



WHO Technical Advisory Group on Leprosy control

**Report of the Twelfth Meeting
Brazzaville, Congo, 10–11 April 2014**

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Acronyms

| | |
|---------|---|
| BCG | Bacillus Calmette–Guérin |
| BL | borderline leprosy |
| ENL | Erythema Nodosum Leprosum or Type 2 |
| G2D | Grade 2 disabilities |
| ILEP | International Federation of Anti Leprosy Associations |
| LL | lepomatous leprosy |
| LLEG | Leprosy Elimination Advisory Group |
| MB | multi bacillary |
| MDT | multidrug therapy |
| NTD | neglected tropical disease |
| PB | pauci bacillary |
| PNG | Papua New Guinea |
| RD | Regional Director |
| ROM | rifampicin, ofloxacin and minocyclin |
| RR | Reversal reaction or Type 1 reaction |
| TAG | Technical Advisory Group |
| UMDT | uniform multidrug therapy |
| WHO | World Health Organization |
| WHO TAG | WHO Technical Advisory Group |

1. Introduction

The WHO Technical Advisory Group (WHO TAG) on Leprosy Control meets usually annually to review the leprosy situation, discuss the challenges faced by the leprosy programme and advise WHO on improving leprosy control globally. See Annex 1 for terms of reference. The Twelfth meeting of WHO TAG was organized in Brazzaville, Republic of Congo from 10–11 April 2014.

2. Objectives

The objectives of the twelfth meeting of WHO TAG were as follows:

- to review leprosy data received at GLP from different leprosy endemic countries and assess progress in achieving the target of reduction of new cases with Grade 2 disabilities (G2D) rate as per the Enhanced Global Strategy 2011–2015;
- to review innovative approaches adopted in major endemic national leprosy programmes (Brazil, India and Indonesia) for improved case detection, drug resistance surveillance and chemoprophylaxis in order to make suitable recommendations for replication in other national programmes; and
- to discuss the draft global leprosy strategy for the period 2016–2020 and recommend suitable approaches to reduce disease burden due to leprosy in high endemic countries.

3. Opening session

At the outset, Dr Joseph Kawuma, WHO TAG Chairman welcomed the participants and invited the members to discuss emerging technical, operational and socioeconomic issues of relevance to leprosy and make appropriate recommendations to the WHO Global Leprosy Programme (GLP).

Dr Francis Chisaka Kasolo, Director, Disease Prevention and Control, WHO, Regional Office for Africa, Brazzaville, Congo opened the Twelfth meeting of WHO-TAG. In his opening remarks, Dr Kasolo, on behalf of Dr Luis Gomes Sambo, Regional Director, WHO African Region, appreciated the Global Leprosy Strategy 2011–2015, which enabled different stakeholders to reaffirm their commitment and focus their efforts in reducing the leprosy burden. He acknowledged the contribution of WHO TAG in its previous meetings and hoped it would provide expert guidance on leprosy control. Dr Kasolo informed the TAG members about development of regional strategic plans for

Member States in the African Region to accelerate elimination of leprosy at sub-national levels, and inclusion of elimination of leprosy and reduction of G2D by 2020 as targets in the Regional Strategy on Neglected Tropical Diseases. This signifies the priority accorded by countries in the African Region in eliminating leprosy. In his message, Dr Sambo emphatically advocated that WHO must continue all efforts with diligence to ensure complete victory on leprosy. He challenged the TAG members to discuss and recommend innovative approaches to sustain leprosy services, improve case detection, reduce stigma and prevent drug resistance in leprosy.

The technical sessions of the TAG meeting were chaired by Dr Kawuma and co-chaired by Dr Paul Saunderson.

4. Report of the Eleventh TAG meeting

The report of the Eleventh TAG meeting held in New Delhi on 30 September 2011 was approved by all TAG members.

5. Current leprosy situation

5.1 Global leprosy situation

Dr Sumana Barua, Team Leader - Global Leprosy Programme, WHO, presented the global leprosy situation and challenges faced by the programme. While new case detection remained static in the last five years (in the range of 228 474–249 007), G2D among new cases showed a marginal increase in 2012 (13 079–14 409). Sixteen countries reported more than 1000 new cases. Brazil, India, and Indonesia contributed 80% to the global new case load. The achievements of the leprosy programme including improved access, free drug supply, establishment of sentinel surveillance for drug resistance, organization of capacity-building workshops, collaboration with partners, development of guidelines for facilitating involvement of persons affected by leprosy, and convening of international leprosy summit which enunciated the Bangkok Declaration towards an aspirational goal for a leprosy-free world. TAG was requested to make appropriate recommendations to address the challenges like sustainability of expertise in leprosy, establishment of referral system and reducing stigma and discrimination for implementation by national programmes. Global leprosy update on 2012 published in the Weekly Epidemiological Record presents the global leprosy data. The draft plan to develop the global leprosy strategy for the period 2016–2020 was presented to the TAG for inputs by members.

