

# Meeting of Global Leprosy Programme Managers

28-29 September 2011  
WHO-SEARO, New Delhi, India



**World Health  
Organization**

Regional Office for South-East Asia

# Meeting of Global Leprosy Programme Managers

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## 1. Background

At the first meeting of Global Leprosy Programme Managers held at the WHO Regional Office for South-East Asia (SEARO), in April 2009, the Global Leprosy Programme developed the Enhanced Global Strategy for further reducing the disease burden due to leprosy 2011-2015. In October 2010, the Eighth Expert Committee Meeting on Leprosy was held in Geneva which recommended that the programme should aim to reduce the occurrence of new cases with grade-2 disabilities/impairments to a level below one per million population at the global level. In addition, as an interim goal, the Expert Committee also endorsed the target set by the Enhanced Global Strategy of reducing by 35% the rate of new cases diagnosed with grade-2 disabilities/impairments per million population by the end of 2015.

Although the implementation of the Enhanced Global Strategy has already started in the Regions and endemic countries, certain aspects of the strategy need further refining and understanding by the national programmes. Therefore, the following main objectives were set for the current meeting of programme managers:

- To introduce key activities outlined in the Enhanced Global Strategy, and
- To review key indicators for monitoring progress at the national levels.

## 2. Inaugural address

In his inaugural address, Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, welcomed the participants with a special mention for Mr Yohei Sasakawa, WHO Goodwill Ambassador, and Chairman of the Nippon Foundation, Tokyo, Japan. In this connection, Dr Samlee paid rich tribute to Mr Sasakawa's laudable efforts in addressing the issue of stigma and discrimination faced by leprosy-affected persons and their families. Mr Sasakawa's untiring efforts in promoting the "human right" of these persons are highly commendable indeed.

Dr Samlee expressed appreciation for the commitment shown by the national programmes and generous support from partners, because of which the Global Leprosy Programme has been able to achieve, to a large extent, the goal set by the Forty-Fourth World Health Assembly in 1991 that was to put to an end to leprosy being a public health problem.

Dr Samlee cautioned that although almost all countries had achieved the leprosy prevalence rate of less than one per 10 000 population more work remained to be done in leprosy control. After elimination, leprosy was still endemic but at a low prevalence rate. "We need to be sure that leprosy will not return to become a public health problem

again. Furthermore, the achievement in reducing leprosy prevalence rates at sub-national level especially in big countries, are not uniform. There still are pockets where the rates are higher than one case per 10 000 population. More efforts need to be energetically exerted to further reduce the leprosy disease burden. The “Enhanced Global Leprosy Control Strategy: 2011-2015”, if successfully implemented will help to sustain the achievements gained in the past, and help to further reduce the disease burden due to leprosy. Leprosy patients throughout the world are now receiving free MDT drugs for their treatment. The numbers of new cases are decreasing globally every year. Under the Global Leprosy Programme, over 15 million leprosy patients have been cured with MDT. In addition, by promoting “early case finding” and “timely treatment”, an estimated 2-3 million people have been protected from getting disabled due to leprosy” Dr Samlee added.

Further commenting on the positive achievement of the programme, Dr Samlee said that awareness and understanding about leprosy had been increasing in the communities. “This situation will help reducing fear of the disease — the fear that leads to social stigma and discrimination against affected persons and their families. People are now aware that leprosy can be cured, they know that free treatment is available for them, and they come forward for it. Leprosy control activities are increasingly being integrated into general health services. This will help in ensuring the most efficient use of available resources for leprosy control. The programme’s effort for integration ensures long-term sustainability of quality services for leprosy-affected people.” Continuing with the theme of integration, Dr Samlee suggested that to a large extent, the primary health care (PHC) approach is the main tool in community-based leprosy control activities. This approach has led to increased coverage of leprosy services, including “rehabilitation”.

On the issue of the main challenges facing the programme, Dr Samlee said that despite all-out efforts, over 240 000 new cases of leprosy occur each year. “We have to ensure that these new cases are diagnosed early and treated promptly. The best care needs to be provided to leprosy-affected people with disabilities and impairments — people who face unbearable social and economic consequences. Our ultimate goal in leprosy control also includes an assurance that affected people will be able to perfectly integrate into the society, and will be able to lead a normal and productive life in the community. As the disease burden continues to decline, the programme will have to face more challenges for leprosy control. Such challenges will be both technical and managerial, with some of these challenges being more difficult to tackle. Political commitment at both national and international levels needs to be maintained at a high level, at least in order to ensure sustained quality leprosy services, in both treatment and rehabilitation. Collaboration among all stakeholders and partners needs to be further strengthened to ensure the required support to the national programmes. In the light of the current global economic down-turn, financial resources for leprosy control activities may be more difficult to mobilize. Therefore, programme activities will need to be strategically prioritized in order to ensure the most efficient and effective use of available resources” Dr Samlee stated.

Commenting on the recommendations made by the Eighth Meeting of the Expert Committee on Leprosy, Dr Samlee said that the Committee emphasized the crucial importance of early “case finding” and “prompt treatment”. Early case finding and prompt treatment are recognized as the “main interventions” of leprosy control programmes to limit “morbidity” and “disabilities”. The Expert Committee also recommended setting up of a goal to reduce “grade-2 disabilities” among new cases to less than one per one million population by 2020. This recommendation should invigorate efforts at improving the case finding activities and help in evaluating the progress towards this long-term goal. Indicators for monitoring the progress need to be effectively identified for the purpose.

Dr Samlee provided future directions to the programme and suggested that more efforts are needed for “primary prevention” of leprosy. There is a dire need for more “investment” in prevention of disabilities and in rehabilitation. Rehabilitation services should be provided for both “physical” and “psychosocial” aspects. There is an urgent need to carry out research with the view to having better drugs, better treatment regimen, and better management of leprosy control programmes. There is a need to critically review our achievements and the lessons that we have learnt and refine/re-strategize our roadmap for future collaborative endeavours in the pursuit towards the ultimate goal of a “Leprosy-Free-World”.

