(Draft)

Global Leprosy Programme

Report of the Global Leprosy Programme for 2010 and Proposal for 2011

World Health Organization
Regional Office for South-East Asia

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Global Leprosy Programme (GLP)

1. Introduction

National leprosy control programmes in various WHO Regions have been successfully implementing the Global Strategy for Further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities 2006-2010 (WHO/CDS/CPE/Cee/2005.53). This strategy which is based on timely detection of new cases and providing free treatment with multidrug therapy (MDT) has been very effective in reducing the disease burden in many endemic countries. In preparation for the next 5 years, WHO in collaboration with the national programmes and various partners have developed the Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy 2011–2015 (SEA-GLP-2009.3) as a follow-up to the current strategy placing additional emphasis on sustaining provision of quality patient care and reducing the burden of disease not only in terms of new case detection but also in terms reducing disabilities, stigma and discrimination and provision of social and economic rehabilitation to people affected by leprosy.

Integrated leprosy control services have played a very important part in sustaining services in many endemic countries. Referral centres those are net-working as part of the general health care system has been crucial in supporting the primary health care services in dealing with complications, prevention of disabilities and rehabilitation.

2. Leprosy situation

A total of 141 countries have submitted reports to WHO at the beginning of 2010 on their country/territory situation. There were 38 countries reporting from the African Region, 36 from the American Region, 10 from the South East Asia Region, 22 from the Eastern Mediterranean Region and 35 from the Western Pacific Region.

Table 1: *Registered prevalence of leprosy and number of new cases detected, by WHO region, beginning of 2010*

WHO Region	Registered Prevalence[a] beginning of 2010	New cases detected[b] during 2009
African	30 947 (0.40)	28 935 (3.75)
Americas	43 370 (0.49)	40 474 (4.58)
South-East Asia	120 456 (0.68)	166 115 (9.39)
Eastern Mediterranean	8 495 (0.17)	4 029 (0.70)
Western Pacific	8 635 (0.05)	5 243 (0.29)
Total	**211 903**	**244 796**

a Prevalence rate is shown in parenthesis as the number of cases per 10 000 population.
b Case-detection rate is shown in parenthesis as the number of cases per 100 000 population.

Table 1 shows the registered prevalence of leprosy globally at the beginning of 2010 and the number of new cases detected during the year 2009 as reported by 141 countries. The registered prevalence at the beginning of 2010 was 211 903 and globally, 244 796 new cases were detected during 2009.

New case detection trends in the WHO Regions from 2003 to 2009 are shown in table 2. The rate of decline during the years 2006 to 2009 has been modest compared to the previous years.

Table2: *Trends in the detection of new cases of leprosy, by WHO regions. 2003 - 2009 (excluding European Region)*

WHO Region	No. of new cases detected						
	2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
African	47 006	46 918	45 179	34 480	34 468	29 814	28 935
Americas	52 435	52 662	41 952	47 612	42 135	41 891	40 474
South-East Asia	405 147	298 603	201 635	174 118	171 576	167 505	166 115
Eastern Mediterranean	3 940	3 392	3 133	3 261	4 091	3 938	4 029
Western Pacific	6 190	6 216	7 137	6 190	5 863	5 859	5 243
Total	**514 718**	**407 791**	**299 036**	**265 661**	**258 133**	**249 007**	**244 796**

Table 3 shows the number of new cases detected during 2009 in 16 countries which reported $\geq$ 1 000 new cases. These 16 countries contribute 93% of the global new case detected during 2009. Angola reported less than 1 000 new cases in 2009 and accordingly has dropped out of the list.

Table 4 shows by WHO Regions, the highest and lowest proportion of MB, children, female and grade-2 disabilities among new cases (in countries reporting $\geq$ 100 new cases.

Table 3: *Detection trend of leprosy in 16 countries reporting ≥ 1 000 new cases during 2009 and number of new cases detected previously*

No.	Country	No. of new cases detected						
		2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
1	Bangladesh	8 712	8 242	7 882	6 280	5 357	5 249	5 239
2	Brazil	49 206	49 384	38 410	44 436	39 125	38 914	37 610
3	China	1 404	1 499	1 658	1 506	1 526	1 614	1 597
4	DR Congo	7 165	11 781	10 369	8 257	8 820	6 114	5 062
5	India	367 143	260 063	169 709	139 252	137 685	134 184	133 717
6	Ethiopia	5 193	4 787	4 698	4 092	4 187	4 170	4 417
7	Indonesia	14 641	16 549	19 695	17 682	17 723	17 441	17 260
8	Madagascar	5 104	3 710	2 709	1 536	1 644	1 763	1 572
9	Mozambique	5 907	4 266	5 371	3 637	2 510	1 313	1 191
10	Myanmar	3 808	3 748	3 571	3 721	3 637	3 365	3 147
11	Nepal	8 046	6 958	6 150	4 235	4 436[a]	4 708[a]	4 394 [a]
12	Nigeria	4 799	5 276	5 024	3 544	4 665	4 899	4 219
13	Philippines	2 397	2 254	3 130	2 517	2 514	2 373	1 795
14	Sri Lanka	1 925	1 995	1 924	1 993	2 024	1 979	1 875
15	Sudan	906	722	720	884	1 706[b]	1 901[b]	2 100 [b]
16	United Republic of Tanzania	5 279	5 190	4 237	3 450	3 105	3 276	2 654
	Total (%)	**491 635 (96%)**	**386 424 (95%)**	**285 257 (95%)**	**247 022 (93%)**	**240 664 (93%)**	**233 263 (94%)**	**227 849 (93%)**
	Global Total	**514 718**	**407 791**	**299 036**	**265 661**	**258 133**	**249 007**	**244 796**

NA=not available
a = detection reported for mid-November 2008 to mid-November 2009
b = includes data from Southern Sudan

Table 4: *Profile of newly detected cases reported by countries with ≥100 or more new cases by WHO region, 2009*

WHO Regions	% multibacillary among new leprosy cases by countries with highest and lowest proportions	% of females among new leprosy cases by countries with highest and lowest proportions	% of children among new leprosy cases by countries with highest and lowest proportions	% of new leprosy cases with grade-2 disabilities by countries with highest and lowest proportions
African	Comoros, 32.70% Kenya, 94.27%	Ethiopia, 6.50% Central African Rep. 59.11%	Niger, 2.16% Comoros, 31.76%	Liberia, 1.45% Burundi, 20.71%
Americas	Bolivia, 34.75% Cuba, 81.82%	Argentina, 17.72% Brazil, 44.84%	Argentine, 0.60% Dominican Rep. 7.78%	Venezuela, 6.0% Bolivia, 14.9%
South-East Asia	Bangladesh, 42.89% Indonesia, 82.43%	Timor Leste, 33.13% Sri Lanka, 43.52%	Thailand, 3.67% Indonesia 12.0%	India, 3.08% Myanmar, 14.9%
Eastern Mediterranean	Somalia, 57.80% Egypt, 88.00%	Somalia, 22.94% Sudan, 45.86%	Sudan, 4.67% Yemen, 16.50%	Egypt, 6.00% Sudan, 19.80%
Western Pacific	FS Micronesia 40.98% Philippines 95.04%	Lao PDR 17.82% Papua New Guinea 40.69%	Lao PDR 1.98% Papua New Guinea 30.30%	Malaysia 4.28% China 22.80%

Table 5: *Number of leprosy cases with grade-2 disabilities detected among new cases[a] by WHO region, 2004-2009*

WHO Region	2004	2005	2006	2007	2008	2009
African	4 549 (0.69)	4 562 (0.62)	3 244 (0.46)	3 570 (0.51)	3 458 (0.51)	3 146 (0.41)
Americas	2 698 (0.33)	2 107 (0.25)	2 302 (0.27)	3 431 (0.42)	2 512 (0.29)	2 645 (0.30)
South-East Asia	6 995 (0.43)	6 209 (0.37)	5 791 (0.35)	6 332 (0.37)	6 891 (0.39)	7 286 (0.41)
Eastern Mediterranean	380 (0.09)	335 (0.07)	384 (0.08)	466 (0.10)	687 (0.14)	608 (0.11)
Western Pacific	754 (0.04)	673 (0.04)	671 (0.04)	604 (0.03)	592 (0.03)	635 (0.04)
Total	**15 376 (0.29)**	**13 886 (0.25)**	**12 392 (0.23)**	**14 403 (0.26)**	**14 140 (0.25)**	**14 320 (0.25)**

[a] Values are numbers (rate/100 000 population)

The trend of new cases with grade-2 disabilities and rates per 100 000 population from 2004 to 2009 are shown in table 5. Annually, around 12,000 to 14,000 new cases with grade-2 disabilities are being detected globally. In 2009, the rate of new cases with grade-2 disabilities ranges between 0.04 in Western Pacific to 0.41 per 100,000 population in the African and South East Asia Regions.

Table 6 shows the trend of relapse cases reported globally each year from 2004 to 2009. Relapse cases reported from countries annually has been fairly stable at about 2 000 to 3 000 cases. The number of countries reporting data on relapses has increased significantly during 2009.

Table 6: *The number of relapsed leprosy cases reported globally, 2004-2009*

Year	No. of countries reporting	No. of relapses
2004	40	2 439
2005	44	2 783
2006	41	2 270
2007	43	2 466
2008	49	2 985
2009	122	3 120

3. Achievements

- Between 1985 and the beginning of 2010, close to 15.5 million persons affected by leprosy were diagnosed and cured with MDT.
- During 2009 biennium, the Global Leprosy Programme, under the leadership of the Regional Director of the WHO South-East Asia Region, has effectively carried out its activities in collaboration with the various Regions, partners and Member States of the Organization. The *Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy 2011-2015* (SEA-GLP 2009.3) and its *Updated Operational Guidelines* (SEA-GLP 2009.4) were developed in collaboration with various stakeholders, and these were endorsed by all partners at the Global Programme Manager's Meeting held in New Delhi in April 2009 (SEA-GLP 2009.6).
- The number of countries that have attained the goal of elimination of leprosy as a public health problem (reporting prevalence rates less than one per 10 000 population) reduced from 122 in 1985 to two at the beginning of 2009 (Brazil, Nepal and Timor Leste). Nepal achieved the goal of eliminating leprosy as a public health problem by the end of 2009.
- Drugs required for multidrug therapy have been made available to all Member States of WHO. This will be continued beyond 2010.

- Measures to eliminate stigma and discrimination against persons affected by leprosy were initiated in endemic countries. Continued efforts are being made to improve collaboration and create greater synergy with national and international partners.
- Efforts are continuing to improve collaboration and create greater synergy with national and international partners.

4. Challenges

- The leprosy control programmes in Member States have been successful in their efforts to reduce the disease burden. However, these cannot afford to be complacent and it is important to sustain political commitment in the context of the declining number of new case cases and the competing priorities.
- Maintaining expertise in leprosy among health workers, especially in countries where the disease has become relatively rare, is another issue that the national programme will have to address.
- There is also a need to augment current information, education and communication (IEC) efforts to improve awareness and reduce stigma and social discrimination against persons affected by leprosy and their families.
- Efforts at reducing the magnitude of the disability burden and developing appropriate tools for the prevention of disabilities and rehabilitation need to be further promoted.
- Research will be needed to develop tools to prevent the occurrence of leprosy (vaccine/chemoprophylaxis) and to develop better and shorter treatment regimens which can be used more effectively in integrated leprosy control programmes.
- Sustaining effective partnerships based on mutual trust, equality and unity of purpose.

5. Activities implemented during 2009 and first half of 2010

The following activities were carried out during 2009 and in the first half of 2010.

5.1 Meetings

- Global Programme Managers' meeting on Leprosy Control Strategy was organized by GLP in SEARO New Delhi, India from 20-22 April 2009, to develop strategy for the next five years (2011-2015). It was attended by over 130 participants representing national programme managers, experts, partners and persons affected by leprosy (report reference SEA.GLP.2009.6). During the 3 days meeting the draft document of the global strategy and the operational guidelines were discussed. The outcome of this meeting was that a consensus was reached and the "Enhanced Global Strategy for further reducing the disease burden due to leprosy 2011-2015" (reference SEA.GLP.2009.3) and its

"Updated Operational Guidelines" and (reference SEA.GLP.2009.4) was endorsed by all the participants.

- The 10th TAG meeting was successfully organized on 23rd April 2009 in New Delhi, India (reference SEA.GLP.2009.5).
- Participated in the inter-country meetings held for the Eastern Mediterranean Region in Cairo, Egypt (July 2009), in the Western Pacific Region in Shanghai, China (June 2009), in African Region in Brazaville, Congo (June 2010) and South East Asia Region, Colombo, Sri Lanka (July 2010).
- A meeting to discuss and review data on drug resistance was held in Paris from 26-27 October 2009 (SEA-GLP 2010.2).
- An informal consultation meeting was organized in London on Monitoring Grade 2 Disability rate and Applicability of Chemoprophylaxis in Leprosy Control in November 2009 (reference SEA-GLP 2010.1)
- Meeting to develop guidelines to Strengthen the participation of leprosy affected people in leprosy services was organized by GLP in Manila, Philippines at the office of the Western Pacific Region on 9th and 10th June 2010.

5.2 Advocacy

- Participated in the advocacy meetings held in India with various partners aimed at supporting national programme activities for leprosy control.
- Participated in the ILEP Technical Commission meetings held in New Delhi, India (April 2009 and June 2010) and in London (March 2010).