5.2 Leprosy situation by region

The African Region: Dr Landry Bide, Regional Adviser (Leprosy), WHO Regional Office for Africa, Brazzaville, Congo explained the leprosy epidemiological situation in African

region. New case detection in leprosy was almost at the same level as in the previous year (20 219 in 2011 and 20 599 in 2012). In 2012, 2709 new G2D cases were reported in 2012 (G2D disability rate 0.40 per 100 000 population). The proportion of multibacillary (MB) cases, child cases and disability cases were almost at the same level as in previous years, indicating stagnation in leprosy control. Seven Member States i.e., Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Madagascar, Nigeria, South Sudan and United Republic of Tanzania continue to report more than 1000 new cases. Twelve out of 19 countries have reported more than 90% treatment completion rates for pauci bacillary (PB) and multi-bacillary (MB). Inadequate supervision and funding of the leprosy programme, and prevailing stigma in the communities were identified as major challenges. Dr Bide emphasized the need to formulate regional plans for capacity-building.

Americas Region: Dr Ruben Santiago Nicholls, Adviser, Neglected Infectious Diseases and Leprosy, PAHO, Brasilia, presented the leprosy situation and challenges in the Americas Region. The data showed marginal reduction of new case detection from 36 832 to 36 178 cases and child cases from 2549 to 2348 compared to 2011. However, a marginal increase is noted in MB cases and G2D cases in the Region, including in Canada and United States of America. The challenge in the leprosy programme is mainly to sustain the achievements in the countries where elimination of leprosy is achieved at the national level and to intensify activities for elimination of leprosy at the national level in Brazil. Some of the challenges in the Region include strengthening of surveillance for new cases, disability management, stigma and sustaining political commitment. Examples of innovative practices from the Region, i.e., integration of key leprosy activities with deworming campaign and trachoma were presented. Dr Nicholls informed that contacts were given bacilles camerto gaureni (BCG) and rifampicin chemoprophylaxis in Cuba, but no significant change was noticed in new cases.

South-East Asia Region: Dr Rui Paulo de Jesus, Regional Adviser (Leprosy) presented the report from the South-East Asia Region. The Region contributed to 66% of the global prevalence and 71% of the global new case burden. In general, all components of new case detection have recorded an increase i.e., new case detection by 7349, MB cases by 3326, female cases by 2499, child cases by 807 and G2D cases by 917 cases in the Region. Six countries in the Region reported more than 1000 new cases in 2012. The Region also reported maximum number of relapse cases.

Some of the challenges are: variations in diagnosis and treatment schedules in different countries, differences in the level and intensity of integration, lack of interprogramme and intersectoral coordination and community participation. The importance of viewing leprosy as part of a broader problem of neglected people with barriers to accessibility was emphasized. The reporting format of national programmes needed a review, including few other epidemiological parameters like G2D cases among children. Leprosy as a disease control programme required greater focus among national programmes and partners at policy and implementation levels.

Western Pacific Region: Dr Nobuyuki Nishikiori, Team Leader, Stop TB and Leprosy Elimination, Regional Office for the Western Pacific reported 5400 new cases in 2012

and said that new case detection had plateaued over the past five years. Pockets of high endemicity “hotspots” existed in the top ten endemic countries. The People’s Republic of China and the Philippines were the only two countries which reported more than 1000 cases annually. The Region had already achieved the target of reduction of G2D to less than 1 per million. A few Member States, namely Cambodia, China, Lao PDR and Viet Nam continued to report more than 10% of new cases with G2D. China, Papua New Guinea (PNG) and the Philippines reported a high proportion (80%) of MB, whereas Marshall Islands, PNG and Micronesia showed a high child proportion (20%). Elimination of leprosy was achieved at the regional level in 1991, but five Pacific island countries have still not achieved elimination at the national level. The challenges in the Region included declining expertise, geographical access barriers and insufficient resources for monitoring and supervision at sub-national levels. Innovative activities reported from the Region included retroactive contact survey in Cambodia, leprosy diagnosis through mobile phone and active case-finding.