### **3. Address by WHO goodwill Ambassador, Mr Yohei Sasakawa**

Mr Sasakawa said that probably leprosy is gradually losing priority in the health service agenda. In India, the number of new cases is decreasing only very slowly. In Indonesia, there is some cause for concern. In Africa, which the Ambassador visited recently, there are ongoing challenges. The need to maintain quality leprosy management in all these places remains imperative. The elimination of leprosy does not mean we have eliminated all problems related to leprosy. We continue to see significant numbers of new cases around the world. People are still suffering from disabilities, stigma and discrimination as a result of the disease. Much work remains to be done, on both the medical and social fronts, to alleviate the suffering caused by leprosy. This is our ongoing mission. On the issue of remaining challenges, Mr Sasakawa said that there are still some difficult problems faced by the programmes. These include the slow decline in the number of new cases, the existence of high endemic leprosy hotspots and difficult-to-reach places, and the high rates of disability among new cases in some countries. Yet, in many countries, leprosy is a fading priority. This is compounded by dwindling expertise and resources. As WHO Goodwill Ambassador, Mr Sasakawa said that he has been calling on political leaders and urging them to maintain leprosy as a public health priority. However, because of competing programmes, “we will have to use our ingenuity to come up with strategic and creative approaches based on the needs of the country or region, for example, hard-to-reach areas, urban slums, and tribal or

nomadic populations, where the disease could be highly endemic. In such situations, it is imperative that we identify the targets and customize each approach according to the circumstances," he added.

Further, supporting the new target set by the Enhanced Global Strategy, Mr Sasakawa emphasized that in order to bring about reduction in new cases with visible disability we will need to find more effective methods to strengthen early case detection and completion of treatment with MDT. "If we can ensure early detection and appropriate treatment, then the number of cases with visible disability will decline. If disabilities are not obvious, the general public will have less reason to discriminate, which, in turn, helps people to voluntarily present themselves for diagnosis. It is our joint effort that will make a difference to people's lives," he said.

In communities where people neither read nor have a radio or television, for example, street performances and dramas can be an effective tool to spread correct information about leprosy. Fortunately, with the WHO guidelines in place, it has become much easier for people affected by leprosy to get involved in assisting in early detection and education. Mr Sasakawa hoped that all concerned countries will find ways to put into practice the WHO guidelines for greater involvement of people affected by leprosy.

In addition to the medical aspects, the Ambassador also emphasized the importance of paying attention to the social aspects of leprosy. In the long history of leprosy, a common response has been to cast out those with the disease. Abandoned by their own families and communities, it was as if a person ceased to exist. There were many mistaken beliefs about the disease – that it was highly contagious, hereditary, heaven's punishment – and these took root in the public mind. Because such beliefs are so deeply ingrained, people affected by leprosy continue to face rejection, exclusion and other forms of discrimination, even after they are cured. Removing the stigma and discrimination associated with leprosy is not an easy task. It is a complex challenge, but we must not hold back our efforts if we are to see a world free from leprosy. In this regard, Mr Sasakawa suggested putting in place three strategies:

- (1) The first is an attempt to sensitize the international community through focusing attention on leprosy as a human rights issue. This has been done by making political appeals to international organizations and national governments to take action.
- (2) The second strategy is to build general awareness and transform social perception and understanding of leprosy through initiatives such as a Global Appeal.
- (3) The third is to empower people affected by leprosy themselves so that they become the primary stakeholders in this medical, social and psychological fight against leprosy.

Regarding the first strategy, in 2003, Mr Sasakawa approached the Office of the United Nations High Commissioner for Human Rights in Geneva. Many years of lobbying later, in December 2010, the United Nations General Assembly in New York

unanimously adopted a resolution on the “Elimination of discrimination against persons affected by leprosy and their family members,” along with accompanying principles and guidelines. This is a historic achievement. “But discrimination and stigma will not disappear of their own accord, just because of this resolution. Tackling the discrimination associated with leprosy requires a united front. Only when NGOs, governments, international organizations, and the people affected themselves join hands, can we hope to end discrimination and restore dignity”, Mr Sasakawa said.

Regarding the second strategy, the annual Global Appeal was launched in 2006. It calls for an end to stigma and discrimination against people affected by leprosy. Over the years it has been signed by world-renowned leaders including several Nobel laureates, leaders of leprosy-affected individuals, rights-based NGOs, faith communities, CEOs of major corporations and leading universities. Each Global Appeal has been disseminated and distributed worldwide. Global Appeal 2012 is to be signed by medical associations. Mr Sasakawa hoped that it will serve to sensitize our partners – medical doctors – and help to tackle the discrimination against persons with leprosy that sometimes exists in healthcare facilities.

Thirdly, Mr Sasakawa has given his support to empower people affected by leprosy so that not only do they reclaim their dignity but also become agents of change, standing up and challenging the injustices they have suffered. For example, Mr Sasakawa helped to establish a National Forum of people affected by leprosy in India. The National Forum provides a common platform from which affected persons can speak out and make their voices heard, and upon which they can join together in actively working to reclaim their dignity and human rights.

Mr Sasakawa cautioned that considering the medical and social challenges that remain, we must guard against complacency, or the disease will come back. “There is still much work to be done. We must improve operational factors to ensure that every new patient is diagnosed early and treated promptly. We must be humble enough to review our activities and ask what we could be doing better. By working together, we can move forward with purpose and achieve our goals” Mr Sasakawa added.

The participants nominated the following to conduct the meeting:

**Chairperson:** Dr H.J.S. Kawuma (Uganda),

**Co-Chair** – Professor Zhang Goucheng (China)

**Rapporteurs-** Dr (Mrs) Nguyen Thi Van (Viet Nam) and Ms Neesha Nasir (Maldives).

## 4. Session 1: Reducing stigma and discrimination

### 4.1 Leprosy-related stigma and discrimination: current situation and new tools to address stigma (*Dr Wim van Brakel*)

Dr. Wim van Brakel suggested that stigma can be seen from two perspectives:

- (1) The people who are stigmatized (anticipated or perceived stigma, internalized or self-stigma and experienced stigma or discrimination), and
- (2) The stigmatizers (enacted stigma or discrimination and perceived stigma – such as fear of the disease, symbolic stigma due to association and stereo type stigma).

Stigma leads to participation restriction, social exclusion and poor quality of life. Impact of stigma on people has been examined from several stigmatizing conditions besides leprosy, such as mental illness, epilepsy and HIV/AIDS, all showing significant similarities. These manifest as:

- Stress, anxiety and depression
- Problems in getting married
- Problems in social relationships
- Problems with employment
- Problems with education
- Leads to concealment of the disease
- Leads to isolation
- Increases gender differences, and
- Increases disabilities/impairments.

Leprosy-related stigma also impacts on public health programmes adversely by:

- Causing delay in presentation to health centre
- Untreated cases continuing transmission of infection
- Late presentation leads to more severe disease needing more expensive treatment
- Poor adherence to treatment and default
- Increased risk of developing drug resistance
- Affecting credibility of public health services.

