Report on the

Regional meeting of national coordinators on leprosy control

Sana’a, Republic of Yemen
4–6 September 2005
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1. INTRODUCTION

The World Health Organization (WHO) Regional Office for the Eastern Mediterranean (EMRO) organized a regional meeting of national coordinators on leprosy control in Sana’a, Yemen, from 4 to 6 September 2005. The objectives of the meeting were to:

- review the leprosy situation in the endemic countries of the Region;
- discuss the global strategy for further reducing the leprosy burden and sustaining leprosy control activities;
- develop plans of action for 2006–2007 based on the global strategy.

The agenda and programme are attached as Annex 1 and 2, respectively. The meeting was attended by participants from Afghanistan, Egypt, Islamic Republic of Iran, Morocco, Pakistan, Somalia, Sudan, south Sudan and Yemen. The list of participants is attached as Annex 3.

The meeting was opened by Dr Hashim Ali El-Zein El-Mousaad, WHO Representative, Yemen, who delivered a message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. He stated that the target to eliminate leprosy as a public health problem by the year 2000 had been extremely useful in generating all-round support from various partner agencies, in particular international donor nongovernmental organizations, to leprosy-endemic countries to reduce the physical, psychological and social suffering of leprosy and to improve efficiency of control. The WHO Strategic Plan for Leprosy Elimination 2000–2005 had encouraged commitment among endemic countries to accelerate elimination activities at national and sub-national levels through promoting community awareness, capacity building of health workers in provision of multidrug therapy services (MDT), and improving case finding and prevention of disabilities, he said.

The large-scale implementation of the Strategic Plan for Leprosy Elimination 2000–2005 had increased coverage for leprosy control activities in hard-to-reach areas and improved detection and treatment of leprosy cases. The drugs required for MDT had been available free of charge in all endemic countries through WHO he noted, and the leprosy burden had been reduced substantially. The idea of integrating leprosy control activities into general health services to sustain provision of high-quality leprosy services for patients in the foreseeable future had received increased support from national programmes. Recently, he said, a new Global Strategy for Further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities for 2006–2010 had been adopted by the WHO Technical Advisory Group on Elimination of Leprosy. He pointed out that the extension of integration of leprosy control activities within the primary health care system depended on the level of knowledge of various categories of health staff about diagnosis and treatment of the disease, availability of referral services, level of support provided by nongovernmental organizations to leprosy control and the availability of appropriate resources to address issues related to prevention of disabilities and rehabilitation. He wished the participants successful deliberations and practical recommendations.
Dr Majeed Al-Junide, Deputy Minister for Primary Health Care, Ministry of Public Health and Population, Yemen, welcomed the participants and expressed appreciation to WHO and nongovernmental organizations for assistance to the national programme in reduction of the burden of leprosy in the country. He emphasized the importance of further efforts to control leprosy in order to overcome the psychological, physical, social and economic hardship caused by leprosy.

The participants reviewed and adopted the agenda and programme of the meeting. Dr Abdul Rahim Al-Samie was elected Chairman of the meeting and Dr Mahshid Nasehi was elected Rapporteur.

2. REGIONAL OVERVIEW

The number of registered cases in the Region has varied over the past 30 years. The available data indicates an increase in the number of registered cases from 63,236 in 1976 to 74,892 in 1985. After introduction and wide use of MDT, the number of registered leprosy cases has significantly decreased. Whereas in 1995 Member States reported 23,219 cases, by the end of 2000 the total number of registered cases has dropped to 8,785 cases. By the end of 2004, the total number of registered cases was 5,398 cases.

Accordingly, the prevalence of leprosy per 10,000 population at the regional level decreased from 1.58 in 1985 to 0.99 in 1990, 0.2 in 2000 and to 0.1 per 10,000 population in 2004. All countries of the Region reached the target of elimination of leprosy as a public health problem at the country level.

The number of detected new cases of leprosy has slightly changed during the past 16 years. 5,340 new cases of leprosy were detected in 1989, 6,563 in 1992, 5,231 in 1995, 5,565 in 2000 and 3,390 in 2004. The majority of new cases were classified as multibacillary (MB) cases. The detection rate per 100,000 population in 2004 was 0.8.

According to available information, countries such as Afghanistan, Bahrain, Jordan, Kuwait, Libyan Arab Jamahiriya, Oman, Saudi Arabia, Syrian Arab Republic, Tunisia and United Arab Emirates, have a very limited problem regarding leprosy. Significant progress in reduction of new cases of leprosy has been achieved in the Islamic Republic of Iran and Morocco. The situation in Somalia and south Sudan needs more clarification. The majority of new cases of leprosy are still registered in Egypt, Pakistan, Sudan and Yemen.

The fact that new cases of leprosy will continue to appear for the foreseeable future, despite the visible achievements in the control of leprosy, dictates the necessity to continue high-quality leprosy services in countries with even a reduced burden of the disease. The national programmes have already accumulated significant experience in integration of leprosy control activities within the existing health care infrastructure.