5.3 Leprosy situation in selected countries

Congo: Dr Francois Missamou, National Coordinator, Brazzaville, Congo, presented the current state of leprosy in the Republic of Congo. A declining trend of new case detection from 70 in 2012 to 53 in 2013 and in MB cases from 52 to 43 was highlighted. A marginal increase of G2D cases from 12 to 15; child cases from six to nine and female cases from 34 to 36 was observed in 2013 as compared to 2012. Nearly 50% of cases came from Likouala district of the northern region of Congo. The challenges facing the country were sustainability of expertise, surveillance system and referral services. Since G2D among children had an emotional appeal, it would be worthwhile to consider the practicality of including this in the reporting format.

India: Dr V R R Pemmaraju, TIP-GLP from the WHO Regional Office for South-East Asia presented the report from India on behalf of Dr C M Agarwal, Deputy Director-General of Health Services (Leprosy), Government of India. The annual new case-detection rate has gone up from 10.5 per 100 000 population in 2011–2012 to 10.78 in 2012–2013 (in absolute numbers from 127 295 to 134 752). Intensive case-detection drives were introduced to improve new case detection in 209 high endemic districts (652 total districts). The results from the National Sample Survey conducted in 2010 indicated an increase in the number of new cases in high endemic pockets. Initiation of special activities in high endemic regions, collaboration with major stakeholders, high level of political commitment, increased allocation of resources for the programme and improved accessibility to disability care services including reconstructive surgery were highlighted as achievements of the national leprosy programme for the year 2013–2014. The Twelfth Five Year Plan took into consideration the key findings of the National Sample Survey and the current leprosy situation. The Plan included placing of special vertical staff in high endemic districts and blocks, strengthening disability prevention and medical rehabilitation services and intensive monitoring and supervision at primary health centres. The national programme has recorded an increase in the number of new cases in 209 districts. Migration of workers, sustaining leprosy expertise at periphery, treatment

completion in urban areas, referral services and prevailing stigma were found to be major operational challenges influencing progress in leprosy control.

Indonesia: Dr Christina Widaningrum, National Leprosy Programme Manager, Directorate-General of Disease Control and Environmental Health, Indonesia, presented the current leprosy situation in her country. The highlights included a static new case detection ranging from 17 000–20 000 over the past five years. During the year 2013, high proportion of MB (83%), G2D cases (9.10%) and child cases (12.1%) were observed in the country. High disease burden was reported in 15 of the 34 provinces. Single dose Rifampicin chemoprophylaxis among healthy household contacts of leprosy cases was initiated as a pilot project in Sampang and Bima districts. She sought the advice of the WHO-TAG on the single dose Rifampicin chemoprophylaxis intervention. Community participation in early case detection, integrated wound-care management (leprosy and diabetes), national appeal against stigma and discrimination and drug resistance surveillance were presented as some of the innovative approaches initiated by the national programme.

6. Bangkok Declaration: Challenges in implementing leprosy control

Professor William C S Smith, Emeritus Professor of Public Health, School of Medicine and Dentistry, Scotland, elaborated on the remaining challenges with a special reference to the Bangkok Declaration. He referred to challenges in three domains: sustaining achievements, reducing transmission and preventing disability. Waning political commitment, reduced funding for leprosy work, competition with other disease control programmes, and inadequate leprosy expertise in integrated health-care settings were seen as the main challenges in sustaining the achievements of the leprosy programme in the leprosy- endemic countries. Technically, reduction of transmission of leprosy is possible through early diagnosis in high endemic and urban areas, among school children, continuing BCG vaccination and screening the contacts of patients. Research to develop early diagnostics and shorter treatment regimen would bring in new tools into practice in breaking the chain of transmission. The final challenge in preventing disability could be in reaching the three million target population for early diagnosis and appropriate treatment. He reiterated the need to develop partnerships with neglected tropical diseases control programme for optimization of resources and actions.

7. Disability care services: Sustaining expertise and integration into general health services

Professor Zhang Guocheng, Deputy Director, Institute of Dermatology and Venereology, People's Republic of China pointed out the enormous challenge of reaching about three million with disability and emphasized the need to make disability care an integral part of the routine health care system which includes specialized service at referral centres. Special attention should be given to promoting self-care by persons affected and living

with disability. Integration with dermatology could be an added advantage and involving persons affected in service delivery would improve the quality of service.