The profile of stigma in the community was illustrated from a study in five districts of Indonesia which clearly showed that stigma exists in the country. In India, there is stronger stigma associated with HIV/AIDS than with leprosy. In addressing stigma, one

single strategy will not be sufficient to address all aspects. Anti-stigma strategies have to be developed considering the affected persons, their families, the community in general, institutions and society. Dr Brakel referred to a study in India in which stigma scores were used to demonstrate that in affected persons with no visible signs (of leprosy), the stigma score remained low with or without rehabilitation, whereas in persons with visible signs, stigma scores improved after rehabilitation of the affected person. A three-year evaluation of the project on stigma elimination conducted in Nepal showed a decrease in participation restriction both in persons with or without visible disabilities/impairments. Dr Brakel listed current and recent initiatives in the area of stigma reduction and the latest available reference materials from ILEP on the subject.

The following points emerged during the discussion:

- Emphasis on involvement of affected people
- The need to get stakeholders committed to stigma reduction efforts
- Involvement of affected people currently seems to be restricted to the level of implementation of programmes; this is not enough; wish to be involved at all stages.
- Examples from Nepal show positive results from involvement of journalists and of counselling at the community level
- Programme managers are requested to work towards ratifying the UN convention at national level and to use this as a tool for advocating for resources
- Important role of positive IEC materials, especially avoiding showcasing any form of deformity/disfigurement.

#### **4.2 Social and economic aspects of leprosy; approaches to address the issue (Dr P.K. Gopal)**

Dr. Gopal thanked the organizers for making it possible for affected persons to participate in the important meeting. He indicated that fear of the disease/leprosy - existed in all cultures and is responsible for stigma and discrimination; where there is no fear there is no stigma and no change in the social and economic position of affected persons. Leprosy as a disease interferes and disrupts the process of socialization in a significant proportion of affected persons. For some the disruption is for a short period and for others it is a life-long disruption. Not all leprosy affected persons need rehabilitation. A country-wide survey in India revealed that only 34% of affected persons need some form of social and/or economic assistance. It is, therefore, important to select the leprosy-affected persons who need assistance. Dr Gopal categorized people affected by leprosy into the following six categories and indicated that strategies for addressing their needs must take the differences into account:

- (1) Have no deformity and have no social or economic problems. Leading a normal life.
- (2) Have deformities, but have no socio-economic problems, leading a normal life.
- (3) Have no deformities, but have socio-economic problems simply because they had leprosy.
- (4) Have deformities and their social and economic life is under threat of dislocation.
- (5) Have deformities and their social and economic status is already dislocated (are rehabilitated).
- (6) Have aged and have reached a state of destitution because of severe deformities and the result of prolonged suffering following dislocation of their social and economic status.

Dr Gopal made the following suggestions to address the issue of dislocation of social and economic status:

- The patient should come for treatment at the early stage to avoid the risk of developing deformity/impairment.
- Participation of affected persons in leprosy services for early case detection, counselling and others should be strengthened.
- The World Health Organization should play a pro-active role in sensitizing national governments and NGOs to develop strategies for improving the socio-economic status of people affected by leprosy.
- National governments should identify existing groups or organizations of persons affected by leprosy and enable them to work for elimination of stigma and discrimination.
- Programmes for socio-economic rehabilitation should be encouraged by governments and NGOs. Affected persons must make the best use of such opportunities.
- The UN resolution ending discrimination against persons affected by leprosy should be implemented by all governments.
- Children of leprosy patients should be assisted to obtain education and employment opportunities; this will lead to improvement of the socio-economic status of the families in the long term.
- The newly developed guidelines by ILEP on stigma reduction should be implemented. There is need to translate the guidelines into local languages.

During the discussion the following suggestions were made:

- Affected people have many unanswered questions. They must be given an opportunity to express their views and suggestions in meetings like this.

- Approaches should be developed to address needs beyond the affected people themselves, for example, the need to ensure education and employment of their children.

In summary, Dr Gopal reiterated that the cure from leprosy will remain incomplete until the affected person regains the social and economic status that allows him/her a dignified life.

### **4.3 Counselling: its role in reducing stigma and discrimination (Mr. Sophea Leng)**

The presentation was mainly based on the work of Kien Khleang Leprosy Rehabilitation Centre (KKLR). Mr Leng said that counselling is a process of supporting those in a difficult situation so that they can solve their problems themselves. In counseling we should identify the clients and help them to express their worries, strengthen their personalities and ways to find good solutions and other support to solve their problems. He highlighted the following benefits from good counselling programmes:

- Enable clients to identify their problems and needs.
- Help clients to express their worries.
- Help clients to express problems related to their personal experience.
- Help clients to get out of their past “terrible experience”.
- Help clients strengthen their personalities.
- Help to find good solutions or suitable support.

Mr Leng presented illustrations of how counselling had led to increased participation in society and helped clients to face society with more confidence.

The discussion following the presentation recommended the following:

- Involving affected persons also as counsellors.
- There is a need to repeat interventions to obtain successful results.
- Counselling also has a positive impact on reducing stigma and discrimination
- Use of sign language to be considered in appropriate situations.
- Counselling should also aim at:
  - decreasing the need to gather in special institutions or settings e.g. leprosaria, and
  - encouraging treatment in the family setting.

## **5. Session 2: Reducing the disease burden**

### **5.1 Global leprosy situation and the remaining challenges**

*(Dr Myo Thet Htoon)*

A total of 130 countries had submitted reports to WHO at the beginning of 2011 on their country/territory situation. There were 36 countries reporting from the WHO African Region, 27 from the Region of Americas, 10 from the South-East Asia Region, 22 from the Eastern Mediterranean Region and 35 from the Western Pacific Region. Thirty-seven countries that had reported in the past did not do so this time, but based on historical information they would not contribute more than 1%-2% of the burden. Mid-year population data for 2010 published by the United Nations Department of Economic and Social Affairs/Population Division were used to calculate the rates.

The number of new cases detected during 2010 as reported by 130 countries was 228 474 (a case detection rate of 3.93/100 000). The registered prevalence globally at the beginning of 2010 was 192 246 (prevalence rate of 0.34/10 000). The number of new cases detected annually continues to show a decline in all the Regions except for the Eastern Mediterranean Regions. Increased coverage along with provision of better services in Southern Sudan is the main reason for detecting more new cases in the Eastern Mediterranean Region. The proportion of cases with MB leprosy among new leprosy cases in the African Region ranged from 61.72% in the Democratic Republic of Congo to 99.21% in Kenya. In the American Region, it ranged from 41.91% in Brazil to 83.06% in Cuba and in the South-East Asia Region it ranged from 42.33% in Bangladesh to 80.96% in Indonesia. In the Eastern Mediterranean Region, the proportion of new cases with MB leprosy ranged from 61.95% in Yemen to 88.38% in Egypt. In the Western Pacific Region the proportion ranged from 29.67% in Kiribati to 93.92% in the Philippines.