5.3 Programme Evaluation

- Supported the National Programme of Myanmar in the review of the programme and developing the work plans for 2010.

5.4 Capacity building

- Capacity building workshops for health service manager in-charge of leprosy control programmes from low endemic countries were carried out in Taiz, Yemen (EMR) in February 2009, Shanghai China (WPR) in June 2009 and Dhaka, Bangladesh (SEAR) in June 2009.

5.5 Monitoring

- A sentinel surveillance network to monitor drug resistance in leprosy was also set up in eight endemic countries.

- The data on drug resistance for the year 2005-2008 was published in the Weekly Epidemiological Record (No. 26, 2009, 84 261-268). Drug resistance data for the 2009 was published in Weekly Epidemiological Record (No.29, 2010, 85, 281-284)
- The global leprosy situation is being monitored and data from over 120 countries have been compiled for 2009 and from over 140 countries in 2010 and published in the Weekly Epidemiological Record (No. 33, 2009,84 333-340 and No.35, 2010, 85, 337- 348).
- Review of detection trends in Yemen, China and Indonesia was carried out and the results published in the Weekly Epidemiological Record (No.21, 2009,84 185-196, No. 17, 2010, 85, 149-156 and No.26, 2010, 85, 249-264)

5.6 Field visits

- Field visits were made to China in April 2010 to review the activities carried out by the national programme.

5.7 Research

- Participated in the review of the U-MDT study that was conducted by WHO collaborating centre, the National Institute of Epidemiology, ICMR, Chennai, India and TDR. Uniform MDT study is progressing according to the protocol.

6. Activities planned for the remaining period of 2010

6.1 Meetings

- Organize an Expert Committee Meeting on Leprosy in Geneva, Switzerland in October 2010
- Organize a meeting on sentinel surveillance for drug resistance in November 2010 in Tokyo, Japan.

6.2 Health Service Manager Work shop

- In collaboration with the Regions and partners, one workshops for health service managers from low endemic countries to be held in PAHO/AMRO.

6.3 Developing strategy for capacity building

- In collaboration with various partners, WHO will be developing a broad strategy for capacity building with the aim to maintain expertise at country level to sustain leprosy control activities especially under low endemic conditions. This strategy will address the training needs of all categories of health workers involved in an integrated leprosy control programme.

6.4 Programme Review

- Review of programme in selected countries in coordination with all the regions.

7. Activities planned for 2011

7.1 Programme coordination

- Technical Advisory Group meeting
- Coordination meetings with partners
- Participate in various advocacy meetings at all levels
- Meetings at country level for programme coordination and planning
- Informal consultation meeting on recent developments in treatment of reactions

7.2 Monitoring and evaluation

- Collect and publish country, regional and global statistics
- Programme evaluations in selective countries in collaboration with the Regions
- Field visits to selective countries to review activities

7.3 Capacity building

- Workshops for health service managers on leprosy control in SEARO.
- Developing a comprehensive capacity building strategy for integrated leprosy control programmes with the aim to maintain expertise at country level in endemic countries.

7.4 Surveillance of drug resistance

- Support sentinel sites and monitor surveillance of drug resistance
- Organize meeting on sentinel surveillance for drug resistance

7.5 Research

- Monitor Uniform-MDT studies in India and Brazil

8. Budget

8.1 Special activities for countries under extraordinary circumstances (ending August 2010)

Broad Areas of work	Allotted Budget	Activities in 2010	Expenditure	Remaining Funds*
Support leprosy control programme in countries faced with extraordinary circumstances	350,833	Support to Afghanistan National Leprosy Control Programme	48,950	301,883
TOTAL	**350, 833**		**48,950**	**301,883**

* PSC 13% has been deducted in the Global Management System

8.2 Summary of expenditure of Global Leprosy Programme for 2007

Broad Areas of work	Activities	Allotted Budget	Expenditure (including PSC)	Remaining Funds
1. Coordination of Global programme	1.1 Technical Advisory Group Meeting	70,000	72,000	-2,000
	1.2 Participation in meetings for advocacy	40,000	42,492	-2,492
	1.3 Office support	20,000	21,160	-1,160
	1.5 Secretarial support	30,000	30,000	0
	sub-total	160,000	165,652	-5,652
2. Monitoring and Evaluation	2.1 Independent evaluation of national programmes	30,000	31,576	-1,567
	2.2. Field visits to review programme activities in selected countries	60,000	47,401	12,599
	sub-total	90,000	78,977	11,023
	TOTAL	250,000	244,629	5,371

8.3 Summary of expenditure of Global Leprosy Programme for 2008

Broad Areas of work	Activities	Allotted Budget	Expenditure	Balance
1. Coordination of Global Leprosy Programme	1.1 Technical Advisory Group Meeting (carried out in April 2009 as roll-over funds)	75,000	76,833	-1,833
	1.2 Participation in meetings for advocacy and programme coordination	40,000	39,227	773
	1.3 Office support	20,000	22,488	-2,488
	1.4 Secretarial support	35,000	35,000	0
	Sub-total	170,000	173,548	-3,548
2. Monitoring and Evaluation	2.1 Programme Review	40,000	33,698	6,302
	2.2 Field visits to review country activities	40,000	37,332	2,668
	Sub-total	80,000	71,030	8,970
	GRAND TOTAL	250,000	244,578	5,422

8.4 Summary of expenditure for the Global Leprosy Programme – 2009

Broad Areas of work	Activities	Allocated Budget	Expenditure	Remaining Balance
1. Coordination of Global programme	1.1 Participation in meetings for advocacy and programme coordination	45,000	33,200	11,800
	1.2 Office support (stationary, printing, and mailing)	20,000	26,524	-6,524
	1.3 Secretarial support	35,000	35,000	0
	Sub-total	100,000	94,724	5,276
2. Monitoring and Evaluation	2.1 Programme Review in selective countries	35,000	35,434	-434
	2.2 Field visits to review country activities	40,000	29,004	10,996
	Sub-total	75,000	64,438	10,562
3. Sentinel surveillance for Drug Resistance	3.1 Collaborative meeting with national programme managers and reference laboratories on sentinel surveillance for drug resistance	40,000	46,783	-6,783
	Sub-total	40,000	46,783	-6,783
	TOTAL	215,000	205,945	9,055

8.5 Summary of expenditure for Global Leprosy Programme – 2010 (as of July 2010)

Broad Areas of work	Activities	Budget received	Budget allocated (-PSC)	Expen-diture	Remaining Balance	Remarks
1. Coordination of Global programme	1.1 Participation in meetings for advocacy and programme coordination	30,000	26,550	12,257	14,293	
	1.2 Office support (stationary, printing, and mailing)	20,000	17,700	14,871	2,829	
	1.3 Secretarial support	35,000	31,000	31,000	0	
	1.4 Technical Advisory Group meeting	75,000	66,370		66,370	Meeting planned for in 1st Qr 2011
	Sub-total	160,000	141,620	58,128	83,492	
2. Monitoring and Evaluation	2.1 Programme Review and advocacy to sustain leprosy control activities in selective countries	50,000	44,250	3,215	41,035	
	2.2 Field visits to review country activities	40,000	35,400	8,598	26,802	
	Sub-total	90,000	79,650	11,813	67,837	
3. Sentinel surveillance for Drug Resistance	3.1 Sentinel surveillance for Drug Resistance Meeting for quality control, standardization of procedures and expansion of surveillance net-work	70,000	61,950	61,950	0	Meeting planned for 9-10 Nov 2010
	Sub-total	70,000	61,950	61,950	0	
4. Strengthening participation of person affected by leprosy	4.1 Workshop to develop guidelines to strengthen participation of persons affected by leprosy	50,000	44,250	46,128	-1,878	Additional funds USD 15,478 received from SMHF
	Sub-total	50,000	44,250	46,128	-1,878	
	TOTAL	370,000	327,470	178,019	149,451	

Out of the remaining funds in 2010 support, USD 66,370 will be rolled over into 2011 as the Technical Advisory Group meeting will be held only during the first quarter of 2011. The balance of USD 83,081 is expected to be used for the activities planned for in the remaining period of 2010 and first quarter of 2011.

8.6 Proposal for Global Leprosy Programme - 2011

Broad Areas of work	Activities	Planned Budget	Remarks
1. Coordination of Global programme	1.1 Participation in meetings for advocacy and programme coordination	30,000	
	1.2 Office support (stationary, printing, and mailing)	30,000	
	1.3 Secretarial support	35,000	
	1.4 Technical Advisory Group meeting		Remaining funds from 2010 to be used
	Sub-total	95,000	
2. Monitoring and Evaluation	2.1 Programme Reviews to sustain leprosy control activities in 3 selective countries	75,000	
	2.2 Field visits to review country activities	40,000	
	Sub-total	115,000	
3. Sentinel surveillance for Drug Resistance	3.1 Drug Resistance Meeting to review data, discuss issues on quality control, standardization of procedures and expansion of surveillance net-work	70,000	
	Sub-total	70,000	
4. Workshop for health service managers from low endemic countries	4.1 To train programme managers from low endemic countries who are working for integrated programmes	40,000	The Netherlands Leprosy Relief and German Leprosy and TB Association has provided the necessary funds
	Sub-total	40,000	
	GRAND TOTAL	320,000	
Request from TNF		**280,000**	

9. Consolidated proposal for GLP and the Regions – 2011

Consolidated proposal for implementation of the Enhanced Global Strategy 2011-2015 and its Operational Guidelines in the regions and headquarters are as follows.

Summary of funds requested for 2011 (in US $)

Regions	Budget (US$)
HQ/GLP	280,000
AFRO	1,225,000
AMRO	423,000
SEARO	1,110,000
EMRO	50,000
WPRO	464,000
Total	**3,552,000**

10. Conclusion

As a result of sustained activities on the part of national programmes and with support from various partners both national as well as international, the disease burden due to leprosy is expected to reduce further in the coming years.

Along with the reduction in new case detections, the damaging impact of the disease on the physical, social and economic well-being of individuals and families affected by leprosy are also expected to be decline. This is expected to be achieved through efforts to empower persons affected by leprosy, getting support from local communities and partners and ensuring that issues relating to stigma, discrimination and rehabilitation are tackled in a more integrated and inclusive manor. As such, persons affected by leprosy needing disability care should be able to access integrated health services.

It is important the current trend of declining disease burden be maintained in all endemic countries. To achieve this national programmes need to ensure that new cases are detected in a timely fashion, cases are properly diagnosed and promptly treated with free MDT, improve management of complications and side effects and increase community awareness about the disease so that cases self report for diagnosis at an early stage.

The Enhanced Global Strategy 2011-2015 has placed emphasis on reducing grade 2 disabilities among new cases and this should help to guide national programmes in ensuring timely case finding before impairment and disabilities sets in and to ensure that patients are promptly treated and cured with MDT. 2010 will be important for national programmes in preparing for the implementation of the Enhanced Global Strategy and in improving the quality of reports on grade 2 disabilities by ensuring that complete and accurate disability assessments are carried out on all new cases.

African Region (AFRO)

1. Introduction

Leprosy is one of the most devastating chronic diseases. Leprosy does not kill but it gnaws at you. It amputates you, both physically and mentally. It impoverishes and plunges you into a situation of cruel dependency. The weakened people affected by leprosy are sometimes, and even often, also rejected by his family and community. He experiences discrimination, which overwhelms him. Eliminating leprosy amounts to saying no to this unacceptable social situation, but which, unfortunately, is still common in many localities of our Region, despite the efforts to reduce the burden of the disease in the African Region.

Despite the social and economic difficulties experienced by Africa, the fight against leprosy in the Region has registered some good results by reducing the burden of the disease and rehabilitating people affected in several of our countries. Today, nearly everywhere, the communities are discovering that leprosy is an infectious disease as many others. The populations are now aware that leprosy can be cured and that its treatment is available and free for all patients in health centres. However, there are still a good number of patients who do not attend the health facilities for early detection and who run the risk of being diagnosed at an advanced stage of the disease, thus exposing them to disabilities. These same people are also becoming the reservoir that is sustaining the transmission of the disease. As a matter of fact, the leprosy burden in several areas and pockets within countries in Africa is a public health problem. Identifying the last patients at the local level is increasingly difficult thus free treatment would fail to reach them before deformities have been occurred. Therefore, greater attention should also be paid to patients who face human rights violations and who require help for their physical and socioeconomic rehabilitation.

Quite fortunately, the efforts by all have helped to drastically reduce the rate of leprosy infection since the adoption of Resolution WHA44.9 of the World Health Assembly in 1991 and Resolution AFR/RC44/R5 in 1994 of the WHO Regional Committee of Africa. To date, the Member-States of the African Region have achieved the objective of eliminating leprosy as a public health problem at the national level. At the beginning of 2010, the average prevalence rate of leprosy in the Region was 0.48 cases for 10,000 inhabitants with reference to the country reports compile at WHO AFRO for 2009[1]. However, in several countries, the objective of eliminating leprosy as a public health problem remains a challenge at the district level, where the situation varies from one country to the other and even from one district to the other. There are communities where the prevalence of leprosy is still higher, with many cases registered. One example is the Tanganyika health sector in RDC with a prevalence rate of 4.97 cases per 10.000 inhabitants in 2009[2] while most of health districts of the country have less thank one case per 10,000 inhabitants. In this context, it is necessary to find new approaches to improve the results at district level. We have also reached a point where we need to intensify our advocacy efforts, as well as the prevention and rehabilitation measures.