8. The role of people affected by leprosy in sustainable leprosy services

Dr Michael Chen, Secretary-General, HANDA Rehabilitation and Welfare Association, People's Republic of China made a pointed reference to the involvement of persons affected as a need to improve services and highlighted the paucity of efforts in this direction. While there are some good examples of participation by persons affected from a few countries like Brazil, China, Ethiopia, India and Mozambique, there was not much progress beyond token participation. The persons affected faced barriers that included the mind-set of professionals towards inclusive strategies and lack of opportunities to develop their capacity. Some remedial measures like better understanding of the disability burden, investing in self-help groups, exchange of information on best practices in participation and developing patient charter could be considered.

9. Reactions and relapses: Recent advances

Dr Paul Saunderson, Medical Adviser, American Leprosy Missions, Norway, said that about 61% of MB cases developed Type 1 reaction either at onset (38%) or during treatment. A scale for severity of reversal reaction had been developed. Some of the challenges in managing Type 1 reaction included early diagnosis of disease and reaction, optimal steroid regimen, side-effects of steroids and non-availability of steroid sparing drugs. There were trials a foot to find out whether 20 weeks or 30 weeks steroid treatment was effective. Incidence of erythema nodosum leprosum (ENL or Type 2 reaction) is around 10% in borderline leprosy (BL) and 50% in lepromatous leprosy (LL). Challenges in managing Type 2 reactions include limited treatment options, adverse effects of steroids and lack of a severity scale. A study in Cebu of 500 smear-positive cases revealed a cumulative relapse of 6.6% and all were sensitive to rifampicin. Challenges in managing relapses are identification, investigation and management. While acknowledging the fact that the routine programme faced challenges in managing reactions, he noted that it was important to put in place a system for suspecting, diagnosing and managing reactions. While relapse is not a major problem, efforts to collect valid data on relapse should continue.

10. Review of global surveillance for drug resistance

Dr Masanori Matsuoka, Chief, Department of Bio-regulation Leprosy Research Centre, Japan, focused on the progress made so far in surveillance for drug resistance in leprosy and future directions in the years ahead. A total of 360 specimens were collected from 2008 to 2010. So far, 37 cases of rifampicin resistance have been reported. Secondary resistance to dapsone was 15%, to rifampicin 7% and to fluorquinolone 1%. The results

obtained from the surveillance indicate that resistance in relapse is not a major problem. Proposed future actions include drug resistance surveillance for new cases, continuation of longitudinal observation and keeping a vigil on resistance.

11. Chemoprophylaxis: Recent developments

Professor WCS Smith discussed recent developments on chemoprophylaxis. Systematic review of evidence including that from the recent trial in Bangladesh showed the efficacy of chemoprophylaxis in reducing the incidence of leprosy among contacts of persons diagnosed with leprosy. It was not clear to what extent current guidelines on contact examination were followed. Priorities in intervention among contacts included a clear direction on contact population coverage, identifying optimal regimen for post-exposure prophylaxis and addressing operational issues and sustainability.

12. Guidelines to clarify the WHO Three Grade Disability Grading System

Professor Zhang Guocheng provided clarifications on the WHO Three Grade Disability Grading System. Ideally, patient assessments should be conducted at each visit to monitor for nerve function impairment and to initiate treatment if detected. During incidents of reaction, patients should be tested at least every two weeks. The absolute minimum requirement is examination of patients at diagnosis and at release from treatment. The guidelines detailed the essential definitions and criteria, principles in sensory testing, muscle functioning testing and examination of eyes. The number and testing sites for sensory testing on hands and feet were defined. Sensory testing in the eye was also explained. The scale to be used in voluntary muscle testing to assess motor nerve impairment was also explained, using a simplified three grade system of strong, weak and paralysed. The guideline also explained difficult case scenarios such as grading, cracks, scars and corneal anaesthesia.

These guidelines were presented to TAG inviting discussion and recommendations for use in the field programme.