The proportions of females among newly detected cases of leprosy in the regions are as follows: in the African Region it ranged from 20.11% in Mali to 48.44% in Burkina Faso. In the Region of Americas it ranged from 24.86% in Argentina to 46.53% in Dominican Republic and in the South-East Asia Region it ranged from 33.24% in Myanmar to 44.35% in Sri Lanka; in the Eastern Mediterranean Region it ranged from 35.74% in Egypt to 42.94% in Sudan and in the Western Pacific Region it ranged from 13.64% in the Marshall Islands to 45.60% in Kiribati. The proportion of children among new cases of leprosy in the regions was as follows: in the African Region it ranged from 1.34% in Niger to 17.43% in Liberia; in the Region of Americas it ranged from 0.85% in Argentina to 16.67% in Dominican Republic; in the South-East Asia Region it ranged from 5.46% in Bangladesh to 11.20% in Indonesia; in the Eastern Mediterranean Region it ranged from 6.06% in Pakistan to 18.29% in Yemen; and in the Western Pacific Region it ranged from 2.95% in China to 44.55% in the Marshall Islands.

The grade-2 disability rate recorded at the end of 2010 (0.23 per 100 000) is the one targeted for reduction by 35% by 2015. So far this is showing a very slow decline. The proportion of new cases with grade-2 disabilities in the regions was as follows: in the African Region it ranged from 4.89% in Cameroon to 21.64% in Madagascar; in the

Region of Americas it ranged from 13.01% in Paraguay to 3.23% in Plurinational State of Bolivia; in the South-East Asia Region it ranged from 2.82% in Nepal to 14.81% in Thailand; in the Eastern Mediterranean Region it ranged from 7.37% in Yemen to 22.81% in Sudan; and in the Western Pacific Region, Marshall Islands reported 0% grade 2 disabilities among new cases and China reported 22.51%. The global rate of new cases with grade-2 disabilities per 100 000 population was 0.23. Over 13 000 new cases with grade-2 disabilities were detected globally during 2010. In 2010, the rate of new cases with grade-2 disabilities ranged between 0.03 in the Western Pacific Region to 0.40 per 100 000 population in the African Region. Annually 2000 – 3000 relapses are reported to WHO. A total of 2113 relapse cases were reported in 2010, which was less than what was reported in 2009 (number reported 3120) as Brazil did not report relapse cases in 2010.

Timor-Leste achieved the goal of elimination of leprosy as a public health problem (defined as a registered prevalence of less than 1 case per 10 000 population) during the last quarter of 2010. Southern Sudan reported a registered prevalence of 5 629 cases at the end of 2010 and 1 565 new cases were detected during 2010. This has contributed to the high registered prevalence reported for Sudan as a whole. More and more countries are reporting cure rates except countries in the African Region. A wide variation is seen in the cure rates between countries in the Regions and also between MB and PB cure rates.

In conclusion, Dr Htoon said that due to the sustained efforts carried out by the national programmes along with the continued support from various partners both national as well as international, the disease burden due to leprosy continues to decline globally. It is important that all endemic countries continue to maintain the current declining trend of the disease. With the implementation of the Enhanced Global Strategy 2011-2015 which places emphasis on reducing grade 2 disabilities among new cases, it is now important that cases are detected early and that patients complete the course of treatment with MDT in a timely manner and are cured. Improved management of complications by means of effective referrals services and increased community awareness about the disease so that cases self-report for diagnosis at an early stage will further help to reduce the disease burden. In collaboration with partners and associations of persons affected by leprosy it is expected that the issues relating to stigma, discrimination and rehabilitation can be tackled in a more integrated and inclusive manner.

The discussion following Dr Htoon's presentation raised the following issues:

- Only 8% of countries reported treatment completion rates in 2010; in future treatment outcome data should be given priority.
- From the African Region, there are concerns about regularity of treatment; the treatment completion rate without allowing for the extension (to nine months for PB and 18 months for MB) appears to be low.
- There were concerns about the non-availability of data on psychosocial aspects of leprosy

## **5.2 From strategy to implementation: Enhanced Global Strategy 2011-2015 for further reducing the disease burden due to leprosy (Dr V. Pannikar)**

Dr V. Pannikar said the current global strategy is the continuation of WHO's earlier strategies for leprosy control and elimination. During the 1950s, with the introduction of dapsone, the institutional treatment approach changed to domiciliary treatment of patients. With the introduction of multidrug therapy (MDT) in the 1980s, and its widespread implementation in the 1990s, a more ambitious concept of eliminating leprosy as a public health problem was introduced. The elimination strategy aimed at reducing the prevalence of cases registered for treatment to less than one case per 10 000 population at the global level. The goal was reached at the global level in 2000 and at the national level in most of the endemic countries in 2005. Since 2006, two more strategies for controlling leprosy were launched. The current one being the "Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy 2011-2015". Both these strategies focus on reducing the disease burden in terms of reducing the occurrence of new cases and occurrence of grade-2 (G2D) impairments and disabilities. In addition to reducing the occurrence of new cases and physical impairment and disabilities in new cases, the emphasis is on ensuring sustainability and quality of leprosy services. The strategy has specifically addressed the issues such as gender equity, human rights and initiatives to reduce stigma and discrimination faced by persons affected by leprosy and their families.

The global strategy has set a target of 35% reduction per population in grade-2 disabilities among new cases, taking the rate of grade-2 disabilities among new cases registered in 2010 as the baseline. The target will be monitored at both global and national levels from 2011 to 2015. The most recently concluded Expert Committee on Leprosy in its eighth report recommended a more ambitious target of reducing the incidence of grade-2 disabilities among new cases to less than one per million population by 2020. Dr Pannikar reviewed the progress made in controlling the disease and reducing the disease burden in medical terms. However, much needs to be done to reduce the disease burden due to physical, mental and socioeconomic consequences of leprosy on the affected individuals and communities.

The major challenges currently faced are:

- (1) Removing the sense of complacency that seems to have set in control programmes after initial success.
- (2) Referral systems in most endemic countries are weak.
- (3) Developing effective tools/tests to detect cases early, including tools/tests for early recognition and management of leprosy reactions.
- (4) Much needs to be done in the field of prevention of disabilities and rehabilitation.
- (5) Sustaining basic expertise in clinical leprosy against the backdrop of declining trends.

- (6) To improve information, education and communication (IEC) components of the programme to be locally relevant, cost-effective and sustainable.
- (7) To develop alternative treatment regimens to combat the threat of drug-resistance.
- (8) To develop effective vaccines for the prevention of leprosy.

On the question of what is meant by disease burden, Dr Pannikar suggested that it could be measured in several ways such as the number of new cases reported, or the number of cases registered for treatment, or the number of cases with impairments/disabilities, or the number of children affected, or number of affected people requiring rehabilitation. Although some of these can be measured with relative ease, for others it may be difficult. Therefore, the global strategy is set to monitor the burden in terms of number of new cases reported annually and among them the number presenting with visible (grade-2) disabilities/impairments.