[1] = Table n°1 in annex : Compilation of MOH annual report for 2009
[2] = « Rapport épidémiologique de la lèpre» MOH / RDC of 2009

The new global strategy that was adopted recently is a good basis for discussions that should enable us, taking into account the context of the African Region, to develop the broad lines of a regional draft strategy by defining the targets, the objectives, the main activities and approaches to be used. The achievement of an objective demands resources. The objectives and the targets to be achieved need to develop new approaches that will help to conduct an effective resource mobilization campaign. Strengthen collaboration among stakeholders will be key and will boost all innovative towards further reduction of the leprosy burden in the African Region.

2. Leprosy contribution to the millennium Goal achievement

Leprosy burden reduction is a factor of the fight against poverty. Leprosy is not a killing disease but it disabled affected people if they are not early detected and treated. Most of affected people are illiterate living in remote and non accessible areas with low environmental health precautions. Most of them only come to health facilities late after physical damages are created. At this stage, they are rejected from families and communities. They are isolated and could not participate in social and economical activities. Most of them are dependant and when there is no support, they become beggars. 80% of disabled beggars in towns and cities are peoples affected by leprosy.

The reduction of leprosy burden is not only the reduction of the number of new cases occurring in a community. It also includes the complications management, re-adaptation, rehabilitation, and reinsertion of people suffering from leprosy stigmas.

3. Leprosy as a component of NTD

Neglected tropical diseases (NTD) affect an estimated one billion people in the world. Up to 90% of the total disease burden is believed to occur in Africa[3]. Neglected tropical diseases affect the poor communities that form a large proportion of populations in the countries. The magnitude of the burden of the neglected tropical diseases is hardly comprehensive. Its harmful consequences on health include serious stigmatisation and psychological effect on patients, negative impact on productivity of affected populations and therefore reduce family and ultimately national economic potential. A significant number of children are affected by the diseases and many of them suffer considerable delay in their mental development which impacts negatively on their school performance and prospects of improved socio-economic status in adulthood.

To achieve existing World Health Assembly and WHO/AFRO Regional Committee resolutions on NTDs and to move closer to Medium-Term Strategic Plan (MTSP) and the Millennium Development Goals (MDGs), the WHO/AFRO Cluster of Disease Prevention and Control is targeting the eradication of dracunculiasis, the elimination of leprosy, lymphatic filariasis, onchocerciasis and trypanosomiasis, and the control of Buruli ulcer, schistosomiasis, intestinal parasitosis, leishmaniasis and endemic treponematosis (yaws and bejel) . The overall objective is to provide effective coordination and support to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of NTDs, including zoonotic diseases in an integrated approach. To that end, comprehensive tools and strategies will be developed for:

[3] = Neglected Diseases : A human rights analysis, WHO, TDR/SDR/SEB/ST/07.2 (2007)

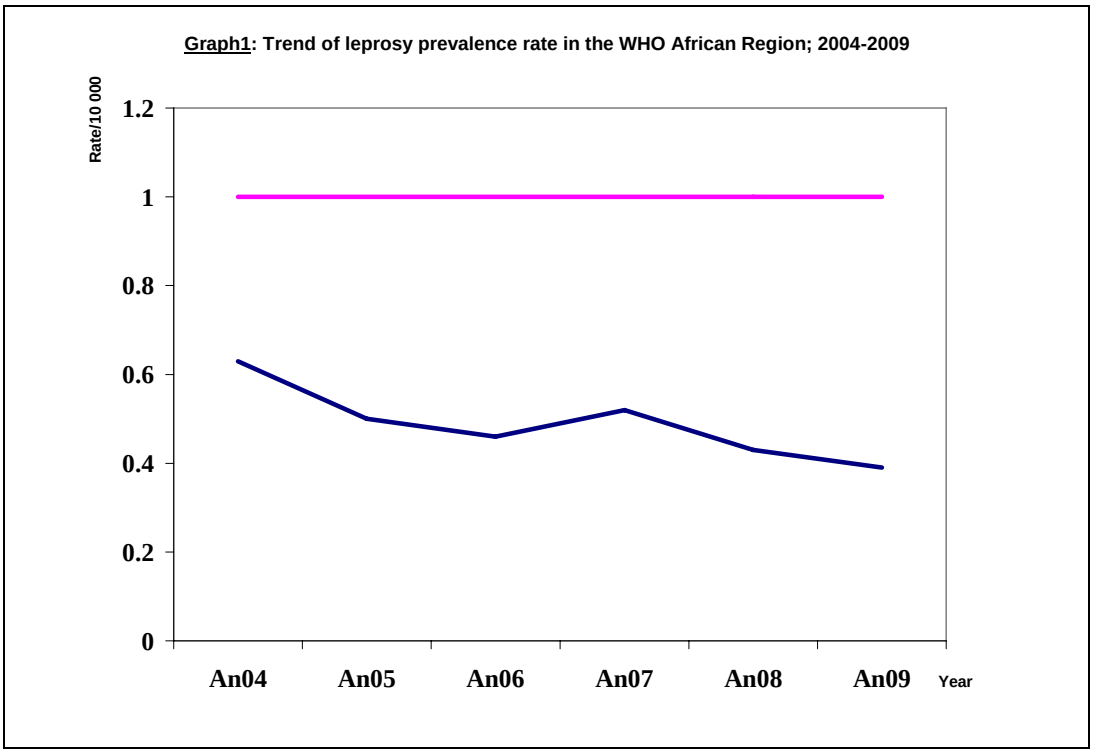
- joint advocacy, resource mobilization and communication component,
- joint plan for strengthening community involvement and participation in NTD control,
- and comprehensive M & E framework for all NTD control activities.

A comprehensive stakeholder analysis and collaboration for better coordination of incomes and inputs will help to strengthen health systems in countries and achieve effectively and efficiently this objective

4. Leprosy situation analysis

4.1 Leprosy prevalence trend in the WHO African Region over the past 5 years

The leprosy prevalence has dropped from 43,381 in 2004 to 31,104 cases in 2009[4]. This means more than 25% of reduction in the prevalence of the disease. The prevalence rate consequently decreased from 0.63 to 0.39 cases per 10,000 inhabitants in the same period (Graph 1 below). This trend confirms the achievement of the elimination of leprosy as a public health problem in the Region.



[4] = WHO compilation of leprosy annual statistical reports published by countries

4.2 Leprosy new cases trend in the WHO African Region over the past 5 years

The number of new cases of leprosy detected each year has dropped from 45,024 in 2004 to 28,947 in 2009. All indicators (table 1 below) which contribute to analyze the trend and the magnitude of the Mycobacterium leprea infection are stable over years. The proportion of multi bacillary cases is between 66 and 75% of new cases. The proportions of children and disability grade 2 among new cases are between 9 and 11% over years. The proportion of females affected are between 17 and 36% indicating that majority of patients are males. In conclusion, the trend of these indicators is coherent and shows that leprosy is decreasing in the Region but the disease contagious level remains the same over years. The translation of this conclusion is that programmes have to maintain leprosy control activities and improve them if not, the disease will explode.

Table 1: *Overview of the trend of leprosy essential indicators in the WHO African Region, 2004-2009*

Indicators	2004	2005	2006	2007	2008	2009
Prevalence rate	0.63	0.5	0.46	0.52	0.43	0.39
Detection rate	6.51	4.81	4.54	5.08	4.11	3.66
% MB/new cases	69	71	72	73	75	0.74
% female/new cases	22	17	24	24	36	29.61
% children/new cases	10	9	9	10	10	8.91
% mutilation grade 2 among new case	10	9	10	10	11	10.88

4.3 Leprosy prevalence trend at countries level

The trend of the prevalence as observed from the MOH annual statistical reports is decreasing in most of countries. However, the situation is worsening in three countries:

- Comoros: 72 cases in 2004 and 179 cases in 2009
- Liberia: 29 cases in 2004 and 484 cases in 2009
- Zambia: 554 cases in 2004 and 711 cases in 2009

The leprosy situation of some specific population needs more attention:

- Pygmies of Equatorial forest in central Africa countries: Democratic Republic of Congo, Central Africa Republic, Congo, Gabon, and Cameroon
- Nomadic shepherds in Niger and Chad
- Refugees and displaced populations in Tanzania, Uganda, Chad, Central Africa, Congo, and Democratic Republic of Congo.

4.4 Prevalence/detection ratio

The prevalence / detection ratio should be less than one, because the duration of the treatment is 12 month for MB cases and only 6 months for PB cases and the reporting period is one year. Only 14 countries have a ratio of less than one. The figures of Congo (2.52) and Liberia (3.03) are worsening[5]. This situation indicates an important decrease in the quality of the management of leprosy cases.

Table 2: *Number of countries of the African Region by range of prevalence/detection ratio in 2009 (WHO compilation of country reports)*

Prevalence/detection rate	Number of countries
Less than 1	19
Between 1 and 2	20
More than 2	3

4.5 Leprosy burden in countries of the WHO African Region

The leprosy essential indicators in countries of the WHO African Region, is in the table 1 of annex. All countries have reached the goal of elimination. However, the 2009 report is showing Comoros and Liberia as countries with prevalence rate at more than one. This situation needs to be investigated. Today, because all countries have reached the leprosy elimination threshold, the major difficulty is to define a high leprosy burden country. The consensus agreed upon with all partners, is that leprosy burden should include the number of new cases, the proportion of new cases with disability grade 2, the proportion of cases in remote and non accessible areas, the charge of work for health workers and resources available to support the leprosy programme.

However, using a simple planning process without consideration of the size of country populations, the number of new cases is used to define three groups of priority in the African Region:

- Six countries with more than 1,000 new cases per year: Dem. Rep. of Congo, Ethiopia, Madagascar, Mozambique, Nigeria and Tanzania. These countries can be considered as high leprosy burden countries because the risk of rapid expansion of the disease in these countries is high.
- Six countries with a number of new cases between 500 and 1000 per year: Angola, Côte d'Ivoire, Ghana, Guinea, Malawi, Niger. These countries can be considered as medium burden countries with a potential risk of expansion.

[5] = Table n°1 in annex related to essential indicators of leprosy in countries of the African Region

- Six countries with a number of new cases between 400 and 5000 per year: Burkina Faso, Cameroon, Chad, Liberia, Sierra Leone, and Zambia. The trend of new cases needs a close surveillance to early detect the trend.

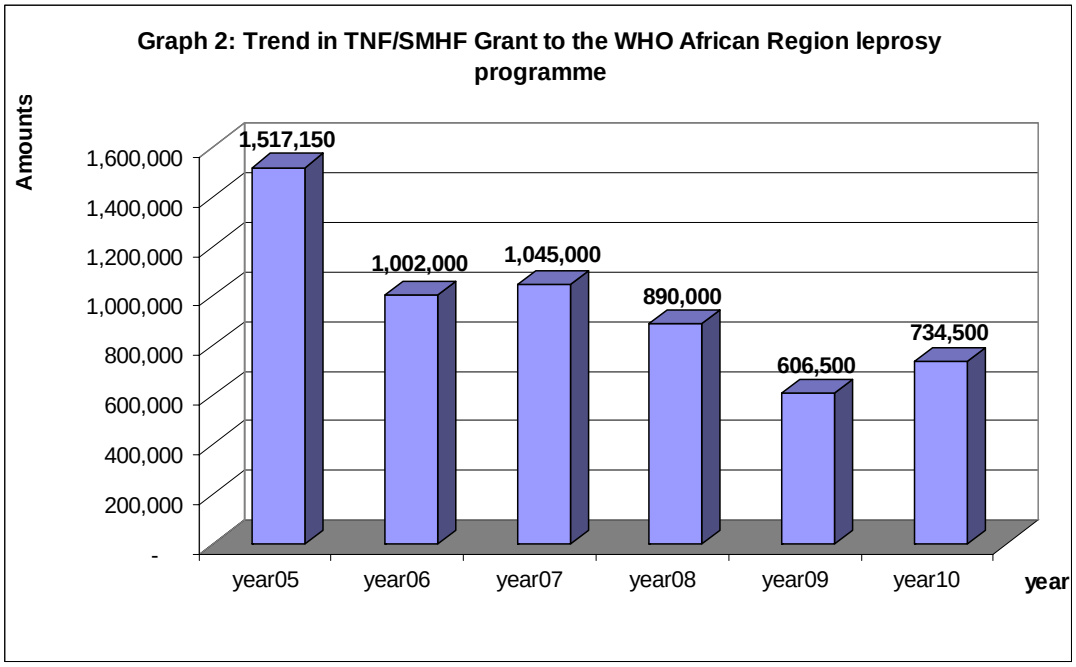
5. Constraints

a) The WHO regional office leprosy programme is under staffed. This programme has been for a while a "one man show" programme but is now part of NTD unit. The NTD strategic orientation is towards an integrated NTD plan development. This orientation should help to compensate the need of staffing of leprosy programme. However the situation of limited number of technical staff at NTD unit will not help to solve the issue of staffing of specific programmes.

b) Data management and information dissemination system are weak. Data flow in countries is not regular. Reports are not available in time. Some country reports are not much reliable or not reflecting the national figures. The software of the computer programme for leprosy data management developed to facilitate data collection and analysis at all levels, is not introduced in programmes for logistic and financial reasons. Most of countries are not publishing leprosy programme achievements. Countries are not sharing best practices on different approaches used to reach unreachable populations in remote and isolate areas.

c) Collaboration and coordination with partners mainly ILEP members is weak. Most of ILEP members are organizing direct support to countries. The need of joint plan at country level under the MOH umbrella is expressed but hardly translated into action. Information sharing on the financial support to programmes is low.

d) The regional leprosy programme budget is insufficient. The contribution of the core budget of WHO to leprosy activities is nearly nil. NTF/SMHF is the unique source of funding to the regional leprosy programme. The trend of NTF/SMHF contributions to the programme is decreasing (graph 2 below). Leprosy new cases are rare and scattered in countries. Most of the time, cases are in remote areas with no access to health facilities. Therefore, efforts to detect early cases and complete an appropriate treatment are more demanding and more costing while funds are decreasing



e) The research in leprosy programme is poor. The technical and financial supports to these activities are weak. The African Region is not contributing to the global study on to leprosy drugs resistance because of operational issues linked to the staff and to the logistic organization.

f) Some constraints linked to the programme implementation are: unstable geographical coverage due to frequent reshuffle of the staff, miss management of leprosy specific drugs, difficulties to get loose clofazimin for reactions treatment, irregular supervision, lack of trainings, and absence of independent evaluation of programmes.