13. Future directions: Global Leprosy Strategy 2016–2020

13.1 Report on uniform multidrug therapy (UMDT) – Multicentric trials

Dr P. Krishnamurthy, presented the interim report on uniform MDT trial carried out in eight centres in India (6) and China (2). The study was carried out using 'relapse' as primary outcome measure. A total of 3396 cases were enrolled from eight sites. At the end of seven years, in more than 90% of the patients, the lesions (skin patches) became clinically inactive. The efficacy of giving six months of MB MDT regimen to all types of

leprosy was studied under programme conditions among 2094 PB and 1302 MB cases. After seven years of follow-up (expected eight years) there were six relapses, four in MB and two in PB giving a relapse rate of 0.069 per 100 person years of follow-up for MB and 0.021 per 100 person years of follow-up for PB. Adverse effects were minimal and the regimen acceptance and compliance were very good. While waiting for final results in the year 2016, the results as of now are very promising, indicating that UMDT is an acceptable tool for reduction of disease burden due to leprosy.

13.2 New drugs and regimens

Professor Emmanuelle Cambau, National Reference Center for Mycobacteria and Resistance to Anti-Tuberculosis Drugs, France, explained objectives of chemotherapy in leprosy, WHO-recommended MDT regimens, chemoprophylaxis, treatment of rifampicin-resistant cases and new antibiotics for leprosy treatment. There are three WHO recommended regimens in practice globally: MB MDT, PB MDT and rifampacin, ofloxacin and minocyclin (ROM) for single skin lesion leprosy cases.

TAG was informed that WHO drug resistance surveillance data shows 15% secondary resistance to dapsone and 7% secondary resistance to rifampicin. While explaining the objectives of chemoprophylaxis, it was suggested that more evidence on its feasibility and effectiveness needs to be documented. One dose treatment with ROM can also be considered for prophylaxis.

Drug resistance in leprosy is not yet recognized as a major problem, but it is important to continue efforts to identify new drugs for leprosy, particularly to treat drug-resistant leprosy cases.

TAG members were informed that a number of antibiotics known to be effective against mycobacterium leprae were available and it was possible to use them in leprosy treatment.

As a technical expert in chemotherapy, she advised continued research in chemotherapy, development of treatment for drug-resistant cases, and identification of shorter uniform treatment regimen for all types of leprosy. She also suggested that TAG should have a sub-committee on chemotherapy to guide GLP on new drugs, preventive chemotherapy, new treatment regimens and clinical trials in the treatment of leprosy.

13.3 Inputs from national and sub-national programme managers for the Global Leprosy Strategy 2016–2020

Dr V R R Pemmaraju, TIP, Global Leprosy Programme, WHO presented the salient points from the International Leprosy Summit and brainstorming sessions organized at the national programme managers' meeting in different regions. The goal of the leprosy programme need not be changed, but should include a focus on socioeconomic determinants. The target of the Enhanced Global Strategy 2011–2015 is difficult to reach

with the current status of new G2D cases at 0.25/100 000. The national programme managers suggested that the following activities be included:

- active case-finding among “high endemic area population, hard-to-reach population, close contacts, urban slums”;
- improvement of the level of socioeconomic determinants of the disease;
- improvement of service access and quality;
- improvement of knowledge, attitude and practice of community about leprosy;
- establishment of drug resistance surveillance (among all cases in low burden countries; and among relapses in all countries);
- improvement of surveillance system;
- continuation of research on chemoprophylaxis, vaccines and new drugs; and
- innovative approaches to improve case-detection and reach of services.

The target of reducing G2D cases per 1000 000 by 2020 as recommended by the Expert Committee can continue for the next strategy.

During the discussion, it was suggested that TAG form a sub-committee on defining the Global Leprosy Strategy covering 2016–2020.

14. Recommendations from the Twelfth Meeting of WHO TAG on Leprosy Control

- (1) TAG recommends interventions such as demonstration sites/projects in order to determine feasibility and wherever possible, effectiveness of chemoprophylaxis in programme conditions. This should follow the establishment of a viable and sustainable system of contact examination. (Refer recommendations of Eighth WHO Expert Committee on Leprosy, 2012, Report # 968)
- (2) The preliminary results of the multicentric study on UMDT are encouraging and might possibly lead to making leprosy treatment simpler. TAG awaits the final report, which is due in 2015.
- (3) TAG recommends continuation and expansion of the efforts of global surveillance of drug resistance even though resistance in relapse does not currently appear to be a major problem. TAG also recommends development of a system by each country programme for identification and follow-up of relapse cases.
- (4) The process of integration of leprosy with other NTD control programmes needs further clarification and orientation at global, regional and national

levels in order to improve collaborative resource mobilization and its effective utilization.