Examples of specific actions undertaken by the national programmes include organization of skin camps in some areas for diagnosis of skin diseases including diagnosis of
leprosy, training of nurses and doctors of physiotherapy units on prevention and treatment of disabilities, training of general staff in difficult to access areas on leprosy diagnosis and MDT treatment, and training of school health staff on diagnosis of leprosy among schoolchildren.

In view of the need to sustain leprosy services in low-endemic situations, the new challenges should be overcome through integration of control activities within existing general health services, building capacity among health care providers and better involvement of communities in leprosy control. Strengthening cooperation between all partners in leprosy control will be extremely important.

3. GLOBAL OVERVIEW

At the beginning of 2005, the global registered prevalence of leprosy was 286 063 cases and the number of new cases detected during 2004 was 407 791. The number of new cases detected globally fell by 21% during 2004 compared with 2003. This decrease was mainly a result of the reduction in the number of new cases detected in India.

The global annual detection of cases has shown a declining trend since 2001. The number of new cases detected has been decreasing in the Eastern Mediterranean, South-East Asia and Western Pacific Regions. However, there is no such trend in the African Region and the Region of the Americas (Table 1).

Table 1. Trends in the number of new leprosy cases detected in 2001–2004 by WHO regions (excluding the European Region)

<table>
<thead>
<tr>
<th>WHO Region</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>39 612</td>
<td>48 248</td>
<td>47 006</td>
<td>46 918</td>
</tr>
<tr>
<td>Americas</td>
<td>42 830</td>
<td>39 939</td>
<td>52 435</td>
<td>52 662</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>668 658</td>
<td>520 632</td>
<td>405 147</td>
<td>298 603</td>
</tr>
<tr>
<td>East Mediterranean</td>
<td>4 758</td>
<td>4 665</td>
<td>3 940</td>
<td>3 392</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>7 404</td>
<td>7 154</td>
<td>6 190</td>
<td>6 216</td>
</tr>
<tr>
<td>Total</td>
<td>763 262</td>
<td>620 638</td>
<td>514 718</td>
<td>407 791</td>
</tr>
</tbody>
</table>

Leprosy remains a public health problem in 6 countries in Africa (Angola, Central African Republic, Democratic Republic of Congo, Madagascar, Mozambique, United Republic of Tanzania), 2 in South-East Asia (India, Nepal) and 1 in Latin America (Brazil). Together, these countries contributed about 84% of the new cases detected during 2004 and 74% of registered cases at the beginning of 2005. The Global Leprosy Programme will be working closely with all partners and national authorities to achieve the elimination goal in these countries as soon as possible.
4. COUNTRY SITUATIONS

4.1 Afghanistan

Leprosy is a neglected disease in Afghanistan. The national control programme and the leprosy unit in the Ministry of Public Health are not extant. Leprosy is not included as a priority disease in the new plan for health reconstruction in Afghanistan under the Basic Package of Health Services. There is no reporting or data collection system for leprosy at the national level. Leprosy patients are registered either in the dermatology section of Maiwand Hospital in Kabul, or in a few clinics that belong to two nongovernmental organizations involved in diagnosis and treatment of leprosy patients, namely LEPCO (Leprosy Control) and GMS (German Medical Services). Exchange of information between Maiwand Hospital and nongovernmental organizations is practically absent. WHO provides drugs for treatment of leprosy. The community awareness about leprosy in Afghanistan is very low. This has led to the existence of a high level of stigma towards leprosy cases.

According to available information from LEPCO and GMS, the case load of leprosy has declined in the last few years; 18 new leprosy cases were diagnosed in LEPCO clinics during 2004; all of them were adults; 3 patients had grade 2 disabilities; 15 cases were found in Hazarajat and 3 cases in rural areas in northern Afghanistan. By the end of 2004, only 21 patients were under MDT treatment in LEPCO clinics. Of them, 17 were MB and 4 paucibacillary (PB) cases. A further 4 MB patients were treated in the GMS clinic in Kabul. Maiwand Hospital reported 4 MB and 16 PB new leprosy cases during 2004.

4.2 Egypt

The Leprosy Control Programme covers a population of 68 846 414 distributed over 18 governorates, i.e. 95.98% of the country’s population. A total of 2285 leprosy patients were registered for MDT at the end of 2004. New cases detected through the year 2004 numbered 1216, and of these 84.54 % were MB and 15.46 % were PB. The percentage of cases with grade II disability was 5.26% and the proportion of children was 7.02%. The prevalence rate of leprosy in 2004 was 0.33/10 000 population at the national level. This goal has been reached at the governorate level except in two governorates, namely Qena (prevalence 1.45/10 000) and Sohag (prevalence 1.13/10 000). The prevalence rate is still higher than 1/10 000 in 20 districts. Detection rate of new leprosy cases has remained relatively stable over the last 10 years. The detection rate stands at 0.18/100 000 in year 2004.

All leprosy clinics work as integrated leprosy/dermatology clinics and are adequately staffed by doctors, well qualified nursing staff, social workers and laboratory technicians. Dermatology clinics at district hospitals diagnose and treat leprosy patients in districts with relatively high prevalence of leprosy, especially in upper Egypt. Training is provided to all categories of staff in leprosy clinics, and primary health care centres, and all dermatologists. Awareness meetings are organized for social workers and community leaders.