6. Leprosy programme challenges

Since 1985, with the introduction of Rifampicin as the corner stone of the treatment of leprosy affected people, the prevalence of leprosy has dropped by more than 90% in the African Region. Over 1.5 million patients have been cured of the disease through multi drug therapy treatment. As of today, all countries in the Region have achieved the elimination of leprosy as a public heath problem. This success would have not been possible without a strong commitment of endemic countries supported by international community including the Nippon Foundation, Sasakawa Memorial Health Foundation, Novartis and the Novartis Foundation for Sustainable Development, bilateral organizations and national and international NGOs, notably the International Federation of Anti-leprosy associations (ILEP).

Leprosy control has reached a critical state where number of patients has been dramatically reduced in recent decades but the disease still exists. Leprosy continues to be

part of major issues contributing to impoverish the population in Africa. The need of maintaining high quality of leprosy case management is high. Major challenges include:

- Improving access to diagnosis through integration of leprosy case management activities into existing public health services.
- Organizing leprosy medicines management by providing effective multi drug therapy blister packs (MDT) free of charge and supporting countries to avoid shortage and expiring stock situations countrywide.
- Early detection of new cases countrywide to ensure the reduction of the risk of deformities and disabilities among patients and ensure that leprosy sufferers can live normal lives with dignity.
- Maintaining high-level political commitment and social mobilization to change the image of leprosy and rehabilitate people affected by the disease.
- Organizing a good surveillance system is essential for sustainable leprosy control in countries which have eliminated leprosy as a public health problem.

On top of all these challenges, further reducing the leprosy burden at all health system levels in countries through a coordinated inter-sectoral approach, substantial funding and greater participation of NGOs and foundations will be more challenging.

WHO Regional Office Leprosy Plan of Action

7. Mission of the programme

The mission of the regional leprosy program is to provide technical orientation, support and guidance to Member States in the WHO African Region in order to contribute to the prevention, control, and elimination of leprosy in the Region, including research in prevention and control of the disease.

8. Core functions of the programme

8.1 Developing regional leprosy strategies and supporting Member States in adapting and implementing strategies, guidelines, and plans of action to reduce the burden of leprosy in the Region

8.2 Coordinating leprosy drug donation and management in countries and supporting the national teams in plans development for case finding, treatment and follow up, and ensure functional information system with regular and reliable reporting frame

8.3 Supporting Member States in monitoring and evaluating progress made in reducing the burden of leprosy in the Region

8.4 Establishing a well-coordinated network of institutions and partners to support endemic countries in building operational capacity and carry forward operational research in support of global leprosy initiatives.

9. Objectives

9.1 Global objective

Reduce 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.

9.2 WHO Regional office specific objective

Eliminate leprosy as a public health problem at all the health districts in at least 22 countries of the African Region during the period of 2011 to 2015.

9.3 Regional targets and milestones

The objectives, indicators and milestones for the regional leprosy programme are summarized in the table 2 in annex.

- The number of new cases with disability grade 2 is expected to be reduced from 3,532 in 2010 to 2,200 in 2015.
- The number of countries with leprosy eliminated at all health districts level will be increased from 2 to 22 by 2015

10. Main interventions

a) Development and disseminate guidelines and strategies to orient the elaboration of leprosy plan within a national NTD integrated plan in countries of the African Region.

b) Support countries to develop and finalize a new national leprosy strategic plan integrated to the national NTD oriented plan.

c) Support countries in capacity building development at national level in collaboration with integrated disease surveillance and response unit.

d) Contribute to the reinforcement of national leprosy information system as part of a strong M & E system for NTD control in countries of the African Region.

e) Maintain evidence-based advocacy and awareness for leprosy programmes and leprosy affected people rehabilitation and reinsertion in countries of the African Region.

f) Support countries to strengthen the leprosy case management activities including reporting and information dissemination.

g) Scale up active case finding, treatment and surveillance activities in high endemic countries by:

   - Coordinating activities for the monitoring of the elimination of leprosy at national level and,

- developing new strategies to enable early case detection and treatment to eliminate leprosy at sub-national levels
- Organizing surveillance activities in collaboration with Integrated Disease Surveillance Unit

h) Support the implementation of research protocols related to the control of leprosy

11. Budget

11.1 Budget distribution for activities and for each year

Year	2011	2012	2013	2014	2015	Total
Staffing	250,000	275,000	300,000	325,000	350,000	375,000
Consultants	40,000	30,000	20,000	15,000	12,000	10,000
Advocacy and social mobilazation	55,000	35,000	15,000	12,000	9,000	5,000
Regional and international meetings	130,000	130,000	130,000	130,000	130,000	130,000
Trainings	300,000	150,000	60,000	-	-	-
guidelines and documentation	20,000	10,000	10,000	10,000	10,000	10,000
Contribution to research activities	10,000	10,000	10,000	10,000	10,000	10,000
Strategic plan development and annual planing	70,000	35,000	35,000	35,000	35,000	35,000
community based interventions	95,000	95,000	95,000	95,000	95,000	95,000
specific intervention in high endemic disctricts	105,000	65,000	45,000	25,000	25,000	25,000
Supervision, monitoring and evaluation	150,000	150,000	150,000	150,000	150,000	150,000
Total	**1,225,000**	**985,000**	**870,000**	**807,000**	**826,000**	**845,000**

11.2 Budget distribution for group of countries for each year

Year	2011	2012	2013	2014	2015	Total
AFRO Regional office	545,000	495,000	480,000	472,000	491,000	510,000
High endemic countries	360,000	260,000	220,000	180,000	180,000	180,000
Medium endemic countries	150,000	105,000	90,000	75,000	75,000	75,000
Specific action in nomadic population	50,000	50,000	50,000	50,000	50,000	50,000
Specific action among refugees sand displaced population	120,000	75,000	30,000	30,000	30,000	30,000
Total	**1,225,000**	**985,000**	**870,000**	**807,000**	**826,000**	**845,000**

11.3 Budget detail for countries and Regional office

The detailed distribution of the budget is in annex B.

11.4 Sasakawa Memorial Health Foundation (SMHF) funds for regional leprosy programme – 2010 mid term report

Year	Budget area	Activities for elimination and further reducing leprosy burden	Leprosy elimination monitoring & surveillance	Advocacy and Community Action for leprosy control	Technical staff support in region & countries	TAG, Inter-country meetings & operational support	Total
2006	Rollover funds from 2006	30,678	0	0	159,226	0	189,904
	2007 grant	152,000	75,000	15,000	450,000	310,000	1,002,000
	Total available for the year	182,678	75,000	15,000	609,226	310,000	1,191,904
	Total expenditures	374,058	30,000	0	622,226	135,600	1,161,884
	Remaining funds at the end of 2007	-191,380	45,000	15,000	-13,000	174,400	30,020
2007	Rollover funds from 2006					30,020	30,020
	2007 grant	360,000	80,000	35,000	470,000	100,000	1,045,000
	Total available for the year	360,000	80,000	35,000	470,000	130,020	1,075,020
	Total expenditures	360,000	80,000	35,000	370,000	75,020	920,020
	Remaining funds at the end of 2007	0	0	0	100,000	55,000	155,000

Year	Budget area	Activities for elimination and further reducing leprosy burden	Leprosy elimination monitoring & surveillance	Advocacy and Community Action for leprosy control	Technical staff support in region & countries	TAG, Inter-country meetings & operational support	Total
2008	Rollover funds from 2007				100,000	55,000	155,000
	2008 grant	105,000	190,000	20,000	460,000	115,000	890,000
	Total available for the year	105,000	190,000	20,000	560,000	170,000	1,045,000
	Total expenditures	115,000	200,000	30,000	560,000	100,000	1,005,000
	Remaining funds at the end of 2008	-10,000	-10,000	-10,000	-	70,000	40,000
2009	Rollover funds from 2008					40,000	40,000
	2009 grant	60,000	110,000	25,000	290,000	95,000	580,000
	Total available for the year	60,000	110,000	25,000	290,000	135,000	620,000
	Total expenditures	60,000	110,000	25,000	290,000	35,000	520,000
	Remaining funds at the end of 2009	0	0	0	0	100,000	100,000
2010	Rollover funds from 2009*					150,000	150,000
	2010 grant	160,000	125,000	50,000	250,000	65,000	650,000
	Special contribution from partners**					51,085	51,085
	Total available for the year	160,000	125,000	50,000	250,000	266,085	851,085
	Total expenditures	226,000	130,000	65,000	251,000	150,210	822,210
	Expected remaining funds at the end of 2010	-66,000	-5,000	-15,000	-1,000	115,875	28,875

* = USD 50,000 as AFRO budget rollover funds

** = USD 51,085 are expected from NLR (USD 11,899), AFRF (USD 28,310.75) and SMHF (USD 10,875) as contribution to the regional meeting

NB = The Programme Support Costs are not included in amounts

Annex A

Table 1: *Essential leprosy indicators by country for the year 2009 in the WHO African Region as from MOH*

Countries	population	Regist.	New	Pre. rate	Det. rate	Relapse	New MB		New female		New Children		New G2 Disabled		Ratio
Algerie	35,423,000	1	1	0.00	0.00	0	0	0.00	0	0.00	0	0.00	0	0.00	1.00
Angola	18,993,000	1,154	937	0.61	4.93	0	805	85.91	310	33.08	110	11.74	119	12.70	1.23
Benin	9,212,000	185	248	0.20	2.69	0	170	68.55	127	51.21	16	6.45	47	18.95	0.75
Burkina Faso	16,287,000	359	412	0.22	2.53	12	343	83.25		0.00	14	3.40	65	15.78	0.87
Burundi	8,519,000	270	280	0.32	3.29		232	82.86		0.00	14	5.00	58	20.71	0.96
Cameroun	19,958,000	530	453	0.27	2.27	2	339	74.83	108	23.84	53	11.70	16	3.53	1.17
CAR	4,506,000	309	247	0.69	5.48	0	167	67.61	146	59.11	68	27.53	41	16.60	1.25
Tchad	11,506,000	586	484	0.51	4.21			0.00	168	34.71	43	8.88	82	16.94	1.21
Comores	691,000	179	318	2.59	46.02	3	104	32.70	119	37.42	101	31.76	6	1.89	0.56
Congo	3,759,000	366	145	0.97	3.86	0	114	78.62	66	45.52	12	8.28	9	6.21	2.52
Côte d'Ivoire	21,571,000	790	884	0.37	4.10	0	630	71.27	208	23.53	81	9.16	171	19.34	0.89
Rép D. Congo	67,827,000	4,348	5,062	0.64	7.46		3,001	59.28	2450	48.40	594	11.73	509	10.06	0.86
Equatorial Guinea	693,000	33	23	0.48	3.32	1	15	65.22	14	60.87	1	4.35	2	8.70	1.43
Eritrea	5,224,000	156	11	0.30	0.21	4	5	45.45	1	9.09	0	0.00	5	45.45	14.18
Ethiopia	84,976,000	4,859	4,417	0.57	5.20	312	3,909	88.50	287	6.50	302	6.84	408	9.24	1.10
Gabon	1,501,000	37	26	0.25	1.73	0	25	96.15	14	53.85	4	15.38	8	30.77	1.42
The Gambia**	1,751,000	34	34	0.19	1.94	0	27	79.41	9	26.47	6	17.65	2	5.88	1.00
Ghana	24,333,000	646	623	0.27	2.56	0	502	80.58	303	48.64	20	3.21	16	2.57	1.04
Guinée	10,324,000	535	636	0.52	6.16		435	68.40		0.00	48	7.55	63	9.91	0.84
Guinea Bissau*	1,647,000	79	75	0.48	4.55		41	54.67		0.00		0.00		0.00	1.05
Kenya	40,863,000	234	157	0.06	0.38	24	148	94.27	71	45.22	10	6.37	32	20.38	1.49
Lesotho	2,084,000	4	5	0.02	0.24	0	3	60.00	2	40.00	0	0.00	0	0.00	0.80
Liberia	4,102,000	1,259	415	3.07	10.12	0	307	73.98	138	33.25	43	10.36	6	1.45	3.03
Madagascar	20,146,000	1,711	1,572	0.85	7.80	0	1,256	79.90	412	26.21	152	9.67	251	15.97	1.09
Malawi****	15,692,000	759	759	0.48	4.84			0.00		0.00		0.00		0.00	1.00
Mali	13,323,000	405	346	0.30	2.60	0	242	69.94	90	26.01	17	4.91	24	6.94	1.17
Mauritanie	3,366,000	27	34	0.08	1.01	0	26	76.47	8	23.53	4	11.76	3	8.82	0.79
Mauritius	1,297,000	0	0	0.00	0.00	0	0		0		0		0		
Mozambique	23,406,000	1,102	1,191	0.47	5.09		887	74.48		0.00		0.00	129	10.83	0.93
Namibia	2,212,000	4	4	0.02	0.18	0	2	50.00	3	75.00	0	0.00	1	25.00	1.00
Niger	15,891,000	457	555	0.29	3.49	1	389	70.09		0.00	12	2.16	86	15.50	0.82
Nigeria	158,259,000	5,099	4,219	0.32	2.67	36	3,733	88.48	1772	42.00	409	9.69	494	11.71	1.21
Rwanda	10,277,000	31	28	0.03	0.27	3	22	78.57	19	67.86	2	7.14	4	14.29	1.11
Sao Tome	165,000	0	0	0.00	0.00	0	0		0		0		0		
Senegal	12,861,000	332	271	0.26	2.11	14	218	80.44	118	43.54	37	13.65	48	17.71	1.23
Seychelles	85,000	0	0	0.00	0.00	0	0		0		0		0		
Sierra Leone	5,836,000	344	462	0.59	7.92	1	277	59.96	192	41.56	39	8.44	36	7.79	0.74
Tanzania	45,040,000	2,614	2,654	0.58	5.89	45	2,138	80.56	1068	40.24	260	9.80	292	11.00	0.98
Togo	6,780,000	138	162	0.20	2.39	0	129	79.63	83	51.23	13	8.02	23	14.20	0.85
Uganda	33,796,000	410	346	0.12	1.02	0	275	79.48	177	51.16	29	8.38	67	19.36	1.18
Zambia	13,257,000	711	446	0.54	3.36	41	335	75.11	87	19.51	68	15.25	23	5.16	1.59
Zimbabwe	12,644,000	7	5	0.01	0.04	2	5	100.00	2	40.00	0	0.00	5	100.00	1.40
TOTAL	**790,083,000**	**31,104**	**28,947**	**0.39**	**3.66**	**501**	**21,256**	**73.43**	**8,572**	**29.61**	**2,582**	**8.92**	**3,151**	**10.89**	**1.07**