- (5) Declining expertise in the face of reducing leprosy burden poses serious challenges to programme preparedness and sustainability. Capacity-building in clinical and programme management should become an integral part of regional and national plans.
- (6) TAG reiterates the importance of participation of people affected by leprosy in leprosy services. Serious attention needs to be given to developing partnerships with people affected by leprosy and their involvement in key domains of leprosy programmes and services facilitated.
- (7) TAG recommends that WHO should adopt the 'Guidelines to Clarify the WHO Three Grade Disability Grading System' for programme use.
- (8) TAG reiterates the need for a critical look at the current global leprosy information system through a working group for better programme monitoring and suggests wider use of additional indicators, including coverage of contact examination and Grade 2 disabilities among children.
- (9) TAG recommends GLP to form working groups on chemotherapy and development of Global Leprosy Strategy 2016–2020.

Annex 1

Terms of reference of the WHO Technical Advisory Group on Leprosy Control

General Background

In 1995, the Leprosy Elimination Advisory Group (LEAG) was established by the Director-General to advise the former WHO Action Programme on Elimination of Leprosy on implementation and management of the strategy to eliminate leprosy as a public health problem by the year 2000. This was defined as reducing the prevalence of the disease to less than one case per 10 000 population. It was disestablished in 1999 following WHO restructuring.

In order to advise WHO on effective implementation of the intensified strategy and monitoring its progress, particularly in the areas of capacity-building, MDT supply, communications and information, as well as monitoring and surveillance, the Director-General decided to establish a Technical Advisory Group (TAG) on Leprosy Control consisting of independent experts. There are currently nine members representing all WHO regions and having different expertise and vast experience in various fields. The last meeting of TAG was held in 2011.

Terms of Reference

The WHO TAG on Leprosy Control is composed of experts who are independent of WHO. Members are chosen for their expertise in leprosy and programme management with particular reference to public health, epidemiology, community mobilization and advocacy, operational research, and disability prevention. They form a strong team with a good technical balance and geographical representation.

The members of this advisory body are selected and appointed by WHO and meet at least once a year. The period of membership is three years, with the possibility of extension.

The deliberations of TAG are open to representatives of national and international partners as observers to encourage open debate.

In addition, TAG may invite, as necessary, representatives from selected leprosy-endemic countries and other experts to its meetings.

The terms of reference of TAG are:

- (1) to closely monitor the implementation of the Global Strategy to further reduce the leprosy burden and sustain leprosy control activities;
- (2) to advise WHO on developing new strategies and approaches for 2016–2020;
- (3) to develop strategies to overcome technical challenges in the light of declining disease burden, including potential emergence of drug-resistance;
- (4) to give technical advice and guidance on developing and implementing tools for prevention of leprosy;
- (5) to identify and facilitate implementation of a research agenda in order to improve the quality of leprosy control activities, including prevention of disabilities and rehabilitation; and
- (6) to support efforts related to reducing stigma and discrimination against individuals and families affected by leprosy.

Annex 2

Speech of Dr Luis Gomes Sambo, Regional Director, WHO African Region at the Twelfth Meeting of the WHO Technical Advisory Group on Leprosy Control 10–11 April 2014, Brazzaville, Congo

It is a great pleasure for me to address you this morning at this opening session of the WHO Technical Advisory Group on Leprosy Control. I would like to express my sincere appreciation to my dear colleague and friend, Dr Poonam Khetrapal Singh, WHO Regional Director of South-East Asia Region, for selecting the African Region to hold this meeting. Your decision to hold the Twelfth session of the WHO Technical Advisory group in the WHO African Region is an indication of the attention given to the fight against leprosy in Africa.

I would like to warmly welcome you, the Member of the WHO Technical Advisory Group on Leprosy Control to the WHO Regional Office for Africa. I also welcome the leprosy experts, national leprosy programme managers, and health development partners and the WHO Global Leprosy team members.

As you are aware, the goal of eliminating leprosy as a public health problem was set by the World Health Assembly Resolution WHA44.9 in 1991. This resolution, which defined elimination as reducing the prevalence to less than one case per 10 000 populations, was reinforced by the WHO Regional Committee for Africa Resolution AFR/RC44/R5 in 1994. In order to ensure the attainment of this goal and in alignment with global efforts, the Regional Office for the Africa developed the Regional Strategic Plans for Leprosy Elimination by 2000 and the Regional Strategic Plans to accelerate leprosy elimination in the remaining countries by 2005, named 'The Final Push.'

We also developed the Global and Regional Strategic Plans for reducing the Leprosy Burden and Sustaining Leprosy Control Activities, 2006–2010. These plans and their implementation contributed to mobilizing support and commitment among leprosy-endemic countries toward ensuring that interventions and services were available and accessible to affected persons.