A defaulter tracing programme started in 1996 to bring defaulters back to treatment and to reduce their number to the lowest possible level. The success rate of the programme ranged
from 69% to 85%. Prevention of disability is based on early case detection, proper treatment with MDT, health education of patients, early detection and proper management of reactions, and neuritis. In 2004, 5.3% of new cases had grade 2 disabilities. Reconstructive surgery was conducted for correction of complications with assistance from special centres and medical colleges.

An eye care programme was started in 2000 providing extra-ocular eye operations for correction of eyelid complications; 246 operations have been done. Cataract operations started in 2003; 38 operations were done at Abu-Zaabal referral centre. The eye care programme is carried on in cooperation with nongovernmental organizations concerned with prevention of blindness. An ulcer care programme was established in all leprosy units and is performed by well-trained nursing staff.

Social aid and rehabilitation for leprosy patients under treatment was started in 1996 by the Ministry of Health in cooperation with local nongovernmental organizations. This support was provided not only to the patients during and after treatment, but also to the patient’s families in the form of income generating projects to make them self-reliant in earning their living. Nongovernmental organizations also provide support for physical rehabilitation by supplying artificial limbs, eyeglasses and foot wear for patients with foot ulcers and loss of sensation.

Statistical reports about leprosy patients are collected from the leprosy units by medical and paramedical supervisors during field visits. All the data are collected in special forms for each activity. The data are sent to the central office in the Ministry of Health and computerized. The data are analysed by the manager of the programme and discussed in detail during an annual meeting for doctors, nurses and social workers. Annual reports are prepared with statistical data at national and sub-national levels.

4.3 Islamic Republic of Iran

Leprosy control activities were integrated within the primary health care system in 1991. The health care network offers services throughout the country and is accessible to 84% of the rural and 66% of the urban population. Case-finding, treatment, training of health staff, public health education, registration and reporting are the main activities of the health care network for the leprosy elimination programme.

The prevalence rate of leprosy at the end of 2004 was 0.02 per 10 000 population. During 2004, only 80 new cases of leprosy were detected among Iranian citizens and 12 cases were detected among immigrants from Afghanistan. The detection rate was 0.12 per 100 000 population. Those new cases belonged to 29 districts of 15 provinces. Out of 80 new cases among nationals, 9% cases had PB leprosy and 19% had grade 2 disabilities. Only 1% of cases were in the age group under 15 years old; 21% had a history of close contact to leprosy cases. All new cases received MDT drugs. Treatment was provided to individual cases either at the nearest health centre, or in further away locations, depending on their choice; 3 cases of relapses were identified during 2004.
In 2004, a special survey was organized in the previously leprosy endemic district of Minab in Hormozgan province; 145 families were investigated and 3 new leprosy cases diagnosed. Leprosy elimination campaigns were conducted in areas endemic in the past in Qazvin and Kermanshah provinces; 11 new cases of leprosy were identified.

Individual investigation forms are sent monthly from the peripheral level to the central level. Analysis of data is done at district, provincial and central levels. Monitoring and evaluation of data is conducted through field visits.

4.4 Morocco

Leprosy in Morocco does not constitute a major public health problem. Annual statistical data indicate constant decrease in the number of new cases. However, leprosy is still far from elimination in areas of the country where the rate of prevalence is relatively high. By December 2004, 302 cases of leprosy (239 MB and 63 PB) received treatment. The prevalence rate was 0.1 per 10 000 population. In 2004, 62 new cases of leprosy were detected. Among them: 38 cases had MB and 24 cases had PB forms; 5 cases were detected among children; 26 cases were detected among females; 6 cases (9.7%) had grade 2 disabilities. Detection rate was 0.2 per 100 000.

Twelve seminars on leprosy control were organized at peripheral levels with participation of 124 doctors and 269 nurses; 5 doctors have been trained at the central level. Conferences for medical staff and meetings for the general public were held on the occasion of Leprosy Day in February 2005.

The national leprosy control programme has decentralized its activities. Provincial services for leprosy cases were strengthened to assure best accessibility to patients. The vertical set-up of the programme is strong, particularly in implementation of the therapeutic strategy. The national programme continued to receive technical and financial contributions and assistance from two nongovernmental organizations (local and international Emmaus-Switzerland).

4.5 Pakistan

Leprosy control in Pakistan is a major success highlighting the benefits of a joint venture between government health departments and nongovernmental organizations. Leprosy was controlled in Pakistan in 1996, four years prior to the WHO target year 2000. The subsequent years have proved that the achievement has been sustainable. Leprosy control has to be followed by comprehensive leprosy services, focusing on the leprosy patient and the community.

By the end of 2004, 1002 leprosy cases had received treatment, MDT coverage was 100% and MDT regularity 99%. Of 655 new leprosy cases detected during 2004, 476 cases voluntarily reported to medical centres.
Leprosy control is combined with blindness control in Punjab, Sindh, Baluchistan and North West Frontier Province, and combined with tuberculosis control in Azad Kashmir and Northern Areas. Triple merger programmes exist on a local level. Nongovernmental organizations are running the referral hospitals for leprosy, besides being responsible for the training, logistics and technical expertise in the national programme.