* = données partielles ** = third quarterly report received *** = 2008 final report **** = 1&2 quarter partial report Le Liberia est passé de 484 à 1259 de prévalence

Table 2: *Regional leprosy programme targets and milestones*

Objectives	Indicators	Targets	Milestones					
			Baseline	2011	2012	2013	2014	2015
Global objective								
Reduce 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 rate of new cases with disability grade 2	0.17/100,000	0.47/100,000	0.43/100,000	0.39 / 100,000	0.35/100,000	0.31/100,000	0.30/100,000
	Number of New cases	11,097	31,097	28,000	26,000	24,000	22,000	20,000
	Number of new cases with disability grade 2	1,332	3,532	3,200	2,900	2,700	2,400	2,200
Regional additionnal objective								
The Africa Region shall have an additional objective which shall be the elimination of leprosy as a public health problem in all the health districts within the period 2011 to 2015	Number of countries with district having a prevalence rate up to 1 case per 10,000 inhabitants	22	44	38	34	30	26	22
	Number of registered cases at the end of the year	15,000	32,342	29,000	21,000	21,000	18,000	15,000

Annex B

Detailed distribution of the budget to countries according to activities and years

WHO AFRO Regional office budget						
Areas of intervention	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**
Staffing	250,000	275,000	300,000	325,000	350,000	375,000
Consultants	40,000	30,000	20,000	15,000	12,000	10,000
Monitoring and evaluation	50,000	50,000	50,000	50,000	50,000	50,000
Advocacy and social mobilazation	25,000	20,000	15,000	12,000	9,000	5,000
Regional and international meetings	50,000	50,000	50,000	50,000	50,000	50,000
Trainings	100,000	50,000	25,000	-	-	-
guidelines and documentation	20,000	10,000	10,000	10,000	10,000	10,000
Contribution to research activities	10,000	10,000	10,000	10,000	10,000	10,000
Total	545,000	495,000	480,000	472,000	491,000	510,000
High endemic countries: Dem. Rep. of Congo, Ethiopia, Madagascar, Mozambique, Nigeria and Tanzania						
Areas of intervention	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**
Strategic plan development and annual planing	40,000	20,000	20,000	20,000	20,000	20,000
Training	80,000	40,000	20,000	-	-	-
community based interventions	40,000	40,000	40,000	40,000	40,000	40,000
specific intervention in high endemic disctricts	80,000	40,000	20,000	-	-	-
national meetings	80,000	80,000	80,000	80,000	80,000	80,000
Supervision, monitoring and evaluation	40,000	40,000	40,000	40,000	40,000	40,000
Total	360,000	260,000	220,000	180,000	180,000	180,000
Medium endemic countries: Angola, Côte d'Ivoire, Ghana, Guinea, Malawi, Niger						
Areas of intervention	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**
Stratégic plan development	30,000	15,000	15,000	15,000	15,000	15,000
Training	60,000	30,000	15,000	-	-	-
community based interventions	30,000	30,000	30,000	30,000	30,000	30,000
Supervision, monitoring and evaluation	30,000	30,000	30,000	30,000	30,000	30,000
Total	150,000	105,000	90,000	75,000	75,000	75,000
Specific action in nomadic population: Democratic Republic of Congo, Central Africa Republic, Congo, Gabon, and Cameroon						
Areas of intervention	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**
Active case finding activities	25,000	25,000	25,000	25,000	25,000	25,000
community based interventions	25,000	25,000	25,000	25,000	25,000	25,000
Total	50,000	50,000	50,000	50,000	50,000	50,000
Specific action among refugees sand displaced population: Tanzania, Uganda, Chad, Central Africa, Congo, and Democratic Republic of Congo						
Areas of intervention	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**
awareness and social mobilization	30,000	15,000	-	-	-	-
training of health workers	60,000	30,000	-	-	-	-
Supervision ant technical support to health workers in camps	30,000	30,000	30,000	30,000	30,000	30,000
Total	120,000	75,000	30,000	30,000	30,000	30,000
General total	**1,225,000**	**985,000**	**870,000**	**807,000**	**826,000**	**845,000**

Americas (AMRO/PAHO)

1. Summary

Endemic countries continued intervention to maintain the reduction in the incidence of the disease and to reduce disease burden. Improved access to leprosy diagnosis and free MDT remains the cornerstone of the leprosy elimination strategy. Integration of leprosy control activities within general health services has been initiated in all the endemic countries based on country-specific situations and available resources. The staff from the specialized programmes is providing key support to the general health services in terms of capacity building, monitoring and supervision. However, sustaining leprosy control activities in the context of low prevalence conditions will continue to be a challenge in the coming years for the majority of national programmes. Countries will need support so that leprosy control activities are sustained and to ensure that the gains made under the elimination strategy are maintained.

PAHO continues to work closely with national programmes especially in developing work plans along with providing technical support, free supply of MDT drugs and in monitoring the leprosy situation at country level closely. In addition, it will continue to collaborate and coordinate efforts with all partners to further reduce the disease burden in all endemic countries.

The main objectives of the national programs were to:

- sustain political commitment to reduce the burden of the disease;
- ensure timely case detection and accessibility of cases to MDT;
- build capacity among general health care staff in diagnosis and treatment of leprosy;
- strengthen the monitoring and supervision of activities;
- enhance community participation in leprosy control.

2. Relevant Situation in 2009

- A total of 47,260 cases were being treated with multidrug therapy (MDT).
- 40,948new cases were detected.
- 7% of the new cases were found among children under the age of 15.
- Approximately 6% of the new cases showed grade 2 disability.
- 57% of the new cases were multibacillary (MB).

3. Profile of New Cases Disaggregated by Country, Americas, 2009

Countries	Cases	MB Cases	Female Cases (%)	Cases in Children under 15 Y.O.	Grade 2 Disability
Argentina	333	266	59	2	27
Brazil	38179	21414	16865	2669	2436
Bolivia	141	49	58	10	21
Bahamas	0	0	0	0	0
Belize	0	0	0	0	0
Chile	0	0	0	0	0
Colombia	468	352	187	11	35
Costa Rica	7	7	2	0	0
Cuba	264	216	111	8	19
Dominican Republic	167	108	71	13	12
Ecuador	81	59	21	1	3
El Salvador	–	5	3(6.0%)	0	1
Guatemala	1	1	0	0	0
Guyana	29	19	12	1	0
Haiti	18	–	–	–	–
Honduras	–	–	–	–	–
Jamaica	7	7	1	0	0
Mexico	207	89	49	1	10
Nicaragua	6	4	2	1	-
Paraguay	404	319	144	16	39
Peru	27	19	3	0	5
Saint Lucia	8	3	2	0	0
Suriname	[(1)] 38	27	14	4	0
Trinidad and Tobago	26	16	11	2	2
United States	–	–	–	–	–
Uruguay	8	7	5	0	1
Venezuela	567	392	188	26	34
Total for LAC only	40,948	23,379	17,805	2,765	2,645

(-) no information

4. Main Achievements

- PAHO/WHO supported the countries with publication of health education and advocacy materials on leprosy. Training courses for primary health workers on diagnosis and treatment.
- Supported a Regional meeting (attended by Argentina, Brazil, Colombia, Cuba, Ecuador, *Dominican Republic, Mexico, Paraguay and Venezuela)* to evaluate leprosy status and to elaborate action plans held in Dominican Republic, whit this objectives:
  - Evaluate the status of leprosy elimination/control in priority countries;
  - Review the main elements of the Control strategy
  - Discuss issues related to sustaining the achievements of leprosy elimination strategy.

The participants discussed approaches for achieving sustainable leprosy control and identified the main activities in this direction. Particularly, it was emphasized the need to integrate all the essential components of leprosy control activities into the existing primary health care system, strengthen referral service and adapt available strategies to local situations, in order to sustain leprosy control at sub-national levels.

- A Regional Meeting whit National Coordinators was held in Lima Peru, October 2010 in order to elaborate a Regional Guidelines for Leprosy Control.
- Updating country data analysis in Argentina, El Salvador, Colombia, Cuba, Ecuador, Dominican Republic, Paraguay and Venezuela at a subnational level.
- Evaluation of Dominican Leprosy Control Program: with the objective of observing the development of the National Leprosy Program at subnational level.
- Provided funding so that the, PAHO Brazilian Focal Point attended the SMHF Consulting Meeting in Tokyo, Japan November 2010.
- Operational supports for Regional Program
- Reviewing and reproducing Leprosy Ecuador Guidelines for Leprosy Control
- Support El Salvador Leprosy National coordinator to attend a leprosy course in Fontilles, Spain.
- *Drug Management for Endemic Countries
- *Updating country case registries, disaggregated by epidemiological variables that allow to evaluate the endemia

5. Statement of Expenditures

Activity	Budget (US$)
• Workshop for improvement in planning, monitoring, and appraisal for monitors (Brazil)	25,600.00
• Workshop in prevention of disabilities in Leprosy (Brazil)	5,300.00
• Workshop with organizers and members of the Communication's Network in Leprosy (Brazil)	18,400.00
• Workshop of planning, monitoring, and appraisal for municipalities, health regional and states with focus in the case-finding in children under 15 years old (Brazil)	5,800.00
• Supervision of the activities implemented after training of 2009 (Brazil)	21,300.00
• Construction and implementation of the line of care in Leprosy (Brazil)	4,200.00
• Advisory Services to the Leprosy control activities in priority municipalities (Brazil)	25,500.00
• Technical visit to the Institute Lauro de Sousa Lima for monitoring of research activities (Brazil)	2,800.00
• Monitoring activities of Leprosy control survey in priority municipalities (Brazil)	23,800.00
• Sub total Brazil	$132,700.00
• Regional meeting to elaborate Regional Leprosy Control Guidelines for	36,200
• Operational support for Regional Program	9,534
• Production of health education materials	9,000
• Supported supervision visit to Argentina National Program	3,680
Supported Ecuador Leprosy National Program in Reviewing and reproducing Leprosy Guidelines	22,650
• Supported El Salvador National coordinator in a Leprosy course, Fontilles	1,800
• Suported Brazil PAHO focal point to attend SMHF Consulting Meeting in Tokyo	6,748
• Evaluation of Dominican Leprosy Control Program: with the objective of observing the development of the National Leprosy Program at subnational level	15,000
• Subtotal Region	106,612
Total	**R$ 239,312**

6. Regional Program on Leprosy Workplan

The main objective of the Regional plan is to facilitate the provision of adequate and high-quality services to leprosy cases at the national and sub-national levels in the Member States the Americas Region with major burden of leprosy. Sustainability in provision of leprosy services will be achieved through active involvement of general health services in:

- detecting of cases and provision of free of charge MDT treatment,
- reducing the disease burden in terms of disabilities and complications;
- improving the negative image of leprosy through effective counseling and health education;
- promoting community participation in rehabilitation interventions; and
- reducing stigma and discrimination of leprosy patients.

