

Summary report on the

Fourteenth meeting of national programme managers on leprosy elimination in the Eastern Mediterranean Region

WHO-EM/CTD/072/E

Rabat, Morocco
29–30 October 2014



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. Introduction

The WHO Regional Office for the Eastern Mediterranean organized a regional meeting of national leprosy control programme managers from 29 to 30 October 2014. The meeting was held in Rabat, Morocco. Its objectives were to:

- provide an update on the epidemiological situation of leprosy at global and national levels, and on innovations in prevention strategies;
- review progress and challenges of implementation of the Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy (2011–2015) in countries of the Eastern Mediterranean Region during 2014; and
- discuss potential solutions to obstacles met in 2014 during implementation of action plans, and outline 2015 plans accordingly.

The meeting was attended by participants from Egypt, Morocco, Saudi Arabia, Sudan and Yemen. From among partners, representatives of AID to Leprosy Patients (ALP) in Pakistan and World Concern in Somalia attended the meeting. The opening session of the meeting was attended by Mr Yohei Sasakawa, Chairman of The Nippon Foundation and WHO Goodwill Ambassador for Leprosy Elimination. Both The Nippon Foundation and Sasakawa Memorial Health Foundation (SMHF) were represented in the meeting. Also attending were WHO staff from headquarters, Regional Office for the Eastern Mediterranean and country offices for Afghanistan, Somalia and Yemen.

The meeting was opened by Dr Yves Soutyrand, WHO Representative in Morocco, who delivered the welcome note. He welcomed the

participants and acknowledged Mr Yohei Sasakawa's efforts that had led to the adoption of UN Resolution A/RES/65/215 by the United Nations General Assembly in 2010, which called for elimination of stigma and discrimination against persons affected by leprosy. Dr Soutyrand pointed out that all countries had achieved the national elimination target: prevalence rates of less than one case per 10 000 population. However there were still districts in some countries that had a higher burden and had not achieved elimination at district level.

Dr Bin Maamoun, representative of the Ministry of Health of Morocco, welcomed the attendants and participants of the meeting. He presented briefly the leprosy situation in Morocco and the efforts for its control.

Mr Yohei Sasakawa, Chairman of The Nippon Foundation and WHO Goodwill Ambassador for Leprosy Elimination referred to the problem of complacency that can set in once registered numbers of patients decline. In these settings, efforts eased off, budgets and personnel were reduced, and leprosy became less of a priority in comparison with other major diseases. Mr Sasakawa then raised the issue of stigma and discrimination, which still existed in many communities, and emphasized the need to intensify efforts to fight them.

Dr Ibtiham Khoudri, Manager of the Leprosy Control Programme in Morocco, reviewed the history of leprosy in Morocco. In addition to implementation of WHO protocol of multidrug therapy, the national programme had introduced the single dose rifampicin chemoprophylaxis in November 2012. Since then the prevalence of leprosy was decreasing dramatically. The new goal of the programme was to eliminate leprosy in Morocco by 2025. The national strategy

2012–2016 included six activities which were expected to contribute to the goal: advocacy and social mobilization; multidrug therapy; prevention of disabilities; review and investigation of grade 2 disabilities; early detection of cases; and single dose rifampicin chemoprophylaxis for contact.

Dr Ibtissam Khoudri (Morocco) was elected as Chairperson. Dr Hany Ziady, WHO Temporary Adviser, served as Rapporteur.

2. Summary of discussions

In Egypt, there were 529 new cases reported in 2013, and most were multibacillary. The programme during 2013 conducted four types of activity: contact examination, training, meetings and social rehabilitation. Among 390 families in eight governorates, contacts were examined and 32 leprosy cases were detected among them. In Qena, which is one of the highest governorates in leprosy burden, the programme initiated a referral centre for severe reaction in Upper Egypt. The annual programme meeting is held for medical and non-medical staff for three days to build capacities and improve performance. Challenges include the presence of two districts that did not achieve the elimination target: Esna in Luxor governorate with a prevalence of 1.28 cases per 10 000 population, and Edfu in Aswan governorate with a prevalence of 1.07 per 10 000 population. Moreover, stigma and discrimination are still high.

In Saudi Arabia, the leprosy cases are very few. Eight new cases were reported in 2013, apart from those among foreign workers. The plans of the national programme include promotion of early case detection by health education and training of health care workers. The programme also plans to translate selected documents into Arabic, and

make use of health events as World Tuberculosis Day and World Health Day to disseminate information on leprosy.

