

Summary report on the

Fifteenth programme managers' meeting on leprosy elimination in the Eastern Mediterranean Region

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Tunis, Tunisia
29 February–2 March 2016



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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Contents

1.	Introduction.....	1
2.	Summary of discussions.....	1
3.	Recommendations.....	5

1. Introduction

The WHO Regional Office for the Eastern Mediterranean organized the fifteenth programme managers' meeting on leprosy elimination in the Eastern Mediterranean Region from 29 February to 2 March 2016 in Tunis, Tunisia.

The objectives of the meetings were:

- to learn about the latest developments in normative guidance, notably the *Global leprosy strategy 2016–2020: Accelerating towards a leprosy-free world* and the deliberations of the WHO Technical and Advisory Group (TAG) on leprosy;
- to discuss and review progress made and challenges faced by leprosy programmes in 2015;
- to identify key actions and steps that would guide leprosy elimination in the Eastern Mediterranean Region during the period 2016–2020.

The meeting was attended by participants from Afghanistan, Egypt, Islamic Republic of Iran, Iraq, Jordan, Libya, Morocco, Pakistan, Somalia, Sudan, Syrian Arab Republic and Tunisia. Representatives of the Leprosy Mission (Sudan), Aid to Leprosy Patients (Pakistan), LepCo (Afghanistan) also attended. The WHO Secretariat comprised staff from WHO headquarters and Regional Office for the Eastern Mediterranean, WHO country offices in Afghanistan, Sudan and Yemen, and WHO temporary advisers, including the Chairman of the WHO TAG on leprosy.

2. Summary of discussions

In 2014, countries of the Region reported 2342 new cases of leprosy (1.09% of the global burden), while the registered prevalence at the end of 2014 was 2212 cases (1.26% of the global burden). This

corresponds to a rate of 0.4 per 100 000 for new notifications and 0.04 per 10 000 for registered prevalence. The Region is considered the WHO Region with the lowest leprosy burden after the European Region. The Western Pacific Region, in spite of an average prevalence rate and case detection rate lower than the Region, had a higher registered prevalence (3939 cases) and a higher number of new cases notified (4337) in 2014. This fact is attributable to the large population of the Western Pacific Region.

In terms of leprosy burden, countries in the Region can be grouped into high- and low-burden countries and countries with no autochthonous cases.

High-burden countries: Four countries collectively account for over 90% of the regional burden, both in terms of registered prevalence and number of new cases detected – Egypt, Pakistan, Sudan and Yemen.

Low-burden countries: Countries that still report only small numbers of autochthonous cases (less than 50 new cases per year).

Countries with no autochthonous cases: A group of countries that no longer report cases among nationals, but may still report cases among foreign-born residents.

The global elimination target for leprosy (elimination as a public health problem), equivalent to a registered prevalence $<1/10\ 000$ population, has been met by most countries in the world and all countries in the Region. The actual prevalence can fluctuate, thus increasing as a result of better case detection, better notification and higher relapse rates, or decreasing as a result of cases being cured or dying or being lost to follow up, of registers being updated, and of fewer new cases occurring. Globally, in 2014, 6.6% of new cases were

still detected with grade 2 disability, with the Region's proportion being the second highest after the WHO African Region, at 12.8%, indicating that cases are still found too late. Drug resistance to leprosy medicines, as a result of weakened control measures, has been documented; unfortunately available information is still limited, and longitudinal observation should be continued. Nevertheless, levels of drug resistance among relapse cases do not seem to be high.

The global strategy was introduced to participants. As the main normative and reference document guiding leprosy elimination activities worldwide, the strategy was developed through a wide consultative process that included national programmes, patients' associations, partners, donors, experts, in addition to WHO staff. Its vision includes: zero disease, zero transmission of leprosy infection, zero disability due to leprosy, and zero stigma and discrimination. Its goal is to further reduce the global and local leprosy burden. Its targets for 2020 include: zero children diagnosed with leprosy and visible deformities; a rate of less than one newly-diagnosed patient with visible deformities per million population; and zero countries with legislation allowing discrimination on the basis of leprosy. The strategy relies on three pillars.

Pillar 1 is "Strengthen government ownership, coordination and partnerships" (its focus is on accountability); Pillar 2 is "Stop leprosy and its complications" (its focus is on action); and Pillar 3 is "Stop discrimination and promote inclusion" (its focus is on inclusion).

As mentioned, the burden of leprosy in the Region is considered low, both in terms of absolute numbers and in terms of rates (case-detection rate and prevalence rate). As the focus of the strategy is on high-burden countries, the strategy might be perceived as less relevant to countries of the Region. However, it will be complemented by an

operational manual that aims at operationalizing the strategy. The manual will also specifically address the needs of low-burden settings.

The presentation of the strategy was followed by a plenary discussion on the strategy itself, its guiding role and its implementation and operationalization in the Region.