The main activities implemented by the national programme include: active case-finding in suspected hyperendemic areas by contact surveys and “skin camps”; proper case-holding and continuous monitoring of treatment outcome; comprehensive services for prevention and treatment of impairments and deformities; comprehensive services for social needs assessment and rehabilitation including networking; maintenance of referral hospitals for leprosy as national resource centres.

Leprosy technicians are required to maintain patient records on prescribed forms. Nongovernmental organizations regularly submit statistics on leprosy control, primary eye care activities and tuberculosis control to the concerned government health departments, WHO and international donors.

The programme faces the following challenges: to maintain appropriate coverage in leprosy control considering the vastness of the geographical area, the size of the population and the very low prevalence of leprosy; to maintain knowledge and experience in leprosy management under very low prevalence conditions; to create awareness about skin diseases in the medical profession; and appropriate coverage of the female population.

4.6 Somalia

Somalia has already reached the leprosy elimination target according to the available information. Unfortunately, data on leprosy are available from limited areas and there is no free access to all areas affected by leprosy. There could be more cases in the communities that have not been reached by leprosy workers yet. Over 80% of the positive cases have some form of deformity.

World Concern is a nongovernmental organization responsible for organization and coordination of leprosy control activities in Somalia. It has developed strategies based on partnership with other agencies willing to execute leprosy activities in various areas in Somalia. World Concern facilitates training activities, MDT supplies, treatment of patients, and recording and reporting of cases. The main tasks are to integrate leprosy activities into the general primary health care system of nongovernmental organizations who provide health facilities and to maintain ongoing leprosy activities according to guidelines provided by WHO.

In 2004, 17 training courses were conducted with participation of 792 health workers. A total of 127 MB and 56 PB new leprosy cases and 10 relapses were diagnosed during 2004. By the end of the year, 259 MB and 78 PB patients had received MDT treatment.
4.7 Sudan

The national leprosy control programme was established in 1991. Several nongovernmental organizations are working under the umbrella of the programme on different types of leprosy control activities, including treatment of cases, training, supervision, provision of transport facilities, medical equipment and disability care. By the end of 1998, the programme had achieved the global target of leprosy elimination at the national level. By 2001, the elimination target was achieved at the state level and by 2003 at the locality level. The main strategy is to extend the MDT coverage to the entire country through integrating leprosy activities into general health services; 280 health units had integrated leprosy into their activities by 2004.

The prevalence of leprosy has dramatically reduced from 1.3 per 10 000 population in 1997 to 0.3 per 10 000 in 2004. By the end of 2004, 720 leprosy cases (601 MB and 119 PB) were under MDT treatment. The number of new cases detected during 2004 was 722 cases, compared to 3633 new cases detected in 1997. Out of 722 new cases, 473 had MB forms of leprosy. The majority of new cases were detected in Blue Nile, White Nile, El Gazira, Bahr El Jabal, West Kordofan and South Kordofan states. All new cases were provided with MDT treatment.

During 2004, 10 000 posters on MDT treatment of leprosy were distributed to public health centres. Sixty seminars for community leaders were conducted in order to promote community awareness about the disease. The programme paid attention to the prevention of disabilities through training doctors and paramedics on methods of communication with leprosy patients, and identification and treatment of clinical complications. WHO provided sufficient number of prednisolone tablets for treatment of cases with clinical reactions to chemotherapy. The proportion of new cases detected with grade 2 disabilities decreased from 50% in 1994 to 9% by 2004.

Leprosy rehabilitation activities have been integrated into the activities of general handicap associations in cooperation with nongovernmental organizations and state authorities. Three rehabilitation centres in Khartoum, Darfour and Kordofan provided services to 15 000 disabled persons, including 2000 leprosy patients.

4.8 South Sudan

The leprosy programme was started in south Sudan in the mid 1990s by international nongovernmental organizations. In 2003, there were 12 nongovernmental organizations involved in leprosy control activities, running 23 health centres and several health units. In 2004, the number of leprosy treatment centres increased to 28, and by 2005, 30 health centres were providing leprosy services.

After the signing of the peace agreement in January 2005, 10 states in southern Sudan with a population of 10.1 million people came under the Government of south Sudan. The immediate objective of the new government will be to improve the coverage of the leprosy control programme by attracting new nongovernmental organizations and to strengthen the
capacity of the local authorities to take over and manage the programme. Integration of leprosy activities is considered an important strategy to scale up leprosy activities and reduce the cost of treatment. In southern Blue Nile, leprosy treatment is now integrated into the primary health care programme and efforts are under way to expand this process. Leprosy is also being integrated into the integrated management of child illness (IMCI) and tuberculosis programmes for training of staff and management of cases.

Since treatment of leprosy cases in southern Sudan is done as ambulatory treatment at home, much emphasis is laid on creating community awareness. Information, education and communication (IEC) materials developed by WHO have been distributed to all treatment centres and are also used during health education sessions in the community, at public gatherings on home visits and in discussions with community leaders.

