have higher burden districts. In 2012 the Egyptian programme has implemented training, awareness-raising activities and monitoring and supervision activities in the four governorates. In the Islamic Republic of Iran, the challenges were mainly the low priority of the programme and the stigma, as well as the presence of a law giving husbands the right to terminate marriage if their wife is infected with leprosy. In Morocco, an outbreak of leprosy occurred in 2011 in Boulmane, which led to mass media coverage of leprosy in the country. The programme raised an initiative to support leprosy efforts under the title 'Morocco without leprosy by 2020'. The plan for that initiative includes multidrug therapy, rifampicin chemoprophylaxis, advocacy and community mobilization, and prevention of disabilities.

Oman and Saudi Arabia have very low burdens of leprosy (3 and 6 new cases in 2011 respectively). However the issue of deporting non-nationals affected with leprosy was raised in the discussions. The issue relates to a GCC countries policy which includes a number of regulations for some communicable diseases including leprosy. Usually the detected case is given the package of treatment drugs for the total period of therapy and is deported. Although it is known that treatment, once started, stops communicability, changing the policy is not easy. Programmes in both countries were asked to start advocacy on the issue with the higher management in their Ministries.

Leprosy remains a public health problem in some areas in South-Central Somalia. WHO and World Concern have been able to reach patients in 6 districts in South-Central Somalia. Also 18 Somali health care workers were trained in ALERT in Ethiopia. Local partnerships in Somalia are



mainly with World Concern and Benadir University, in addition to 6 local nongovernmental organizations. Financial support for leprosy comes from WHO and ALM (American Leprosy Mission) only. Pakistan leprosy control activities are a good example of joint ventures between governments and nongovernmental organizations, where nongovernmental organizations are running the referral hospitals, in addition to being responsible for the training, logistics and technical expertise in the national programme. Skin camps constitute a good strategy for active case finding of leprosy, where patients with different skin conditions go to the camps and leprosy cases are diagnosed among those seeking medical advice. In addition financial contributions to the leprosy control services from the government, WHO and international nongovernmental organizations, local contributions as a form of charity also is a good source for support to the programme. Tunisia is very low in leprosy burden. South Sudan has highest burden of leprosy in the Region and has still not achieved elimination of the disease. Many problems exist in face of the proper operation of leprosy elimination activities. Discussions with the South Sudanese participant concentrated on opportunities for support WHO can offer to the new country. This can be through special funds for countries with emergency situations and difficult-to-reach areas. It was agreed that the participant needs to approach the national programme to brief them on the need to open channels with WHO on possibilities for future collaboration. Sudan has achieved elimination; however, it was noted that according to reported data, capitals of localities did not achieve the elimination target. This is because of maldistribution of health services which led to many cases from small cities and villages seek medical services in big cities. In spite of the support from partners in the country, leprosy is still considered a health problem in Sudan, with high levels of stigma and high rates of grade-2 disability.

In Yemen, the problems facing the programme are destruction of the infrastructure of the health system and insecurity, leading to inaccessibility.

It was stressed that the target is to reduce the new patients with grade-2 disability, and that the rate is per population and not percentage of new case detection. This rate can be used with other indicators to estimate under-detection, need for physical and social rehabilitation. Approaches to reducing grade-2 disability in new cases are prevention of leprosy, early case detection and treatment and prevention of disability activities. Prevention of leprosy can be reached by maintaining high BCG coverage, and using single dose of rifampicin chemoprophylaxis in close contacts. Early diagnosis can be reached by raising community awareness and health care staff. Health care staff should suspect leprosy in diagnosis, should have good clinical skills and should examine contacts and use chemoprophylaxis. A survey was carried out on grading of disability among leprosy new cases. It resulted in a finding showing that there are some problems in grading disabilities among health care workers especially in relation to cracks, healed ulcers, muscle weakness, eye changes, and visible changes outside the eyes and feet. A review of patient forms in different countries showed that the forms provided by Egypt, Islamic Republic of Iran, Sudan and Yemen include the minimum required data available in the operational guideline of the enhanced strategy.

There are several factors that exclude leprosy from the list of eradicable diseases. These factors include: absence of a test for infection; long incubation period; uncertainty over the mode and sources of transmission; absence of tools for primary prevention such as vaccines; and absence of tests to identify people at high risk. The factors also include existence of at least one potential animal reservoir, namely armadillos.

### **3. Recommendations**

*To national leprosy programme managers*

1. Consider “updating” leprosy registers and look at issues of multidrug therapy duration. Only point prevalence at the end of the year should be reported to WHO, even if the country system uses period prevalence in its internal statistical calculations.
2. Consider enhancing the linkage of leprosy control to general health services as considered appropriate by the government and develop models suitable to the respective national and subnational situation. National programmes are encouraged to promote usage of dermatological services where possible.
3. Lobby with the concerned authorities for change regarding unsolved human rights issues related to leprosy.
4. Encourage contact examination for all new cases, and consider pilot studies on the use of chemoprophylaxis for prevention as an important tool for preventing transmission.
5. Identify and implement appropriate information, education and communication interventions to encourage self-reporting.
6. Assess capacity-building needs to ensure competence in case finding, reliable disability assessment and proper management of cases. This issue should be followed up in the next national programme managers’ meeting.
7. Use the checklist in the operational guidelines regarding management of patient data and record-keeping. Data on leprosy should be part of the national HMIS. Countries are recommended to report subnational/district leprosy data in order to identify high-priority areas.

8. Strengthen coordination with international nongovernmental organizations as well as national nongovernmental organizations according to the national and subnational needs.

*To WHO*

9. Continue with the initiative of including a field visit in the national programme managers meeting in the future.
10. Call for a regional consultation meeting on adapting leprosy control activities to very low prevalence conditions.
11. Maintain capacity-building efforts by organizing regional and national workshops on leprosy.
12. Follow up on the recommendations of this meeting every four months, and include progress reports on the implementation of recommendations in country presentations in the next national programme managers' meeting.



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