PAHO/WHO will continue to provide technical support in planning, implementation, monitoring and evaluation of the leprosy control activities and supply of MDT drugs to Member States. The specific objectives of the Regional Plan include:

- building capacity and competence of primary health care staff in leprosy control;
- improving community awareness and involvement in control and rehabilitation of leprosy;
- Monitoring – to strengthen the mechanisms in
- Strengthening monitoring, supervision and evaluation of leprosy control activities within integrated program.

7. Requirements for endemic countries

- Sustained national political commitment and partner support.
- Involvement and coordination of governmental and nongovernmental organizations.
- Supply of medicines and other materials and equipment: Guarantee Drug Resistance Surveillance.
- Advocacy for expansion of sequential clinical examination coverage of all contacts of index Leprosy cases.
- Assure above 99% completion of MDT treatment of new cases.
- Operational aspects of integration of leprosy services within general health services especially under low endemic situation.

8. Monitoring Disease Trends

Activity	Budget (US$)
• Strengthen disease-monitoring trends at national and state levels in the ten countries that have registered more that 100 new cases over the past two years: Argentina, Brazil, Bolivia, Colombia, the Dominican Republic, Ecuador, Mexico, Paraguay, and Venezuela	46,000
• Strengthen disease-monitoring trends at national and state levels in the ten countries that have registered more that 100 new cases over the past two years: Brazil	25,000
• Special activities for the endemic municipalities among countries with large populations: Brazil	25,000
• Special activities for the endemic municipalities among countries with large populations: Brazil and Mexico	50,000
• Support: (1) transporting skin smears to be collected for drug resistance surveillance in leprosy, (2) provision of stainless steel blade and tubes, (3) kits for extracting DNA, (4) PCR primers and (5)DNA sequencing materials.	50,000
Sub Total	**196,000**

9. Capacity-Building and Competence within Integrated Programs

Activity	Budget (US$)
• Continue capacity-building for health workers in Argentina, Bolivia, Brazil, Colombia, Ecuador, Haiti, Mexico, and Paraguay, in accordance with WHO guidelines, with the goal of standardizing treatment under proper case-management conditions	36,000
• Continue capacity-building for health workers in Brazil and also to build a training program in collaboration to support Paraguay and Argentina, in accordance with WHO guidelines, with the goal of standardizing treatment under proper case-management conditions	46,000
• Support for low case reporting surveillance and Program management in Brazil	8,000
• Organize integrated surveillance, in order to achieve an efficient monitoring system for program supervision and evaluation, including impact measurement	50,000
• Organize integrated surveillance, in order to achieve an efficient monitoring system for program supervision and evaluation, including impact measurement in Brazil	28,000
Sub Total	**168,000**

10. Technical Support and Coordination Meetings

Activity	Budget (US$)
• Participate in national and international meetings inside and outside the Region	10,000
• Support two Intercountry meetings in Spanish- and English-speaking countries to promote the Global Strategy and Operational Guidelines	20,000
• Travel support for national professional that will contribute whit the national leprosy coordinator in execute Global Surveillance System for anti Leprosy drug resistance in Brazil	18,000
Sub Total	**48,000**

11. IEC Activities

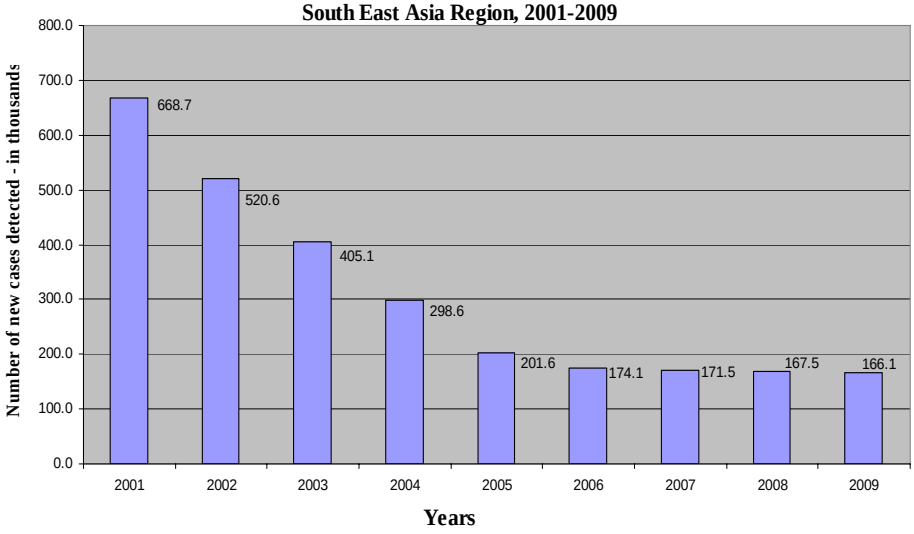
Activity	Budget (US$)
• Communication strategy that will strengthen empowerment and social participation	5,000
• Setting a Regional Task Force on leprosy to facilitate collaboration between partners	6,000
Sub Total	**11,000**
Grand Total	**423000**

South-East Asia Region (SEARO)

1. Programme updates and country situation

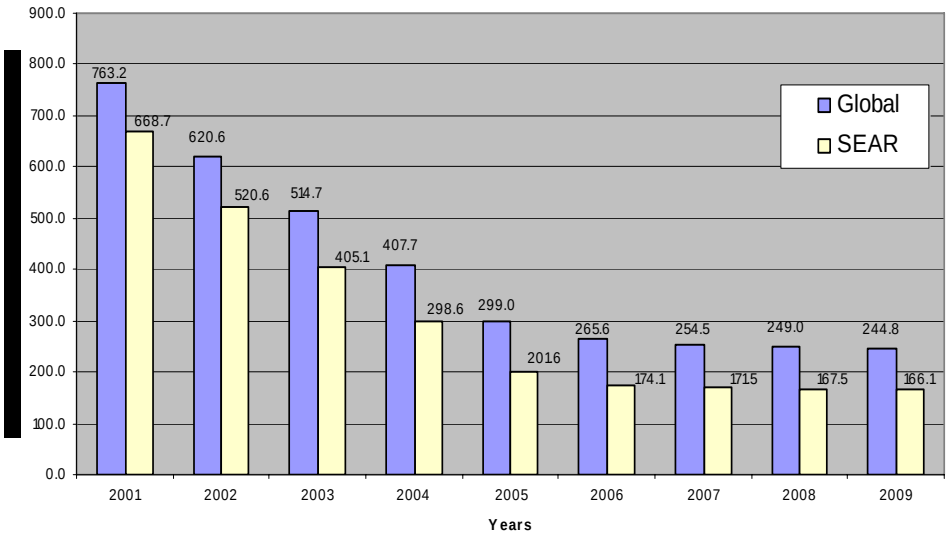
- The South-East Asia Region achieved the goal of elimination of leprosy as a public health problem at the end of December 2005 with the regional prevalence rate of 0.87 per 10,000 population;
- In the beginning of 2010, the regional prevalence rate was 0.66 per 10,000 population with a total of 120 456 cases on treatment, in the Region;
- A trend in the detection of new leprosy cases in the Region from 2001 to 2009 is shown in the below Fig. 1;
- Trends of new case detection of leprosy globally and in South East Asia Region from 2001 to 2009, shown in Fig. 2;
- 56.8% of global total registered prevalent cases are in SEA Region at the beginning of 2010, as shown in Fig. 3;
- 67.9% of the global total new cases detected in SEA Region during 2009, as shown in Fig. 4;
- Globally, there are 16 countries that reported 1 000 and more new cases during 2009;
- 6 of these 16 countries are in this Region (Bangladesh: 5 239, India: 133 717, Indonesia: 17 260, Myanmar 3 147, Nepal: 4 374 and in Sri Lanka: 1 875 cases);
- Ten of the 11 countries of the Region have achieved elimination at the national level, leaving only Timor-Leste to achieve the goal, as shown in Fig. 5
  - **Timor-Leste:** at the end of 2009, there were 168 cases on MDT treatment with PR: 1.4 per 10 000;
- The detail leprosy situation among the Member countries of the Region is shown in Table 1;
- Two priority countries (India and Indonesia) with large population and with large number of new leprosy cases reporting annually, are also targeting for sub-national elimination:
  - In India, 33 of the total 35 States/ Union Territories, and;
  - In Indonesia, 21 of the 33 provinces achieved elimination, at the end of December 2009,
- Bangladesh, Myanmar, Nepal and Sri Lanka: in spite of large number of new cases detected annually, have achieved and sustained elimination at the national level and are making concerted efforts to further reduce the leprosy burden.

Fig. 1: Trends in the detection of new cases of leprosy in South East Asia Region, 2001-2009



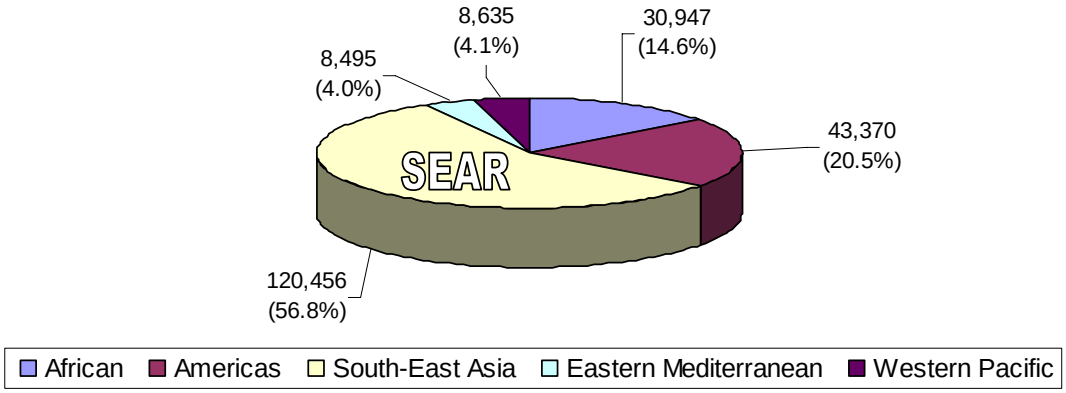
Data source: Weekly Epidemiological Record; No. 35; Vol.85; 27 August 2010

Fig 2: Trends of new case detection of leprosy, Globally and in South East Asia Region 2001 - 2009



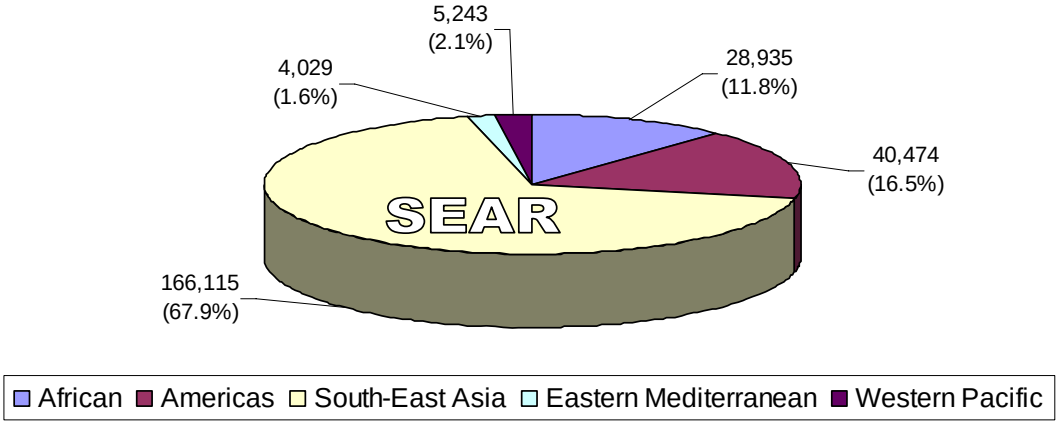
Data source: Weekly Epidemiological Record, No. 35; Vol.85; 27 August 2010

Fig. 3: Registered prevalence of leprosy by WHO Region: beginning of 2010



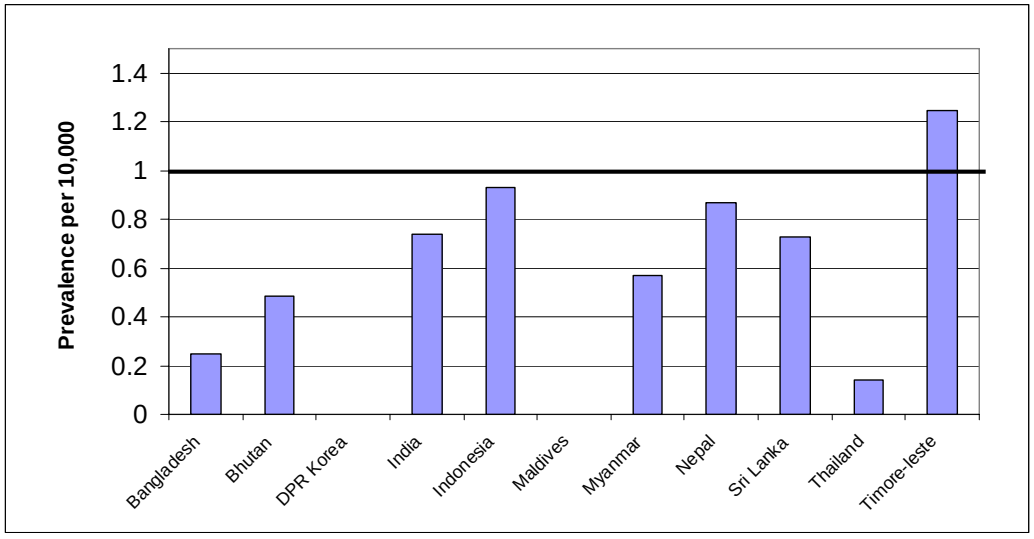
Data source: Weekly Epidemiological Record; No. 35; Vol.85; 27 August 2010