Training of health workers on leprosy diagnosis and treatment is an important part of the leprosy programme in southern Sudan. In 2005, four training workshops for health workers from different treatment centres were conducted in various parts of southern Sudan; 54 workers were trained compared to 40 health workers in 2004.

During 2003, 2139 new cases of leprosy were diagnosed. Of those, 1521 had MB leprosy. In 2004, 1794 new cases were diagnosed, including 1407 MB cases. Among new cases, 200 were children. The reporting system in southern Sudan does not include differentiation in sex and disability grades, in order to simplify the system for health workers.

4.9 Yemen

The national leprosy elimination programme implements its activities with support from WHO and nongovernmental organizations in 85% of the populated areas in the country. Leprosy has declined from a peak of 2379 registered cases and a prevalence rate of 1.9 per 10 000 population in 1989 to 399 registered cases and a prevalence rate of 0.19 per 10 000 by 2004. Case detection is carried out through examination of suspected patients in governmental and private health units, active examination of contact persons and organization of special surveys in endemic districts and remote areas. In 2004, 415 new cases were detected and the detection rate was 2.1 per 100 000. Among new cases, 246 had MB and 169 had PB forms of leprosy; 7.7% of new cases had grade 2 disabilities.

Seventy physicians and 163 medical assistances were trained on leprosy diagnosis and case management during 2004 and 3 medical officers from the national programme received overseas training. Health education campaigns were conducted in four governorates during 2004; and 1440 health workers, 3292 teachers and 71 283 students participated in these campaigns, and 20 000 posters and 50 000 pamphlets on leprosy were printed and distributed to health centres, schools and communities.

The main obstacles to leprosy control in Yemen continue to be social stigma, an inadequate budget, a poor communication system and the difficult terrain.
5. GLOBAL STRATEGY FOR FURTHER REDUCING THE LEPROSY BURDEN AND SUSTAINING LEPROSY CONTROL ACTIVITIES.

A new global strategy for further reducing the leprosy burden and sustaining leprosy control activities (2006–2010) was adopted by the WHO Technical Advisory Group on Elimination of Leprosy at its 7th meeting which took place in WHO headquarters, Geneva, Switzerland, 4–5 April 2005. This strategy is a natural evolution of the WHO Strategic Plan for Leprosy Elimination (2000–2005), designed to address the remaining challenges and further reduce the disease burden due to leprosy. The new strategy was formed on the basis that new cases of leprosy will continue to appear for the foreseeable future in most of the currently endemic countries and that health services must continue to provide quality services for leprosy control beyond the year 2005. In view of the need to sustain leprosy services for many years to come, there has to be a shift from a campaign-like elimination approach towards the long-term process of sustaining integrated, high-quality leprosy services which, in addition to case detection and treatment with multidrug therapy, also include prevention of disability and rehabilitation.

The main objectives of the new strategy are:

- to provide quality services to all cases;
- to integrate leprosy control activities, including referral services;
- to increase collaborative activities with partners;
- to enhance advocacy efforts to reduce stigma and discrimination.

Early case detection and provision of multidrug therapy will remain the cornerstone of leprosy control. An integrated approach using general health staff will facilitate provision of high-quality leprosy control activities, including referral services for complications and chronic care that are easily and equitably accessible to all. The global strategy calls for continued national commitment and resources, backed by international agencies, to ensure that leprosy services are sustained. Given the heterogeneity of the leprosy situation in the world, the global strategy will encourage national governments to develop appropriate country-specific goals and targets and effective plans of action to ensure accessibility, timely case detection and completion of treatment.

A key strategy for improving and sustaining leprosy services will continue to be involvement of peripheral general health workers and community health volunteers in leprosy control tasks. The major theme of community awareness is to provide accurate information about the disease, its curability and availability of services at the nearest health facility. The objective of such efforts should be to encourage self-reporting of new cases and to reduce stigma and discrimination against affected individuals and their families. All programmes should ensure that all members of the community have easy and equitable access to leprosy services. Special initiatives should be aimed at finding people living in difficult areas or situations who are in need of treatment and to ensure that they complete multidrug therapy.

Coordination between government and nongovernmental organizations, as well as local health authorities, dermatologists and general practitioners should be encouraged, particularly
to ensure that leprosy services are provided by all agencies and all new cases are treated with multidrug therapy. Data collection for leprosy should be the basic minimum and should be an integral component of the monthly reporting formats used by local health services. The referral network must be part of the integrated system, providing referral services for other diseases.

It is expected that with implementation of the new global strategy by the year 2010 the following outcomes will be achieved:

- further reduction of disease burden to very low levels;
- improved quality of diagnosis, case management and registration;
- integrated leprosy services in endemic countries;
- efficient integrated referral facilities;
- improve tools and procedures for prevention of disability and rehabilitation;
- improved working arrangements with partners.

6. SUSTAINING LEPROSY CONTROL ACTIVITIES

Sustainability is the capacity of the programme to maintain quality and coverage of services at a level that will provide continuing control and further reduction of a health problem at a cost that is affordable to the programme and the community.