Dr Pannikar listed some of the key areas/activities to be addressed while implementing the new strategy:

- (1) **Underserved population:** It is important to reach persons affected by leprosy living in difficult-to-access areas or special situations, or in underserved and marginalized population groups, since the most crucial element of any leprosy control programme is to reach every person who is in need.
- (2) **Urban areas:** The major focus within urban areas should be on improving services for people living in the slums. Many health outcomes are more severe in slums than in their neighbouring urban or rural areas.
- (3) **Community awareness and education:** The IEC activities are important in early detection, early symptom/signs reporting and for changing community attitudes to leprosy and those affected by leprosy. Although IEC activities have been a key part of leprosy control activities for decades, much of IEC activity has been conducted on a limited evidence base, and there has been little effort to evaluate the effectiveness of such interventions.
- (4) **Referral system:** An integrated leprosy control programme needs the support of an efficient referral system to be effective. A referral system will play a crucial role in deciding the quality of services in an integrated leprosy control programme. Strengthening the existing referral facilities and, where necessary, creating an adequate number of such facilities to form the national referral network, should be one of the key priorities for all leprosy-endemic countries.
- (5) **Prevention, limitation and management of disabilities:** Prevention of disabilities begins with diagnosing leprosy early, recognizing and treating complications such as neuritis and reactions, identifying patients at risk of developing secondary disability and intervening in time. All patients presenting with any grade of disabilities and those at risk of developing new disabilities will need support through preventive measures such as provision of footwear, protective devices, and advice on self-care. These measures are equally relevant for persons who have already completed treatment.

- (6) **Humanitarian issues:** The disease has a strong social and psychological impact on the persons affected by leprosy (including their families) and the societies in which they live. In this regard, the programme needs to give greater attention to gender concerns and disparities. In addition, enhanced efforts will be required to ensure involvement and participation of persons affected by leprosy especially in areas of advocacy, awareness, rehabilitation and case-finding.
- (7) **Building and maintaining national capacity:** National action should be directed at identifying suitable experts and institutions and establishing training programmes for national-level experts including dermatologists and trainers. They will be an important resource for national efforts to sustain clinical expertise in leprosy.

In concluding his presentation, Dr Pannikar said that the main principles of leprosy control, based on timely detection of new cases and their treatment with effective chemotherapy in the form of multidrug therapy, will not change over the coming years. The emphasis will remain on sustaining provision of quality patient care that is equitably distributed, affordable and easily accessible. However, there is an urgent need to ensure that leprosy remains on the agenda of health planners and policy makers. In addition, the national programmes should implement the Enhanced Strategy, adapting it to their situation and reduce the disease burden in their own communities.

### 5.3 Approaches to achieve reduction in grade-2 disabilities (Professor W.C.S. Smith)

Professor Smith said that the new target for the Enhanced Global Strategy is reduction of grade-2 disability among new cases as a rate per population and not as a proportion in new cases. This target should be used to introduce more initiatives to reducing disabilities. This is important for affected people and their communities.

Professor Smith suggested three approaches to reduce grade-2 disabilities in new cases:

- (1) Prevention of leprosy
  - Improve social and economic circumstances
  - Maintain high levels of coverage with BCG
  - Consider use of single dose rifampicin in healthy, close contacts
- (2) Early case detection and treatment
  - Community awareness and early help-seeking behaviour
  - The ability of health care staff to suspect and diagnose leprosy
  - Extent of the practice of contact examination.

- (3) Activities for prevention of disabilities
  - Identification of loss of sensation
  - Patient education and self-care
  - Early detection and management of reactions.

In reiterating the importance of finding grade-2 disability in a new case, Professor Smith suggested that in such cases, the health workers should use this opportunity to explore the reasons for delay in diagnosing such cases. It will then be possible to develop solutions to prevent such delays in future.

On the issue of chemoprophylaxis, Professor Smith said that epidemiologically, it is well known that close contacts are at a higher risk of developing the disease than non-contacts or distant contacts. Therefore, at the time of diagnosing a new case, his/her contacts should be identified, examined and, if possible, given chemoprophylaxis – a single dose of 600 mg of rifampicin for an adult has shown to be safe and effective in some recent studies.

## **6. Session 3: Country presentations: intensifying case finding activities**

### **6.1 Democratic Republic of Congo (*Dr J.N. Mputu Luengu*)**

The national programme manager, Dr Mputu Luengu, described the general health system and the current leprosy situation in the Democratic Republic of Congo (DRC). The DRC is one of the high endemic countries in the African Region. The new case detection was about 5000 in 2010 of whom about 11% were children and 11% of new cases had grade-2 disabilities/impairments. The country has adopted the primary health care strategy since 1985 and leprosy control has been fully integrated into general health care services.

The programme has developed case finding strategies according to levels of leprosy endemicity. There are 515 health zones/districts which are subdivided into: high-endemic, low-endemic, urban, and areas with special communities (pygmies, cross-border patients and refugees). In high endemic zones, the strategy includes capacity building of care providers, strengthening community participation and active case finding through examination of the household contacts of new patients. Strategies for intensifying case finding in areas with special communities include capacity building for health workers in the closest health facilities and organization of leprosy days during periods when the communities are accessible. The strategy for urban zones include strengthening community awareness through media, improving capacity of urban health workers and setting up a reference network to provide MDT services. Dr Mputu asserted that intensifying case finding activities, coupled with MDT and prevention and management of disabilities will definitely lead us slowly but surely towards a world without leprosy.

## 6.2 Egypt (*Dr Salah Mohamed Abdel Naby*)

In Egypt, leprosy is integrated in dermatological services at the governorate level and sub-centres at the district level. The country achieved the elimination goal i.e. in 1994 at the national level and at the governorate level in 2004. About 700 new cases were detected in 2010 with a case detection rate of 1/100 000 and the proportion of grade-2 disability among new cases was 8%. About 51% of new cases were reported from only four governorates designated as high risk areas.

Dr Salah presented an illustration of the benefit of contact examination carried out in high-endemic governorates. He also discussed the comparative advantage of doing contact examination during home visits compared to inviting contacts to health centres for examination. The programme intends to continue investing in other interventions for improving early case detection including training of general doctors and dermatologists, nurses and social workers.