Leprosy is a public health problem in two regions in Somalia: Middle Juba and South Central Somalia. Leprosy indicators are not available for 2013 and 2014. Local partnerships include World Concern, Benadir University, local nongovernmental organizations in Somalia and a local radio channel (Radio ERGO). Benadir University facilitates sending doctors for training at ALERT centre in Addis Ababa, Ethiopia. Challenges in leprosy control activities include insecurity and inaccessibility of endemic areas, lack of political commitment and the absence of local partners. Even World Concern, which used to be a strong partner in Somalia, has some difficulties and did not send data in 2013–2014. Stigma and discrimination remain the main challenges against case detection and treatment. Suggestions for the way forward include encouragement of the Ministry of Health to identify a leprosy focal point/manager, as well as a reliable partner. It is also recommended to integrate leprosy into primary health care services, raise community awareness, fund raise, train staff, establish a referral system at regional levels in endemic areas, and promote community and consumer participation in all leprosy activities. World Concern is one of the main partners in leprosy. It serves 16 countries globally including Somalia. During the period 2010–2012 World Concern had an operational programme in leprosy in South Somalia area. It was supported by American Leprosy Mission (ALM), and also by The Nippon Foundation (through WHO). Problems in funding from its donors have affected its performance in Somalia.

All states in Sudan reached elimination of leprosy; however six localities are still lagging and did not reach 'locality-level elimination'. During 2013, 698 new cases were reported. It is

suggested to dedicate more efforts in localities with high leprosy prevalence. More priority is needed for leprosy, especially given that it is the primary disabling disease in the country. More supervision, monitoring and evaluation are needed. Referral system needs to be strengthened. Training of health care workers needs to be maintained to keep appropriate expertise. The introduction of other programme indicators was recommended, such as the proportion of grade 2 disabilities among new cases and the proportion of children among new cases in these hotspots. Health education is needed to raise community awareness and fight stigma and discrimination.

The National Leprosy Elimination Programme in Yemen is situated in Taiz. The Skin and Venereal Diseases Hospital in Taiz acts as a leprosy referral hospital and has 136 beds. It has a full range of services for leprosy patients, which includes in addition to treatment, eye care, training centre, footwear workshop, laboratory, outpatient department, and an operating theatre. Yemen eliminated leprosy in 2000. Every year, 300–400 cases are detected. The largest number of reported cases is in Hadramout governorate (153 cases in 2013). In addition to support from WHO and the German Leprosy Relief Association (GLRA), the programme receives support from local nongovernmental organizations and businesses. The programme applies as much as possible integration of leprosy services into primary health care services. The programme uses a number of strategies including: contact examination, training of health care workers, health education, holding annual meetings for leprosy staff all over the country. There are 36 clinics offering multidrug therapy, while there are four regional clinics. Constraints include insecurity, lack of fuel for transport, destruction of health system during the past three years, social stigma and low financial resources.

Leprosy has been eliminated in Pakistan since 1996, where currently the Leprosy Control Programme needs to adapt to the very low prevalence conditions. Pakistan presents a good example of partnership between different stakeholders: Ministry of Health, provincial health departments, WHO, GLRA and national nongovernmental organizations. nongovernmental organizations, including AID to Leprosy Patients in Rawalpindi, run the referral hospitals for leprosy, besides being responsible for training, logistics and providing expertise to the national control programme. In 2013, the newly reported cases were 431, while those under treatment were 657. Leprosy activities include networking with national eye health programme, tuberculosis control programme and dermatology programme. Active case finding is done through contact surveys and skin camps. Primary health care staff are involved in skin camps for capacity building. Training with integrated information, education and communication are implemented for medical, nursing and paramedical staff. WHO provides anti-leprosy drugs and health education material for training. GLRA contributes with the main share of nongovernmental organization budgets. The government pays part of the salaries, provides the infrastructure and medicines. In addition, there are local resources in the form of donations from nongovernmental organizations and individuals to the leprosy concerned nongovernmental organizations. Challenges include the need to cover the vast geographical area of the country and the huge population with appropriate services, though there is a very low prevalence of leprosy. As well, it is difficult to maintain knowledge and skills in leprosy management in such circumstances. Future plans include strengthening the two referral hospitals, integration of leprosy control with dermatology services, and training of all dermatologists in leprosy.