Fig. 4: Number of new leprosy cases detected, by WHO Region during 2009



Data source: Weekly Epidemiological Record, No. 35; Vol.85; 27 August 2010

Fig. 5: *Status of elimination of leprosy as a public health problem (with prevalence of below 1 case per 10 000 population) at national level among the SE Asian countries of WHO*



Data source: Weekly Epidemiological Record, No. 35; Vol.85; 27 August 2010

Table 1: *Leprosy situation in the South East Asia Region at the beginning of 2010*

Country/ territory	Registered Prevalence[a]	New case Detection[b]	New MB[c]	New Female	New Child	New D-G 2[d]	Relapses[e]	Cure rate (%)	
								PB[f]	MB[g]
Bangladesh	4 163	5 239	2 247	2 128	366	542	6	95.56	92.36
Bhutan	30	12	11	4	0	1	0		
India	87 190	133 717	64 782	47 361	13 331	4 117	670	94.68	89.48
Indonesia	21 026	17 260	14 227	6 887	2 073	1 812	48	80	79.46
Maldives	7	11	6	3	0	0	3	80	45.5
Myanmar	2 816	3 147	2 189	1 106	165	468	25	96.07	95.38
Nepal	2 445	4 394	2 216	1 479	282	178	23	92	97
Sri Lanka	1 849	1 875	893	816	186	119			
Thailand	762	300	215	108	11	41	16	94.40	82.41
Timor Leste	168	160	119	53	13	8	2	25.6	74.3
Total	120 456	166 115	86 905	59 945	16 427	7 286	793		

Data source: Weekly Epidemiological Record, No. 35; Vol.85; 27 August 2010

2. Updates on technical supports to the Member countries:

- For capacity building:
  - Country-based workshops conducted by the national leprosy programmes in Bangladesh, India, Indonesia, Myanmar and Timor-Leste with WHO technical support ;
- Meeting of the National Leprosy Programme managers of the Region was held in Colombo at the end of July 2010;
- Country support:
  - Nepal
    - TIP recruitment completed who supported the country in achieving elimination and in strengthening monitoring and supervision at the District level.
    - Regional office supported four special/intensified activities at the District levels in collaboration with the ILEP partners and WHO Country Office, focusing on awareness campaigns at district levels, review of cases on treatment and updating the patients' registry. These activities were planned during RA-LEP country visit and undertaken with the technical support of the LEP-TIP (September to December 2009),.
    - Advocacy activities are planned during Q4, 2010, to initiate Enhanced Global Strategy (2011 – 2015).
  - Timor-Leste:
    - TIP recruitment completed (May to August 2010)
    - Programme review and technical support from the Regional office with the view to achieve elimination (April 2010).
    - Undertaken intensified activities in collaboration with partner (TLMI) and WHO Country Office, focusing on awareness campaigns at district levels, review of cases on treatment and updating the patients' registry. These activities were planned during RA-LEP country visit (April 2010) and undertaken with the technical support of the LEP-TIP.
    - Country-based capacity building workshop conducted, GLP training modules were translated into national language.
  - India:
    - Technical support with the view of achieving elimination among the States and Union Territories those are yet to achieve elimination.
    - Identified areas of WHO technical support during coordinating meeting with ILEP member organizations (29 June to 1 July 2010).
  - Indonesia:
    - Enhanced WHO technical support for the high-endemic province in collaboration with other partners.

- Technical support for conducting workshop for the provincial leprosy officers of the low-endemic provinces.
- Undertaken intensified activities (rapid survey) in collaboration with partners and WHO Country Office, focusing on awareness campaigns at district levels, review of cases on treatment and updating the patients' registry.
- Advocacy activities to initiate Enhanced Global Strategy (2011 – 2015).

Information dissemination/operational research activities in the Region:

- WHO-Weekly Epidemiological Record published the trends on leprosy case detection in Indonesia (with GLP support)
- WHO-Bulletin published the article on Neglected Tropical Diseases (including leprosy) in South East Asia.
- Discussion is underway to support for conducting country-based operational research activities (Bangladesh, Indonesia, Myanmar and Nepal)

Brief report of the Colombo meeting:

Meeting of National Leprosy Programme Managers, held in Colombo, Sri Lanka from 27 to 29 July, 2010

General objective:

To contribute towards reducing the burden of leprosy in the region.

Specific objectives:

(1) To review the progress being made by national leprosy programme in relation to current Global Strategy (2006-2010)

(2) To identify challenges, opportunities and lessons learnt;

(3) To make recommendations for acceleration and intensification of activities in countries particularly that are reporting large number of new cases in the Region; and

(4) To prepare follow up actions at the Country level towards implementation of the Enhanced Global Strategy of Leprosy (2011-2015).

Total number of participants: 58

- From national programme: 28
- Partners active in SEA Region: 15
- Persons affected by leprosy: 2*
- WHO-Country office staff: 10
- GLP-Team Leader: 1
- Regional Office staff: 2

*The representatives of the persons affected by leprosy (from India and Indonesia) had the venue with the Leprosy Programme Managers and the partners to discuss their activities with proposals on strengthening their participation in leprosy services, in accordance to the Enhanced Global Strategy (2011-2015).

Flow of discussion during the meeting:

(1) Instead of conventional country presentations, topic-wise presentations in reviewing the progress of leprosy situation in Member countries:

(2) One expert (from the partner organizations) introduced the topic with the view to set the scene for presentation and discussion.

(3) National Programme Managers focused their country presentations on the assigned areas/topics.

(4) Other participating countries shared their experiences.

a) Timely case detection and case management

b) Disability reduction

c) Rehabilitation and reduction of social stigma

d) Surveillance and Monitoring

Group works

Participants were divided into 4 groups:

- 2 groups representing countries where the disease burden is high and carried out group discussions on, “Acceleration and intensification of leprosy control activities” and;
- 2 groups representing low burden countries discussed about “Sustaining leprosy control activities”.

Major achievements through implementing the Global strategy (2006-2010) in the Region:

- 2006-2010 Global Leprosy Strategy and the Operational Guidelines are in implementation in all member countries;
- Ten of the 11 member countries (except Timor-Leste) achieved elimination at the national level compared to the 8 Member countries in the beginning of 2005 (except India, Nepal and Timor-Leste).
- Total number of new cases detected annually reduced from 201 635 cases in the beginning of 2005 to 120 456 cases in the beginning of 2010;
- The Region sustained 100% of treatment coverage of all registered leprosy case with multi-drug-therapy, supplied to the Member countries free of cost.
- Two priority countries (India and Indonesia) with large population and with large number of new leprosy cases reporting annually are also targeting for sub-national elimination.

- At the end of December 2009:
  - In India, 29 of the total 35 States/ Union Territories, and;
  - In Indonesia, 19 of the 33 provinces achieved elimination,

Challenges identified by the national programmes in implementing the Global strategy (2006-2010) in the Region:

- Less priority with limited resource allocation within the MOH;
- Sustaining basic skill on leprosy among the health staff and awareness in the communities;
- Prevention and care of disabilities, ensuring community-based rehabilitation of cured/disabled leprosy persons;
- Intensified case detection in the endemic pockets in large countries with large number of new cases;
- Capacity building at the sub-national levels depending on endemicity;
- Establishing surveillance with special emphasis on difficult to reach areas;
- Undertaking advocacy activities for reducing social stigma towards leprosy affected persons and their families;
- Promote operational research activities on leprosy due to limited resources;
- Integration of IEC activities for leprosy with other health programmes;

Important/main recommendations of the meeting are:

- The Enhanced Global Strategy 2011-2015 was endorsed by all member countries and it is to be adapted based on local conditions;
- Countries where the disease burden is high are to focus their activities at the sub-national levels based on new case detections trends so that the disease burden in these areas can be further reduced;
- Periodic programme review of the national programmes in selected countries are to be carried out with technical support from WHO and in collaboration with partners so as to ensure that leprosy control activities are carried out satisfactorily;
- National programmes will further improve their on-going efforts to strengthen the participation of persons affected by leprosy in leprosy services;
- Advocacy at the central/national levels and community mobilization activities should be country specific focusing on early case detection to reduce occurrence of grade 2 disability;
- WHO should continue to provide with technical support and IEC materials at the national as well as sub-national levels;
- Advocacy with the politicians, policy makers, partners to be continued through the efforts of the WHO Goodwill Ambassador for Leprosy Elimination.

- WHO should continue to provide with technical support in undertaking operational research activities in collaboration with the partners.

Regional Goals and Targets for 2010-2011:

- Target # 1: Leprosy elimination

  Achieve elimination of leprosy as a public health problem in Timor-Leste by 2010.

- Target # 2: Capacity building

  By the end of 2011, reduce prevalence of leprosy below 1 case per 10,000 population at the sub-national levels in India and Indonesia (two priority countries with large number of new leprosy cases) through capacity building to be coupled with advocacy and awareness campaigns;

- Target # 3: Strategy implementation

  Initiate implementation of the Enhanced Global Strategy and Operational Guidelines (2011-2015) in all Member countries.

- Target # 4:

  Operational Research

  Conduct operational research in collaboration with other partners with the view to improve leprosy services in the Member countries.

Road map for 2010-2011:

- Technical support to Timor-Leste in Implementing intensified leprosy elimination activities with the view to achieve the goal of elimination.
- Ensure data collection on the Grade II disability due to leprosy in all Member countries with the view to appropriate implementation of the “Enhanced Global Strategy and Operational Guidelines for Further Reducing the Disease Burden to Leprosy (2011-2015) that targets on the reduction of the Grade II disability at the national level during the period.
- Conduct national advocacy meetings on the enhanced global strategy and operational guidelines (2011-2015) in all Member countries.
- Conduct national training workshop using the modules prepared based on the global leprosy strategy and the operational guidelines.
- Provide technical support to Member countries in sustaining leprosy services for timely diagnosis, prompt treatment with MDT, expansion of prevention of disabilities (POD), rehabilitation and self-care activities.
- Provide technical support to Member countries in undertaking activities towards reduction of stigma and discrimination against people affected by leprosy and their families.
- Ensure regular and adequate supply of free MDT drugs.

- Support conducting operational research for the effectiveness of MDT programme, monitoring the emergence of rifampicin resistance.
- Participate during the global leprosy TAG meeting.

WHO will continue to provide technical support to member countries to achieve and sustain national level elimination and to further reduce the burden. WHO will continue to advocate for and assist the countries in mobilizing the required resources and in strengthening partnerships.

3. Updates on leprosy activities in selected Member Countries

3.1 Bangladesh

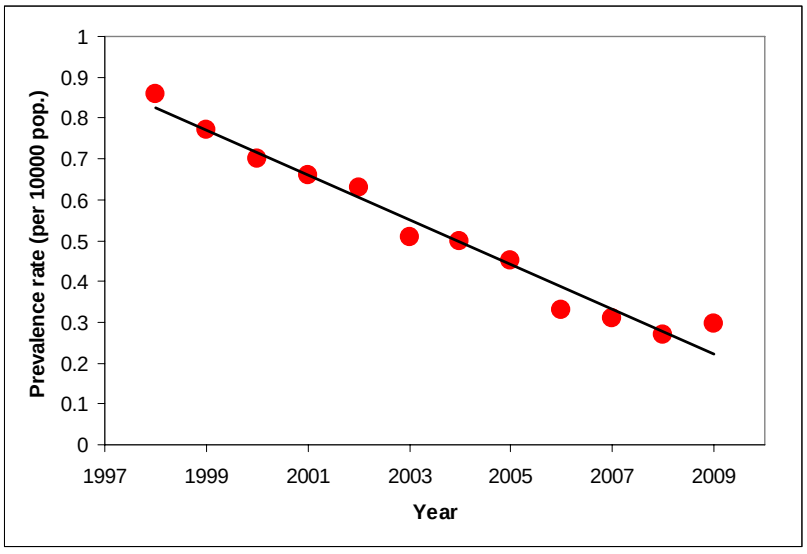
1. Purpose of report

This report provides a brief overview of activities undertaken by the National Leprosy Elimination Programme (NLEP) of Bangladesh and funded by The Nippon Foundation (TNF).

2. Background

Elimination – less than one case per 10 000 population – was achieved in the country as a whole in 1998, two years ahead of the global target. In absolute numbers, Bangladesh ranks fifth in the world with over 5000 new cases diagnosed annually. The NLEP has continued its efforts to further reduce the prevalence of leprosy. At the end of the biennium only four districts representing less than two percent of the country's population, reported a prevalence exceeding the elimination target.