## 6.3 Thailand (*Dr Ruch Wongtrungkapun*)

Dr Ruch presented a detailed review of progress with leprosy elimination in Thailand from 1984 to 2010. The prevalence rate decreased from about 9 per 10 000 in 1984 to 0.1 per 10 000m in 2010, while during the same period, the new case detection decreased from 7 per 100 000 to 0.6 per 100 000. About 400 new cases were notified in 2010. About 78% of new cases were self-reporting and about 7% were detected from examination of house-hold contacts. On the profile of new cases, Dr Ruch said that although the proportion of grade-2 disabilities among new cases has remained almost constant at about 15% for many years, the rate of grade-2 disabilities among new cases has been decreasing, which was about 0.9 per million in 2010.

On the issue of challenges, Dr Ruch explained that after elimination the priority and political commitment has been low for leprosy. In addition, lack of awareness and skills among the medical officers and health staff is causing delays in diagnosis and misdiagnosis of leprosy cases. This has also resulted in persistence of stigma and inefficient services for prevention of disabilities.

The programme has adapted the Enhanced Global Strategy and its target of reducing the rate of new cases with grade-2 disabilities per 100 000 population by at least 35% by the end of 2015, compared to the baseline at the end of 2010. The programme has identified high-risk areas for improving case finding. The criteria for high-risk areas include areas where:

- A new case reported among children any of previous five years
- new cases reported in every year of previous five years
- cumulative 10 or more new case reported in the last five years.

Other initiatives to support intensifying case detection will include involving persons affected by leprosy in case detection in their own community, using disability surveys and using local volunteers for case finding activities.

## **6.4 Cambodia (Dr Lai Ky)**

The national programme manager from Cambodia, Dr Lai Ky explained the leprosy situation in the country. The programme is trying to detect new cases early as this will prevent transmission and reduce the risk of disabilities/impairments.

During 2010, 262 new cases were detected. Of these about 10% were reported with grade-2 disabilities, only about 20% were females and 8% were children. The programme follows both active and passive case finding strategies. Passive case finding is mainly through the use of local radio, health education posters and training health staff and the community about early clinical signs of leprosy. The active case finding method uses several special activities, such as factory surveys, contact examinations and rapid surveys in selected districts. Dr Lai Ky said that although leprosy is not a priority disease in Cambodia, the leprosy control programme is likely to continue and will be strengthened in high-endemic areas.

## **7. Session 4: Case management and strengthening of the referral systems**

### **7.1 Madagascar (Dr. Adriamira Randrianantoandro)**

Dr Andriamira, the National Leprosy Programme Coordinator of Madagascar presented the leprosy situation in the country. Madagascar has been reporting between 1500 and 1600 new leprosy cases annually during the last five years. During the first half of 2011, already 768 new cases were notified. During 2010, a total of 1521 new cases were reported, of these, about 11% were children while 22% presented with grade-2 disabilities at the time of detection. The proportion presenting with disabilities is highest in the last five-year period.

Dr Andriamira presented the current status of leprosy case management as a SWOT analysis; among others he presented the intended integration of leprosy into other health programmes as a strength, but also saw it as a threat, because when it happens, some partners have threatened that they might withdraw their support. He described referral systems and the roles of personnel at different levels (municipality, district and regional level). He also presented an outline of the current problems relating to the implementation of the referral system including difficulties experienced with transporting referred patients because of poor access, lack of funds and sometimes insecurity. It is also difficult to meet the costs of maintaining patients during their stay in the referral facilities for management of complications. In summarizing the future plans Dr Andriamira emphasized the need to maintain and strengthen the existing partnerships in order to successfully implement the plans.

## **7.2 Brazil (Dr Rosa Castalia Franca Riberio)**

Dr Rosa, the national programme manager, said that in Brazil, leprosy is more prevalent in the municipalities bordering the Brazilian Amazon. In 2010, 34 894 new leprosy cases were registered of whom 7% were children. The programme has experienced a 36% drop in new case detection over the last 10 years at the rate of about 4% per year. Treatment completion rate/cure rates are generally better for PB than MB cohorts but are on the average 82% in 2010. Grade 2 disability among new cases is about 7%; however, only 89% of new cases have a disability assessment at the beginning.

Dr Rosa described the structure of the health system and the three tiers of health service delivery (primary, secondary and tertiary) and their relevance to the leprosy control programme. The primary or basic care level is responsible for diagnosis, simplifies neurological assessment and disability assessment, examination and support to contacts, starting treatment with MDT and providing simple tools and self-care support for prevention of disabilities. At the secondary and tertiary levels, more attention is paid to management of lepra reactions, laboratory investigations, making and fitting special footwear, rehabilitation and correction of physical disabilities including surgical services, hospitalization for complications etc. Dr Rosa described existing partnerships and the roles of the different partners in the health system. The partners include organizations of leprosy affected persons. Dr Rosa presented a flow chart to illustrate the leprosy case-management and the referral system.

## **7.3 Sudan (Dr Mohamed Salah El Tahir El Samani)**

The National Leprosy Coordinator, Dr Salah described the current leprosy situation in the country. The programme detected 829 new cases during 2010 of whom 741 (90%) were classified as MB and 125 (15%) reported with grade-2 disabilities at the time of diagnosis. Most basic health centre staff only suspect and refer cases to master clinics for confirmation of diagnosis and treatment. These referral clinics have facilities to confirm the diagnosis, to manage reactions and do skin smears. Dr Salah said that the programme operations often need to be modified during the rainy season when parts of the country become inaccessible. There are “master-of-master clinics” that are established at the state level. They provide tertiary-level services, including surgical services.

In conclusion, Dr Salah identified the following priority areas for improved case management and referral services:

- Keeping expertise
- System for validation of cases and data
- Sustaining political commitment
- Sustaining motivation of staff
- Maintaining partnerships (e.g. with GLRA and WHO).

#### **7.4 India (Dr C.M. Agrawal)**

Dr Agrawal, the Deputy Director-General (Leprosy) summarized the general leprosy situation in India. India achieved elimination of leprosy as a public health problem in December 2005 at the national level. At the sub-national level, by the end of 2010, 32 out of 35 states had also reached this level. The new case detection rate is continuously declining; however, the decline is much slower in the last five-year period than in the previous years. On the other hand, the proportion of grade-2 disabilities among newly detected cases has shown a steady increase in the last five years.

Dr Agrawal outlined the referral system and the reasons for referral including: confirmation of diagnosis, management of complications and surgery. The country has established a wide network of primary health centres, district hospitals, specialized institutions and regional centres for management of leprosy and its complications. This infrastructure provides services on all days and free-of-cost for leprosy patients. In addition, the programme with NGO support has established quality control units at district levels. The treatment completion/cure rates are more than 90% for both PB and MB patients. However, the completion or cure rates are much lower in urban areas compared to rural areas.