Reasons to sustain leprosy control activities are justified by the need to: protect achievements made by national programmes to date in leprosy control; uphold credibility of national health services; diagnose, treat and provide care for new cases; and detect reactions and relapses and prevent the emergence of drug resistance and resurgence of leprosy transmission.

Mechanisms for sustaining leprosy control activities include: integration into existing/general health services that are well supported by a referral network providing services for other diseases as well; building capacity and competence among health care providers through education at medical/paramedical schools, motivation, on-the-job training, and retraining and technical supervision; increasing awareness among the community and building up capacity through IEC and community involvement; provision of equal access to MDT services and social justice for leprosy cases; and unity, consensus and trust between all partners.

In the context of sustaining leprosy services, the general health services will take full responsibility for leprosy control as part of their routine day-to-day activities. The nature of care and category of staff involved will vary from country to country, depending on the structure and resources of the general health services. Integration will improve efficiency and effectiveness, optimize the use of resources, promote greater equity, reduce stigma and discrimination, and ensure long-term sustainability.
In low-endemic countries, to make the programme more efficient, proper referral facilities should be identified at district/provincial/state levels to support peripheral health workers in diagnosis and management. Supervision of activities at the peripheral level should be the responsibility of general health supervisors.

7. OPERATIONAL ISSUES

7.1 Case detection and management in the Islamic Republic of Iran

Diagnosis of leprosy is done by medical practitioners based on the history, physical examination and laboratory examination of skin smear or biopsy of the lesion. Case detection is done through routine case-finding or through special surveys organized in previously leprosy endemic areas or areas without reports on leprosy during recent years. Duration of leprosy elimination campaigns was between 4 to 12 months, depending on the population size, implementation of active case-finding, availability of human resources and interruption of activities by other health programmes, like polio mopping up campaigns. During 2000–2004, leprosy elimination campaigns were organized in the provinces of West Azerbaijan, Hamadan, Fars, Kordestan, Qazvin and Kermanshah. In total, 63 new leprosy cases were detected.

In 2004, a special action project for the elimination of leprosy (SAPEL) was conducted in the previously leprosy endemic district of Minab in Hormozgan province, which is located in the south of the country and has a population with low socioeconomic status and difficult access to health services. During the project, 145 families were investigated, 20 suspected cases were identified and 3 new leprosy cases were diagnosed. Treatment of cases was provided at the nearest health centre to places of residence, if it was acceptable to the patients, since many cases prefer to get their treatment in places far from their houses, even in other districts. The duration of treatment was done according to WHO guidelines, but some dermatologists continued the patient’s treatment course upon the results of their smear examination at the end of the 12th month of treatment.

7.2 Monitoring of detection of leprosy cases in Egypt

Proper supervision and monitoring of fieldwork is done by the senior staff of the programme. A standard system of recording is followed in all leprosy clinics. Statistical reports are collected from the leprosy units by medical and paramedical supervisors during field visits and sent to the central office of the national programme in the Ministry of Health and Population. These reports are reviewed and recorded on a computer system. The data are analysed by the manager of the programme, and the positive and negative aspects of reports are discussed in detail during an annual meeting of doctors, nurses and social workers. Annual reports are used for preparation of the leprosy situation at subnational and national levels.
7.3 Community awareness in south Sudan

Community awareness is defined as the process of providing the community with accurate information about the diseases affecting them and availability of services that can be used to manage the disease. Community awareness is promoted by national programmes in order to: encourage community members who have the disease to report themselves to available services; enable the patient to understand the disease, including its etiology, transmission, clinical presentation, diagnosis, treatment and side effects, and complications; promote patient adherence to treatment to reduce defaulting; reduce stigmatization and discrimination against patients or their families; and educate patients about their rights and the rights of their families.

Awareness creation can be done in health institutions where patients go to get health services. This is directed to both patients and their families. It can also be done in the community by health workers when they follow up patients or organize community awareness meetings. This is important for reduction of stigma and discrimination against cases in the community. Awareness is important for decision-makers and leaders so that they can introduce laws against discrimination.

The traditional system for creation of community awareness has always been production and distribution of simple printed IEC materials that can be translated into local languages. However, the disadvantages of this method are that many people in developing countries may not be able to read or understand the messages, they may not be distributed widely and often the national programmes experience lack of resources to develop IEC materials. The use of mass media can be effective if people have access to radio, television and newspapers. The obstacle for wide use of media for health education is the cost of radio/television airtime and space in print media.

Interpersonal communication allows discussion of different aspects of the disease with patients, their family members or the community in general. This is important because it creates a mutual understanding between the patient and the health worker and allows the patient, family members or the community to ask questions and have a dialogue with the health worker.

Integration of leprosy into primary health care services means that leprosy awareness can also be integrated into the health education programmes of other diseases, including malaria, tuberculosis and HIV/AIDS. Interpersonal communication can be improved through organization of integrated community awareness teams that can educate communities in the rural areas.