I am pleased to note that in spite of many health system and socioeconomic challenges, the Member States of the WHO African Region remain committed to the elimination of leprosy. This commitment has helped to achieve significant results, many of which you will be discussing during this meeting. It is noteworthy that all Member States achieved the elimination target of less than one case per 10 000 populations in 2005 and the overall number of new cases has continued to decrease in the Region. However, seven countries are detecting more than 1000 new cases per year. In addition, two

countries have seen their prevalence increased to more than 1 case per 10 000 populations. The reduction of rate of severe cases (with at least Grade 2 disability) among the population is not significant. Also, discrimination against affected people remains a challenge.

In 2013, the Sixty-third Session of the Regional Committee for Africa adopted a comprehensive resolution on national tropical disease (NTDs), and also endorsed the Regional Strategy on Neglected Tropical Diseases in the WHO African Region, 2014–2020. Sustaining elimination of leprosy and further reduce severe leprosy disabilities by 2020 is one of the targets defined in this Strategy. This is an indication that leprosy elimination remains a priority in the Region and that AFR Member States are committed toward achieving the 2020 leprosy goals.

The Regional NTD Strategy is anchored on four mutually reinforcing objectives, which together strengthen programme capacity to achieve goals and targets of leprosy and other NTD control programmes. These objectives are:

- (1) to scale up integrated access to NTD-related interventions;
- (2) to enhance planning for results, resource mobilization and financial sustainability of national NTD programmes;
- (3) to strengthen advocacy, coordination and national ownership; and
- (4) to enhance monitoring, evaluation, surveillance and research.

With the new momentum around NTDs, we are elaborating an integrated plan to combat skin diseases.

With only six years to 2020, this meeting of TAG is important, as we expect it to provide technical guidance on the priorities that are most effective toward accelerating the achievement of the 2020 targets.

I understand that this WHO/TAG was reconstituted and approved by the Regional Director of SEAR in 2013 and this is the first meeting of the reconstituted group. I would like to congratulate you on your appointments. Your work is invaluable in guiding the work of WHO and the countries.

Last year, the leprosy programme developed a report on the progress towards the reduction of the burden of leprosy in the African Region, which will assist in your deliberations. During the next two days, I understand that you will review the leprosy situation in 2012–2013 and progress towards the targets for 2020. I would like to challenge you to also discuss and recommend innovative approaches to improving case-finding, responding to leprosy drug resistance and tackling stigma against leprosy-affected persons.

We have come a long way in our battle against this age-old disease. We must continue with diligence to ensure complete victory. Before I end my remarks, I would like to use this opportunity to acknowledge the contributions and commitments made by

donors and nongovernmental and development organizations, particularly, the International Federation of Anti-Leprosy Associations (ILEP), towards the reduction of the burden of NTDs within the African Region.

With the strong support and commitment from all stakeholders – and technical guidance from this Technical Advisory Group – we are set towards making history by ending leprosy in the African Region – and the world.

Annex 3

Agenda

- (1) Opening Session
- (2) Approval of the Report of the Eleventh meeting of WHO TAG
- (3) Current global and regional leprosy situation
- (4) Current leprosy situation and innovative approaches in national programmes in major endemic countries
- (5) Challenges in implementing leprosy control focusing on Bangkok Declaration
- (6) Disability care services: sustaining expertise and integration in general health services
- (7) The role of people affected by leprosy in sustainable leprosy services
- (8) Reactions and relapses: recent advances
- (9) Review of global surveillance for drug resistance in leprosy
- (10) Chemoprophylaxis in leprosy: recent developments
- (11) Definition of G2D cases
- (12) Future directions: Global Leprosy Strategy 2016–2020
 - (a) Report on uniform MDT: multicentric trials
 - (b) New drugs and regimens in treating leprosy
 - (c) Inputs from national and sub-national programme managers for Global Leprosy Strategy 2016–2020
- (13) Review and analytical comments from Chairman, WHO TAG on leprosy control
- (14) Discussions on issues deliberated in the Twelfth meeting of WHO TAG
- (15) Conclusions and recommendations

Annex 4

List of participants

Members of the Technical Advisory Group on Leprosy Control (TAG)

Professor Paul E M Fine
Professor - Communicable Disease Epidemiology
Department of Infectious and Tropical Disease
London School of Hygiene and Tropical Medicine
London
England