Country presentations outlined the organizational management of leprosy programmes; provided updates on the current epidemiological situation and trend in each country; discussed public health activities currently implemented (surveillance; finding, referral and reporting of cases; contact tracing and examination; training and capacity-building; social, disability management and rehabilitation programmes; community mobilization and health awareness; supervision, monitoring and evaluation; supply of multidrug therapy drugs and other medicines); outlined clinical practice and outcomes (management of leprosy and its complications, treatment completion, cure rate, default rate, etc.); provided details on coordination and integration with other public health programmes/interventions and existing partnerships; presented operational research activities on single-dose rifampicin (in Morocco); highlighted strengths and weaknesses, achievements and difficulties encountered by the national leprosy programmes; and briefly introduced the key activities planned for 2016.

The presentation by the Chairman of the TAG reported on the conclusions and recommendations of the thirteenth TAG meeting held on 26 November 2016. The TAG endorsed the global strategy; recommended a review and update of the 2009 operational guidelines, the global leprosy monitoring and evaluation system and other relevant guidance documents; suggested strengthening linkages between leprosy and other disease control programmes, such as neglected tropical diseases and tuberculosis; recommended that drug

resistance surveillance should be expanded; and recommended that evidence on chemoprophylaxis of contacts and on uniform multidrug therapy should be reviewed, and guidance developed.

During the following plenary discussion participants debated ways to scale up and adapt the global strategy to the regional and country context, thus progressively reducing the burden, achieving elimination as a public health problem at subnational level, and “finishing the job”. Key areas debated during the plenary discussion included early detection of cases (including passive surveillance, active case finding and contact management), programme strengthening, human right issues, non-resident or foreign-born cases of leprosy, management of relapse cases and chemoprophylaxis of contacts.

3. Recommendations

To Member States

1. Strengthen early case detection of all leprosy cases in order to reduce transmission and decrease the proportion of newly-detected cases with grade 2 disability. In this regard, passive surveillance, active case-finding and contact management should be considered for implementation:
 - Strengthen appropriate capacities within all relevant levels of the health system in order to enable identification and referral of leprosy suspects, and enforce reporting of any newly-detected patient.
 - Encourage active case-finding among higher risk population groups as identified by the local context, and in areas of current or previous geographical clustering of cases. Consider measures such as organization of camps for skin diseases (not limited to leprosy) to reduce stigma.

- Screen contacts sharing the household with any identified patient for leprosy, preferably by clinical examination at yearly intervals for at least five years after patient's detection, or at least upon patient's detection and again five years later. Screened individuals – or, in case of children, their parents or guardians – should be taught about signs of leprosy and urged to report to health care providers in case of their finding. Contact management should be conducted in agreement with the patient.
2. Reinforce leprosy programmes by:
- promoting national ownership and leadership;
 - ensuring high-level commitment from decision-makers, including sufficient allocation of funds;
 - sustaining expertise among health staff on management of suspects and patient, and on planning and execution of leprosy elimination activities;
 - ensuring adequate referral systems, especially when/where leprosy becomes rarer;
 - maintaining an efficient surveillance system for leprosy, including in countries that report zero incidence of cases;
 - involving patients in leprosy elimination activities;
 - enhancing synergies with other health programmes, such as tuberculosis, neglected tropical diseases, and others;
 - ensuring that newly-developed diagnostic and treatment tools are made available for routine interventions.

To WHO

3. Develop and disseminate a position statement against existing discriminatory practices related to family law, deportation of foreign leprosy cases from a country, eviction of children affected by leprosy from schools, and dismissal of leprosy patients from

work. Disseminate existing guidance on human rights of leprosy patients to all countries and promote its adoption.

4. Develop a definition, reporting format and guidance for cases of leprosy proceeding from countries different from the country of detection. Ensure fair diagnosis and treatment of any detected leprosy patient. Encourage cross-border collaboration.
5. Include an updated definition of relapse cases in operational guidelines developed by WHO and guidance on multidrug therapy protocol for such cases. Facilitate access to drug resistance surveillance for all countries.
6. Compile and analyse available evidence on chemoprophylaxis and develop relevant guidance and encourage countries to implement pilot interventions on chemoprophylaxis of leprosy contacts under programmatic conditions so as to generate scientific evidence in this regard.
7. Mobilize financial and technical resources and provide technical support for implementation of the action plan at country level (WHO, Food and Agriculture Organization of the United Nations, United Nations Environmental Programme).

The image features a minimalist, abstract design composed of several rectangular blocks. A large teal block occupies the top right and bottom right portions. A grey block is positioned at the top left. A horizontal grey band runs across the middle. A dark grey block is located in the bottom left. The bottom of the image is a solid grey bar containing contact information.

World Health Organization
Regional Office for the Eastern Mediterranean
P.O. Box 7608, Nasr City 11371
Cairo, Egypt
www.emro.who.int