7.4 Strengthening partnership in leprosy control in Pakistan

The current partners in leprosy control activities in Pakistan include the Federal Ministry of Health, provincial governments and their district health authorities, international donors, namely WHO and German Leprosy and Tuberculosis Relief Association, national nongovernmental organizations, communities and patients. The nongovernmental
organizations are running the referral hospitals for leprosy and are responsible for the training, logistics and technical expertise in the national programme.

Further strengthening of partnership in leprosy control in Pakistan is needed in order to increase sustainability of leprosy control activities, maintain leprosy at very low prevalence rates, improve early case-finding and reduce disabilities among new cases. In order to achieve these objectives, the national programme should maintain leprosy control activities according to national guidelines, integrate leprosy into concepts of basic dermatology, develop IEC programmes for primary health care staff and initiate community programmes in difficult to reach areas. Lobbying for continued political commitment to control leprosy should be maintained. It is also important to maintain national and provincial, and create district, boards on leprosy control, as well as to work with relevant government departments, such as the Zakat and Social Welfare Department.

The main challenges are to maintain knowledge and experience in leprosy management under very low prevalence conditions, to establish referral links for skin diseases between district and provincial levels, to achieve appropriate coverage of the female population and to maintain community awareness on leprosy.

7.5 Referral system in Yemen

The referral process is defined as sending the patient, who cannot be treated at the lower level health facility, to the higher level facility for treatment. In general, leprosy cases that can be dealt with in the same health facility with lesser cost must not be referred. Suspected cases are kept in the register for confirmation of diagnosis by the leprosy supervisors and then provided with MDT treatment and health education.

Leprosy cases are referred to district hospitals when the lower level health facilities do not have capacity to deal with them. At the district level, the patient should not stay longer than the time needed for diagnosis and start of MDT treatment. Information about the referral case is sent back for follow-up treatment at the peripheral level health centre and dermatology services. The leprosy case is registered in the district register. The treatment of cases is followed up during the quarterly supervision visits by district or governorate leprosy coordinators. The skin and venereal diseases hospital in Taiz is the main referral hospital for the treatment of leprosy and its complications.

8. PLANS OF ACTION FOR 2006–2007

8.1 Afghanistan

- Appointment of a national focal point in the Ministry of Public Health for promotion and coordination of leprosy control activities in the country.
• Establishment of a coordination board on leprosy control with representatives of the Ministry of Public Health, Maiwand Hospital, nongovernmental organizations, WHO and other organizations.

• Development of national guidelines for training of primary health care staff on leprosy control.

• Preparation of a national manual for primary health care staff on leprosy case management, recording and reporting of data. The Ministry of Public Health should be responsible for collecting relevant information from all health facilities, including those run by nongovernmental organizations.

• Sustainable provision of MDT drugs to all parties working in control of leprosy. Proper monitoring of MDT supplies will be carried out by Ministry of Public Health with assistance from nongovernmental organizations.

• Design and printing of appropriate health education materials.

8.2 Egypt

• Contact examination surveys in three provinces (Kafr El-Sheikh, Sohag and Qena).

• Thirty (30) training courses for primary health care physicians and 25 training courses for primary health care nurses in provinces of Kafr El-Sheikh, Sohag, Qena, Manufia and Qaliubiya.

• Three training courses for dermatologists on diagnosis and treatment of leprosy and management of reactions in three provinces.

• Twelve training courses for social workers on leprosy awareness at the community level in endemic villages in Assiut, Sohag and Qena provinces.

• Organization of seminars for community leaders on leprosy control in Assiut, Sohag and Qena provinces.

8.3 Islamic Republic of Iran

• Provision of health education to communities, patients and members of their families through television/radio programmes, production of posters, pamphlets, video tapes and DVD films.

• Training of primary health care physicians, disease control staff, skin/infectious diseases specialists and laboratory technicians in diagnosis and treatment of leprosy.

• Organization of two joint meetings and three field visits with welfare and rehabilitation organization.
• Implementation of leprosy elimination campaigns in four provinces.
• SAPEL projects in two provinces.

8.4 Morocco

• Evaluation of the present national policy on treatment of leprosy.
• Development of strategy for integrated control of leprosy within primary health care.
• Leprosy registers of the national programme and nongovernmental organizations will be updated.
• Data on leprosy cases will be computerized.
• Training seminars for provincial health supervisors on IEC in leprosy will be conducted.
• Information campaigns on leprosy will be organized during celebration of World Leprosy Day.
• Contact examination surveys will be carried out in Chefcaouen, Larache and Sidi Kacem provinces.
• Training courses on leprosy management for primary health care staff will be organized in six provinces (Larache, Chefchaouen, Sidi Kacem, Oujda, Taza and Boulemane).

8.5 Pakistan

• Leprosy control activities will be carried out according to national guidelines.
• Sustainability of leprosy control will be achieved through integration with national blindness and tuberculosis control programmes.
• Leprosy will be integrated into basic dermatology in special action programmes (skin camps).
• All previously hyper-endemic leprosy areas will be covered with special action programmes (skin camps).
• High quality training in leprosy for dermatologists will be organized.
• Contact check-up of registered cases will be carried out.
• Leprosy will be included in the syllabuses of all medical schools.
8.6 Somalia

- Establish referral centres for treatment of leprosy and complications in each major geographical region.
- Continue to address the socioeconomic needs of the patients.
- Continue health education through training workshops, media campaigns and other channels of information dissemination.
- Assist new partners in integration of leprosy control activities into their health programmes.
- Provide training on leprosy for primary health care staff in the South Central region.
- Prepare and print of posters in the local languages.
- Expand partnership network to cover new areas.