Dr Herman Joseph S. Kawuma
Medical Adviser
German Leprosy Relief Association
Kampala
Uganda

Dr Padebattu Krishnamurthy
President
Damien Foundation of India Trust
Bangalore
India

Dr Masanori Matsuoka
Chief
Department of Bio-regulation Leprosy Research Centre
National Institute of Infectious Diseases
Tokyo
Japan

Dr (Ms) Maria Leide W. Oliveira
Medical Professor
Rio de Janeiro Federal University
Rio de Janeiro
Brazil

Professor William C S Smith
Emeritus Professor of Public Health
School of Medicine and Dentistry
University of Aberdeen
Aberdeen, Scotland
United Kingdom

Professor Zhang Guocheng
Deputy Director
Institute of Dermatology and Venereology
Chinese Academy of Medical Sciences
Jiangsu
People's Republic of China

Dr Paul Saunderson
Medical Adviser
American Leprosy Missions
Alesund
Norway

Professor Emmanuelle Cambau
National Reference Centre for Mycobacteria &
Resistance to Anti-Tuberculosis Drugs
Laboratoire de Bactériologie-Virologie; Groupe
Hospitalier Lariboisière-Fernand Widal
Paris
France

National Programme Managers

Dr Francois Missa mou
Coordinateur National MTN
Brazzaville
Republic of Congo

Dr Christina Widaningrum
National Leprosy Programme Manager
Directorate-General of Disease Control and
Environmental Health
Jakarta
Republic of Indonesia

Special Invitees

Dr Michael Chen
Secretary-General
HANDA Rehabilitation & Welfare Association
Guangzhou
People's Republic of China

Partner Organizations

Dr Marcos Virmond
President
International Leprosy Association
Bauru SP, Brazil

Mr Douglas Soutar
General Secretary
International Federation of Anti-Leprosy Association
(ILEP)
London, United Kingdom

WHO Secretariat

**Regional Office for Africa
Brazzaville, Congo**

Dr Landry Bide
Regional Advisor–Leprosy

Dr Alexandre Tiendrebeogo
Monitoring and Evaluation Officer

Dr Onyeze Adiele
Regional Adviser NTD

**Pan American Health Organization
Brasilia DF, Brazil**

Dr Ruben Santiago Nicholls
Advisor–Neglected Infectious Diseases and Leprosy

**Regional Office for South-East Asia
New Delhi, India**

Dr Sumana Barua
Team Leader–Global Leprosy Programme

Dr Rui Paulo De Jesus
Regional Advisor–Leprosy

Dr V R R Pemmaraju
Temporary International Professional–Global Leprosy
Programme

**Regional Office for the Western Pacific
Manila, Philippines**

Dr Nobuyuki Nishikiori
Team Leader of WPRO–Stop TB and
Leprosy Elimination

The Twelfth meeting of WHO TAG on Leprosy Control was organized in Brazzaville, Republic of Congo from 10-11 April 2014 to discuss emerging technical, operational and socioeconomic issues of relevance to leprosy and make appropriate recommendations to the WHO Global Leprosy Programme (GLP). WHO TAG members reviewed leprosy data from different leprosy endemic countries and progress in achieving global targets in reduction of new cases with grade 2 disabilities (G2D) rate. They also examined the innovative approaches adopted in major endemic national leprosy programmes (Brazil, India and Indonesia) for improved case detection, drug resistance surveillance and chemoprophylaxis in order to make suitable recommendations on replication in other national programmes. The members discussed the plan and process of developing a global leprosy strategy for the period 2016-2020.

The WHO Regional Advisers from the African, American, South-East Asia and Western Pacific regions presented their data and programme situation for suggestions from the members of WHO TAG. At the end of the meeting, a set of recommendations was made by WHO TAG covering areas like improving case detection by integrating with neglected tropical diseases, organizing chemoprophylaxis demonstration sites, continuing drug resistance surveillance, putting efforts in sustaining clinical and programme management expertise, strengthening participation of people affected and improving data management system in the programme. WHO TAG recommended GLP to form working groups to work on chemotherapy, data management and developing a global leprosy strategy for the period of 2016-2020.

The TAG members also recommended that WHO programme officials participate in research initiatives taken up by partners like International Federation of Anti-Leprosy Associations and others.



**World Health
Organization**

Regional Office for South-East Asia
World Health House
Indraprastha Estate
Mahatma Gandhi Marg
New Delhi-110002, India



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