In enumerating the remaining challenges, Dr Agrawal stated that there is a need to improve early detection of cases, reduce defaulting in urban areas and monitor quality of services. There is also poor linkage between secondary and tertiary services, including lack of specialists at referral levels. He listed a number of challenges including default especially in urban settings and the lack of dedicated staff following integration. In summarizing plans for the programme, Dr Agrawal stated that this will include systematic training of health staff, strengthening POD services and further strengthening and revising the role of many training institutions in the country.

#### **7.5 Viet Nam (Dr Nguyen Thi Hai Van)**

Dr Van, Secretary, National Leprosy Control Programme, described the national leprosy situation. Leprosy is categorized as one of the eight social diseases supported by the government since 1995. The elimination target was reached in 2000 at the national level; however, there are 19 provinces (out of 63) with a prevalence rate more than one case per 10 000 population. In addition, there are difficult-to-reach areas and populations in some high plateau and Southern provinces. During 2010, the programme reported 317 new cases, of whom about 4% were children and 19% had grade-2 disabilities at the time of detection.

Leprosy control is supported by a network of practitioners in dermatology and venereology from peripheral to national levels. The particular challenges relating to case management are:

- Wrong diagnosis and missed opportunities for case finding
- Ensuring regular availability of MDT and ensuring equitable distribution
- High staff turnover

In conclusion, Dr Van said that the programme is trying to improve the quality of MDT services and making it easily accessible and affordable to the affected people. There is a five-year plan in place to provide disability care and rehabilitation services to all leprosy affected persons, integrate them into their communities and to ensure that they have proper housing for their families. The programme is also using GIS for mapping of new cases in order to prioritize case finding activities.

## **8. Session 5: Improving quality of care**

### **8.1 Research- Final results from >20 year leprosy skin test trial in Nepal and other research developments. Is a diagnostic skin test feasible? (Prof Patrick J. Brennan)**

Professor Brennan from the Department of Microbiology, Immunology and Pathology, Colorado State University, USA reviewed the history of research initiatives for developing leprosy skin tests and origins of the present skin test antigens starting with Dharmendra and Fernandez lepromin derived from human leprosy nodules in 1919 and later to purified antigens from armadillo tissue.

The objectives of the study were based on (i) safety (measured by primary safety end points) and (ii) efficacy (measured by primary immunogenicity end points). Although, safe skin test antigens have been identified these will need large-scale testing. The unexplained anergy among BL/LL patients poses new challenges. Professor Brennan said that it also remains difficult to interpret the induration from skin tests as a measure of infection or simply immunological response. Similarly, it is difficult to differentiate between TB and leprosy as the underlying problem.

On the issue of other developments, Professor Brennan mentioned that that four *M. leprae* genome sequences (TN, Br4923, NHDP63 and Thai53) are now available. All these show remarkable similarities with 99.995% sequence identification. The *M. leprae* DNA can be grouped into four major Single Nucleotide Polymorphism (SNP) types. The progenitor strain (SNP type-2) probably originated in East Africa, this gave rise to SNP type-1 which spread eastwards with human migration into Asia, SNP type-2 also gave rise to SNP type-3 which disseminated westward into the Middle East and Europe (through trade routes), this, in turn, gave rise to SNP type-4 found in West Africa and countries linked to West Africa by slave trade (e.g. Americas).

Leprosy is endemic in some parts of the USA (Texas Gulf coast and Southern Louisiana) affecting between 100-150 new cases per year. At least 25% of new cases occur in US born citizens. The Texas Gulf coast and Southern Louisiana are also home for armadillos. On the question of whether armadillos transmit leprosy to humans, Professor Brennan said that a unique *M. leprae* genotype (3I-2-v1) was found in 28 of the 33 wild armadillos and 25 of the 39 US patients who resided in areas where exposure to armadillo-borne *M. leprae* was possible. This genotype has not been reported elsewhere in the world. Wild armadillos and many patients with leprosy in the southern United States are infected with the same strain of *M. leprae*. Armadillos are a large natural reservoir for *M. leprae*, and leprosy may be a zoonosis in the Region.

## 8.2 Prevention of disabilities: good practices (*Dr Hugh Cross*)

Dr Hugh Cross, Consultant, American Leprosy Mission, USA, said that a number of countries are implementing POD programmes. Presence of a prevention of disability component in the programme adds quality to leprosy control services. The main characteristics of countries that have optimal POD programmes are that they have:

- a person or group with responsibility for POD
- specific action plans for leprosy POD
- undertaken an assessment of the extent of leprosy-related disability
- specific plans for POD-related operational research.

As Myanmar satisfied most of the criteria and was presented as a case study and model, Dr Cross summarized the lessons learnt from the Myanmar experience and identified factors contributing to the success of the POD programme:

- Commitment of midwives
- There are specialist leprosy staff
- Strong political commitment
- Supported by ILEP partners in enabling implementers to meet patient's requirements, sent staff for further education and for experiences in other countries with good programmes
- Clear division of duties between Basic Health Staff and specialist staff.
- Implemented and used outcomes of Health Systems Research
- Involved family members; services were centered on the home
- Have a good recording and reporting system
- Have facilities for ulcer care at the local health centre.

In conclusion, it was emphasized that sustainability of such initiatives should be ensured through local and national efforts.

## 9. Session 6: Improving activities for prevention of disabilities

### 9.1 Argentina (*Dr Silvia Noemi Paredes*)

Dr Silvia, Chief, Leprosy Control Programme, presented the country profile of Argentina. In 2010 the country had reported 354 new cases, 80% of whom were MB, about 8% with grade-2 disabilities and less than 1% new cases were children. However, the registered prevalence reported is 632, which shows high P:D ratio.

Dr Silvia also described the present POD practices, the recording documents used and the related challenges. Among the challenges, she listed mainly the lack of national standards and inadequate referral system for POD. The future plans include advocating for prioritization of POD in the national policy.

## **9.2 Morocco (*Dr Abdellatif Idrissi Azzouzi*)**

Dr Azzouzi, Head, National Leprosy Elimination Programme, said that Morocco is a low-endemic country for leprosy. Therefore, it has low priority in the Ministry of Health. The programme is entirely institution based and all new cases are detected through passive methods and limited contact examinations. During 2010, only 40 new cases were reported with one child case and no new case with grade-2 disability was reported at the time of diagnosis. However, during the previous years, cases with grade-2 disabilities have been reported. The programme tries to investigate each disabled case to identify causes for delayed presentation and implement preventive and corrective measures.

## **9.3 Indonesia (*Dr Christina Widaningrum*)**

Dr Christina, national leprosy programme manager said that Indonesia has declared 2011 as Prevention of Disability Year. The programme reported more than 17 000 new cases during 2010, of which more than 80% were classified as MB, about 12% were children and 11% presented with grade-2 disabilities at the time of diagnosis.