8.7 Sudan

- Organization of 10 orientation training courses for paramedical staff, 7 refresher courses and 5 seminars for doctors on leprosy diagnosis and case management.
- Organization of 40 seminars on leprosy awareness for community leaders.
- Continuous training of patients on disability prevention and provision of drugs for treatment of reactions.
- Support for the activities of rehabilitation centres in El Fulla, Genna and Damazin.
- Strengthening of supervision.

8.8 South Sudan

- Continue integrating leprosy activities into the primary health care programme.
- Building capacity of health workers in diagnosis and treatment of leprosy through sustained training.
- Strengthen managerial capability of Ministry of Health staff in leprosy control.
- Provide effective advocacy campaigns to communities.
- Strengthen the monitoring and supervision system.
8.9 Yemen

- Organize special workshop on integration of leprosy services with general primary health care system.
- Continue training of primary health care doctors, paramedical and medical students on leprosy suspicion, diagnosis and treatment.
- Maintain the activities of contact examination in each leprosy clinic for all newly detected cases.
- Strengthen communication with private health services for referring suspected leprosy cases.
- Organize active case-finding in targeted districts and sub-districts.
- Provide simplified guidelines and materials for the health units on suspected leprosy.
- Conduct 20 health education campaigns in rural and urban areas to create awareness on leprosy.
- Continue activities on prevention of disabilities among patients and training of primary health care staff.
- Maintain the ongoing social rehabilitation programme.

9. RECOMMENDATIONS

Based on the WHO Global Strategy for Further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities (2006–2010), this regional meeting recommends the following:

1. Each programme should develop and identify referral systems that will be able to support the general health services. These referral services should be integrated within the general health services, for example within dermatology, to ensure sustainability.

2. Leprosy control should be included in the biennium workplan between WHO and governments.

3. The provision of quality services to leprosy patients in low-endemic and underserved areas and populations should be ensured through the general health care system.

4. Programmes should ensure provision of proper counselling services and long-term care for patients suffering from chronic complications and leprosy reactions.
5. All programmes should ensure equitable provision of leprosy services without discrimination.

6. Supportive working arrangements between all partners should be maintained at national and sub-national levels to ensure sustainability of leprosy services.

7. National programmes should assess the magnitude of the disability burden due to leprosy and develop locally appropriate home/community-based strategies for prevention of impairments and provision of rehabilitation.

8. Information, education and communication within communities should be further strengthened in order to reduce stigma and discrimination against affected persons and their families.

9. Surveillance systems should be established to monitor and deal with relapses and the possible emergence of drug resistance.

10. Leprosy control services in Afghanistan, Somalia and south Sudan need to be further strengthened and supported by all partners.
Annex 1

AGENDA

1. Opening session
2. Global situation on leprosy control
3. Regional situation
4. Country presentation
5. Global strategy for further reducing the leprosy burden
6. Sustaining leprosy control activities
8. Recommendations
9. Closing session
Annex 2

PROGRAMME

Sunday, 4 September 2005
08:30-09:00 Registration
09:00-10:00 Opening Session
    Message from Dr Hussein A. Gezairy, Regional Director, WHO/EMRO
    Message from H. E. The Minister of Public Health and Population, Yemen
    Introduction of participants
    Election of chairman and rapporteur
    Adoption of agenda and programme of work
10:00 – 11:00 Objectives of the meeting, Dr N. Neouimine, WHO/EMRO
11:00 – 12:00 Global status of leprosy control, Dr Myo Thet Htoon, WHO/HQ
12:00 – 13:00 Regional Situation, Dr N. Neouimine, WHO/EMRO
13:00 – 17:00 Country situations

Monday, 5 September 2005
09:00 – 10:30 Presentations from nongovernmental organizations: Afghanistan, Pakistan, Somalia, south Sudan, Yemen.
10:30 – 11:30 Global strategy for further reducing the leprosy burden
    Dr Myo Thet Htoon, WHO/HQ
11:30 – 13:00 Sustaining leprosy control activities, Dr Myo Thet Htoon, WHO/HQ
    Building capacity among health care providers, Sudan
    Reaching special population groups, Somalia
    Improving community awareness and reporting, south Sudan
    Strengthening partnership between government, nongovernmental organizations and communities, Pakistan
13:00 – 17:00 Preparation of plans of action for 2006–2007

Tuesday, 6 September 2005
09:00 – 10:30 Discussion on national plans for 2006–2007
10:30 – 13:00 Operational issues
    Case detection and management, Islamic Republic of Iran
    Monitoring and evaluation, Egypt
    Referral services and rehabilitation of cases, Yemen
    Experience in community mobilization, Yemen
13:00 – 15:00 Conclusions and recommendations
15:00 – 16:00 Closing session
Annex 3

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