Most of the cases in Afghanistan are reported from the central part of the country. In 2013, 39 new cases were reported, of which 8% were among children, and 47 cases were under treatment. The national strategic plan 2013–2015 includes training of at least 500 health care workers on leprosy, and production of information, education and communication materials. Challenges facing the leprosy control programme in Afghanistan include reduced resources, instability, fewer numbers of skilled personnel and high turnover of field staff.

Recommendations of the 12th meeting of the WHO Technical Advisory Group on Leprosy Elimination, held in Brazzaville, Congo on 10–11 April 2014, focused on a number of important issues. These included: pilot studies for determining effectiveness of chemoprophylaxis in programme conditions, waiting for the final results of the study on uniform multidrug therapy; continuation and expansion of global surveillance of drug resistance; integration of leprosy with other neglected tropical disease control programmes; concentration on capacity building in clinical and programme management; participation of people affected by leprosy in leprosy services; adoption of the Guidelines to clarify the WHO three-grade disability grading system' for programme use; and the need for working groups for better programme monitoring, chemotherapy and developing global leprosy strategy for 2016–2020.

Participants of the meeting were divided into two groups in the group work session. Both groups worked on the common topic of how to eliminate discrimination related to leprosy. The suggestions of the groups included development of good role models and media dissemination of success stories where people could overcome both the disease and its related discrimination. Education and advocacy are also important, where community leaders and political figures need to

contribute in such activities. Knowledge, attitudes and practice (KAP) studies need to be implemented to assess the situation in the different communities and react according to the results of these behavioural studies.

The first group (Egypt, Pakistan, Sudan and Yemen) worked on innovative approaches to achieve subnational elimination. Suggestions included exploration of suitable local networking options, using ex-patients as case finders, involvement of local community leaders and local media, raising awareness related to skin health, implementation of KAP studies to reveal gaps and plan programmes accordingly, active contact examination, strengthening relations with dermatologists and primary health care providers, and screening of school pupils in highly endemic villages. The second group (Afghanistan, Morocco, Saudi Arabia and Somalia) worked on innovative approaches in countries with low endemicity. Suggestions included increasing surveillance activities, monitoring and evaluation of leprosy control activities, training of health care workers, education of the community, development of partnerships with other programmes as appropriate, concentration of activities in 'hot spots', integration of leprosy with neglected tropical diseases and coordination with nongovernmental organizations to eliminate stigma and discrimination.

3. Recommendations

To Member States

1. Concentrate leprosy control efforts on subnational elimination, i.e. elimination of leprosy in districts with high leprosy burden, or 'hot spots'. Concerned countries are requested to prepare plans of

action with appropriate indicators and time-frames for efforts to achieve subnational elimination.

2. In countries where foreign workers are diagnosed with leprosy and are subject to deportation according to national policy, notify the national leprosy programmes in the native countries of the workers before deportation. This will ensure that they have access to treatment and medical care in their countries.
3. Make use of available opportunities by integration of some of their activities in other neglected tropical disease control programmes' activities as appropriate, and by establishing partnerships with different stakeholders.
4. Make use of funding opportunities in the context of Bangkok Declaration. This should be done through the proper channels, i.e. the Regional Leprosy Programme and Global Leprosy Programme.
5. Keep in place the leprosy reporting system networking even in countries with very low endemicity. This will also entail maintaining leprosy focal points in place in these countries.

To WHO

6. Support research on better diagnostic tools for leprosy.
7. Identify service delivery indicators indicators to measure access to services and the risk of discrimination and that are more gender sensitive, especially indicators that entail collection of data for women.
8. Support research on cost-effectiveness of country level interventions for leprosy chemoprophylaxis such as the ones being implemented in Morocco

9. Support activities related to capacity-building, especially in countries with low endemicity where skills and expertise related to leprosy are declining.
10. Translate guidelines on drug resistance into local languages and ensure the availability of other WHO leprosy programme guidelines.
11. Expand leprosy therapy to cover treatment regimens for relapsing cases (with a fresh course of MDT) and drug resistant cases (with second line medicines).
12. Continue support for supervision and monitoring activities in countries to ensure the quality of leprosy care is maintained within acceptable standards.



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