Dr Christina suggested that for the prevention of disability programme, the following components are necessary:

- Early detection and treatment (IEC activities, availability of MDT at health centres)
- Nerve function assessment and action for preservation of nerve function (training on nerve function assessment, POD leaflets for patients)
- Management of reactions (referral systems, stocking of prednisolone and loose clofazimine);
- Self-care: working with many self-care groups, and
- Provide medical and surgical rehabilitative services.

## **9.4 China (*Professor Zhang Guocheng*)**

Professor Zhang Guocheng, Deputy Director, Institute of Dermatology and National Centre for Leprosy Control said that China has been consistently reporting the proportion of disabilities grade-2 among new cases as above 20% for more than 10 years. Dr Zhang described the reasons for developing disabilities and attributed this to the delay in detection and low quality of case management. If reaction and neuritis are detected very late, it can result in the development of disabilities or the existing disabilities may become more severe. He suggested that low quality of POD and rehabilitation programme also may play a very important role in preventing and worsening of disabilities.

The presentation was also based on the basic elements of POD as follows:

- Prevention of primary impairments through early case detection, training of general health workers and use of LECs
- Treatment with free-of-charge MDT
- Routine nerve function assessment and treatment of early neuritis with prednisolone as required
- Provide nerve decompression surgery in deserving cases
- Have a footwear-making and distribution programme
- Provide ulcer prevention/care kit
- Community-based rehabilitation programme
- Manufacture and repair prostheses

In conclusion, Professor Zhang stated that the best way to prevent disabilities is to detect leprosy and neuritis early and treat it effectively.

## 10. Conclusions and recommendations

The main conclusion and recommendations agreed by the participants are summarized below:

- (1) Endorsed the plan of action for the implementation of the Enhanced Global Strategy and its goal of reducing the occurrence of grade-2 disabilities among new cases.
- (2) Concluded that renewed efforts will be needed to improve the quality of services for early case detection, prevention and limitation of disabilities including improved management of leprosy reactions, strengthening of the integrated referral systems, collection of data for monitoring and socio-economic rehabilitation of people affected by leprosy.
- (3) Recommended that countries carry out situational analysis to identify high-burden areas for purposes of developing and implementing intensive and innovative approaches for controlling leprosy in those areas.
- (4) Considered that more specific efforts should be made to eliminate stigma and discrimination against people affected by leprosy by, among others, involving persons affected by leprosy in planning, advocacy and monitoring leprosy services.
- (5) Agreed that more innovative approaches will be needed to further reduce the disease burden due to leprosy and recommended that particular attention be paid to identify leprosy among high-risk groups, such as contacts.

- (6) Appealed for further investigation of operational conditions required for successful implementation of the available tools for diagnosis, immunoprophylaxis and chemoprophylaxis of leprosy and
- (7) Called for renewed efforts to improve the quality of the information collected and used for calculating the essential monitoring indicators.

## Agenda

### Wednesday, 28 September 2011

- 09:00-09:30 hours    Opening of the meeting
- Opening address by Dr Samlee Plianbangchang, WHO Regional Director, South-East Asia Region
  - Opening address by Mr Yohei Sasakawa, WHO Goodwill Ambassador and Chairman of The Nippon Foundation
  - Introduction of participants by Dr Myo Thet Htoon
  - Nomination of chairperson, co-chairperson and rapporteurs

- 10:00-10:30 hours    Keynote presentation: The work of WHO Goodwill Ambassador in the fight for promoting human rights for person affected by leprosy (*Mr Yohei Sasakawa*)

### Session: 1 - Reducing stigma and discrimination

- 10:30-11:00 hours    Leprosy related stigma and discrimination: current situation and new tools to address stigma (*Dr Wim van Brakel*)
- Discussion
- 11:00-11:30 hours    Social and economic aspects of leprosy: approaches to address this issue (*Dr P.K. Gopal*)
- Discussion
- 11:30-12:00 hours    Counselling: its role in reducing stigma and discrimination (*Mr Sophea Leng*)
- Discussion

### Session: 2 - Reducing the disease burden

- 12:00-12:30 hours    Global leprosy situation and remaining challenges (*Dr Myo Thet Htoon*)
- Discussion

14:00-14:30 hours From strategy to implementation: Enhanced Global Strategy for further reducing the disease burden due to leprosy 2011-2015 (Dr V. Pannikar)

- Discussion

14:30-15:00 hours Approaches to achieve reduction in grade-2 disabilities among new cases (Professor WCS Smith)

- Discussion

### **Session 3: Country presentations: Intensifying case-finding activities**

15:00-17:00 hours Intensifying case-finding activities (10 minutes each)

- Democratic Republic of Congo
- Dominican Republic
- Egypt
- Thailand
- Cambodia
- Discussion

## **Thursday, 29 September 2011**

### **Session 4: Case management and strengthening of the referral systems**

09:00-10:00 hours Country presentations (10 minutes each)

- Madagascar
- Brazil
- Sudan

10:30-11:30 hours Case management and strengthening of the referral systems (Continued)

- India
- Viet Nam
- Discussion

**Session: 5 - Improving quality of care**

- 11:30-12:00 hours      Research: Final Results from a >20 Year Leprosy Skin test Trial in Nepal, and Other Research Developments; Is a Diagnostic Leprosy Skin Test Feasible? (Professor Patrick Brennan)
- Discussion
- 12:00-12:30 hours      Prevention of disabilities: good practices (Dr Hugh Cross)
- Discussion

**Session 6: Country presentations: Improving activities for prevention of disabilities**

- 14:00-15:30 hours      Improving activities for prevention of disabilities (10 minutes each)
- United Republic of Tanzania
  - Argentina
  - Morocco
  - Indonesia
  - China
  - Discussion
- 16:00-16:30 hours      Conclusions and Recommendations
- 16:30 hours              Closing ceremony

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At the first Global Leprosy Programme Managers' meeting held at the WHO Regional Office for South-East Asia (SEARO), in April 2009, the Global Leprosy Programme developed the Enhanced Global Strategy 2011-2015 for further reducing the disease burden due to leprosy. Although implementation of the Strategy has already started in the Regions and endemic countries, certain aspects of the Strategy need further refining and understanding by the national programmes. In order to address these issues, the second meeting of the global programme managers was organized at the WHO-SEARO on 28-29 September 2011. The meeting was attended by about 46 national programme managers, representatives from partner organizations as well as, including representatives from associations of affected persons and experts. The participants endorsed the plan of action for the implementation of the Strategy and its goal of reducing the occurrence of grade-2 disabilities among new cases. In addition, the meeting recommended that more specific efforts should be made to eliminate stigma and discrimination against people affected by leprosy by, among others, involving persons affected by leprosy in planning, advocacy and monitoring leprosy services.



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