Fig.1: ***Trends in leprosy registered prevalence rate, Bangladesh, 1998-2009***



The core support of WHO to NLEP is prioritized towards maintaining the minimum expertise for suspecting, diagnosing and managing leprosy. Leprosy is increasingly becoming a rare disease in many parts of the country. This is a fortunate result of the sustained efforts over the years but poses serious challenges.

Leprosy services are integrated in general health care services and supported by nongovernmental organizations (NGOs) in designated geographical areas. While the Government bears most of the cost related to infrastructure and emoluments of government health staff involved in leprosy control and NGOs raise their own funds for their staff, infrastructure and bulk of activities, the NLEP heavily depends on two major sources of income for programmatic purposes, i.e. WHO and TNF.

The WHO regular budget specifically allocated to leprosy was US$ 68 000 in the 2008-09 biennium while US$ 45 000 is allocated during the current 2010-11 biennium. In addition, the Medical Officer (TB) funded from the same regular budget, spent approximately 25% of his time for leprosy. Funds from TNF for NLEP activities were also channeled to WHO. In addition, multidrug therapy (MDT) blister packets were also received in-kind for several years covering 100% of the programme needs.

This report focuses only on activities undertaken by NLEP or WHO using funds provided by TNF. The period covered includes July 2009 to June 2010.

3. Activities undertaken

The activities shown in Table 1 were undertaken by NLEP or WHO and charged to funds from TNF. All funds were channeled through WHO.

Table 1: *Activities undertaken by NLEP with funds from TNF (July '09-June '10)*

Serial Number	Activity description	Mechanism	Amount spent (in US$)
1.	Review meeting of core groups of leprosy workers	DFC	8 737
2.	Supervision of MDT centres	DFC	10 080
3.	Conducting training course for medical officers	DFC	10 039
4.	Operational research project on extended contact examination	TSA	5 033
5.	Printing of Operational Guidelines on Leprosy Control	MED	1 794
6.	Assessment of impact of vocational training and community-based rehabilitation (CBR)	DFC	4 003
7.	Drugs for skin camp	MED	595
8.	Orientation of scouts, religious and other community leaders on leprosy	DFC	3 994
9.	Vocational training for people affected by leprosy	DFC	5 601

Serial Number	Activity description	Mechanism	Amount spent (in US$)
10.	Special campaigns in high-prevalence pockets: training of key community groups	DFC	8 437
11.	Procurement of drugs for leprosy skin camps in high-prevalence pockets	MED	1 622
12.	Workshops for guideline development for Prevention of Disabilities and IEC materials	DFC	3 285

Table 2 shows the planned activities for which TNF funds have already been identified from the current grants (awards 55070 and 52715). It is expected that these activities will be completed by the end of 2010.

Table 2: *Activities planned and to be charged to available TNF grants*

Serial Number	Activity description	Mechanism	Amount available (in US$)
1.	Attending international training course on management and evaluation	GEA	10 992
2.	Procurement of drugs for skin camps	MED	5 000
3.	Special campaigns in high-prevalence pockets: skin camps	DFC	10 537
4.	Capacity building of central and peripheral-level health workers involved in leprosy	GEA	12 000
5.	Procurement of drugs for skin camps	MED	5 000

4. Results

The funds provided by TNF were significant and allowed NLEP to execute a good number of activities included in its work plan. As such there was a good visibility of TNF contributions in NLEP.

As the funds were channeled through WHO, WHO mechanisms had to be used and WHO rules had to be applied. In line with the general recommendations for WHO to focus its contributions more at a higher strategic level, alignments of the work plan had to be made in this regard. This resulted in a reduced funding for routine training and supervision as well as for vocational training and CBR as these activities were not considered to be core of WHO's mandate. Instead assessments were undertaken on the impact of vocational training and CBR and an operational research study was conducted on determining the additional effect on case detection through expanded contact surveys. Skin camps were also organized for which drugs were procured with the TNF grant.

5. Conclusions and recommendations

The Bangladesh NLEP has depended heavily on funds from TNF which provided the bulk of funding for its operations. In view of the reduced overall funding (all sources), NLEP activities have been prioritized. The reality that WHO moved away from implementation of routine programme activities (which should be undertaken by government) to more strategic areas has made that NLEP is confronted with a change in scope of activities.

It is recommended that funding is obtained for the activities already planned and for which no funds have been identified. This will allow WHO to implement its work plan to a maximum extent. This in turn is expected to result in keeping leprosy on the health agenda.

Efforts also need to be undertaken to look for synergies with other programmes. The natural partner would be the National Tuberculosis Control Programme as this comes under the same Directorate. But other programmes could also be considered. The focus on revitalizing primary health care may provide some scope for obtaining funds for activities aimed at strengthening the overall heath system including capacity building of first-line health care providers in a range of common health problems and providing basic health services. If leprosy is included in such a basic package, then TNF could contribute in funding such integrated activities.

As the WHO Medical Officer (TB) is currently funded from the TB budget but spends approximately 25% of his time for leprosy, TNF may consider funding a quarter of the position cost.

As WHO is not really mandated to fund routine programme and supervision activities, TNF may consider making funding also available directly to NLEP in addition to the funding channeled to WHO.

3.2 India

LEPROSY EPIDEMIOLOGICAL STATUS 2009-10

The year 2009-10 started with about 86,000 leprosy cases on hand as on 1st April 2009, with PR 0.72/10,000. Till then 32 States/ UTs had attained the level of leprosy elimination. A total of 510 districts (80.9%) out of total 630 districts also achieved elimination by March 2009.

After detailed scrutiny, more emphasis was placed on new case detection at the block level in the high endemic districts. A total of 472 blocks in 14 State with ANCDR>30/100,000 population were identified for urgent remedial action. The States were advised that in all the districts where these blocks are located, there should be a well trained District Leprosy Officer. In addition one officer should be identified in each of these blocks to strengthen the process of supervision and monitoring of the program activities.

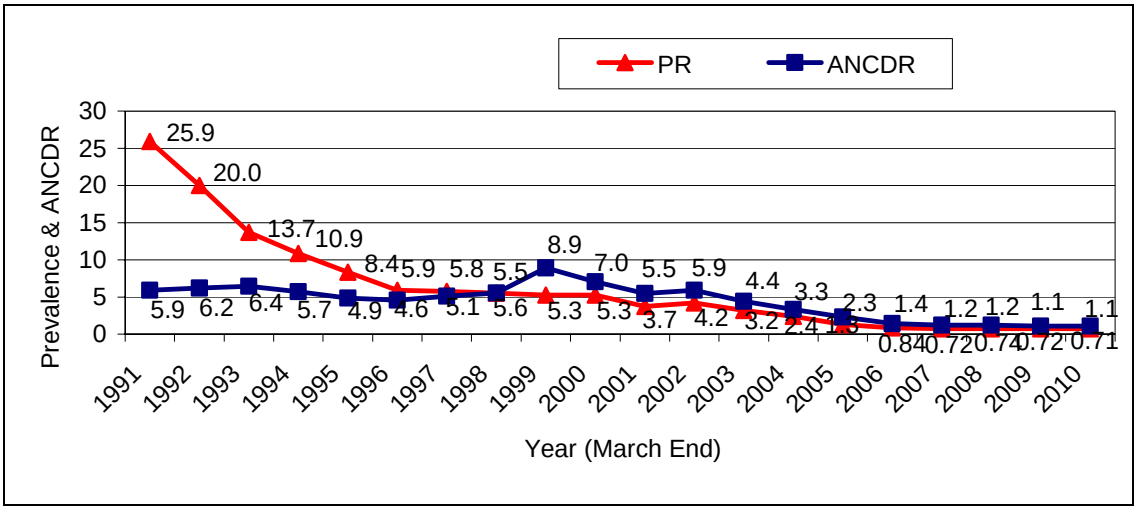
Based on the reports received from all the states and UTs for the year of 2009-10 **(Annexure –I),** current leprosy situation in the country has been observed as below.

(1) A total of 1.34 lakh new cases were detected during the year 2009-10, which gives Annual New Case Detection Rate (ANCDR) of 10.93 per 100,000 population. This shows ANCDR reduction of 2.32% from 11.70 during 2008-09.

(2) A total of 0.87 lakh cases are on record as on 1st April 2010 giving a Prevalence rate (PR) of 0.71 leprosy cases per 10,000 population.

(3) Detailed information on new leprosy cases detected during 2009-10 indicates the proportion of MB (48.5), Female (35.4), Child (9.97), Visible Deformity (3.1), ST cases (13.3) and SC cases (18.5).

(4) Trend of leprosy Prevalence (PR) and Annual New Case Detection (ANCDR) are indicated in the graph below:



Status of States

Further analysis of information received from the States / UTs **(Annexure – II)** has shown the following situation.

(5) 3 States / UTs viz. Bihar, Chhattisgarh and Dadra & Nagar Haveli has remained with PR between 1 and 2.5 per 10,000 population. These 3 states/UTs with 10.5% of country's population, contribute 19.0% of country's recorded caseload and 21.9% of the country's new cases detected during the year 2009-10.

(6) 32 States/ UTs had already achieved the level of elimination i.e. PR less than 1 case per 10,000 population and they are:

Nagaland, Haryana, Meghalaya, Himachal Pradesh, Mizoram, Tripura, Punjab, Sikkim, Jammu & Kashmir, Assam, Manipur, Rajasthan, Kerala, Arunachal Pradesh, Daman & Diu, A & N Islands, Pondicherry , Gujarat, Karnataka, Lakshadweep, Tamil Nadu, Andhra Pradesh, Uttaranchal, Madhya Pradesh, Maharashtra , Goa, Orissa , Uttar Pradesh, Delhi, Jharkhand, West Bengal and Chandigarh.

(7) Increased number of new cases detected during the year 2009-10 over 2008-09 were in the following 10 states (i) Orissa, (ii) Bihar, (iii) Maharashtra, (iv) Jharkhand, (v) D&N Haveli, vi) Tamil Nadu (vii) Kerala, (viii) Nagaland, (ix) Rajasthan and (x) Meghalaya. New case detection were lower than previous year in the remaining 24 States/UTs.

(8) Proportion of Child cases were more than 10% of new cases detected in 11 States/UTs of (i) Andhra Pradesh 12.04% , (ii) Maharashtra 11.50%, (iii) Bihar 15.99%, (iv) Tamilnadu 17.44%, (v) Goa 20.93%, (vi) D&N Haveli 23.72%, (vii) Jharkhand 10.61%, (viii) Mizoram 20.00%, (ix)Karnataka 11.91%, (x) Kerala 13.80%, (xi) A&N Islands 26.67%.

(9) PB Child proportion were high in 5 States/UTs of (i)Tamil Nadu 15.91%, (ii) Bihar11.39% (iii) D&N Haveli 15.38%, (iv) Andhra Pradesh 9.01% and (v) Kerala 10.41%.

Status of Districts

(10) District wise situation on the basis of ANCDR as on 31st March 2010 is given at **Annexure III**. 405(63.98%) districts out of total 633, have ANCDR < 10 per 100,000 population and 87 districts have ANCDR > 20/100,000. Only 5 districts with ANCDR > 50/100,000 population are in Chhattisgarh (2), Gujarat (1), Maharashtra (1) and West Bengal (1).

Year wise endemicity of districts on ANCDR basis

ANCDR/100,000	2005-06	2006-07	2007-08	2008-09	2009-10
<10	317	376	377	394	405
10-20	141	132	141	159	141
>20-50	124	97	90	73	82
>50-100	13	5	6	4	5
>100	1	1	0	0	0
Total	**596**	**611**	**614**	**630**	**633**

(11) District wise situation on PR basis as on 31st March 2010 is given as **Annexure–IV**. Progress in district situation during last 5 years are as below –

Year wise Status Of Districts on PR basis

PR/10,000	2006	2007	2008	2009	2010
<1	439	487	482	510	510
1-2	128	105	111	94	103
2-5	28	18	20	25	20
5-10	0	0	1	1	0
>10	1	1	0	0	0
Total	**596**	**611**	**614**	**630**	**633**

A total of 510 districts (80.57%) out of total 633 districts have reached PR<1/10,000. However, the number of districts with PR between 1 to 2/10,000 have gone up from 94 to 103. As a result number of district with PR>2/10,000 have gone down from 26 to 20.

As on March 2010 only 20 districts in 7 states are having PR > 2/10,000. These states are Chhattisgarh (5), Uttar Pradesh (1), Gujarat (7), Orissa (2), Maharashtra (2), West Bengal (2) and D&N Haveli (1). No district is having PR >5/10,000.

(12) Position of districts as per grade II disability status has been given as **Annexure–V**. Altogether 306 districts (48.34%) are with >2% gr. II disability amongst new cases detected.

Treatment Completion Records

(13) Out of the total 1.32 lakh new cases deleted from record, a total of 1.22 lakh (92.9%) completed their treatment within the specified period and were released from treatment (RFT) as cured during **2009-10 (Annexure – VI).** Poor performing states are Delhi (52.9%), Tripura (64.3%), Sikkim (75%), Rajasthan (75.3%), Goa (87.7%), Uttarakhand (88.6%), West Bengal (82.6%), Haryana (85.6%), Himachal Pradesh (89.4%), Assam (82.6%), Punjab (88.2%), A&N Islands (89.5%) and Daman & Diu (88.89%).

(14) Out of the total 15204, "others cases" deleted from record during 2009-10, a total of 10847 (71.3%) completed their treatment in time and were released from treatment (RFT) as cured during 2009-10 **(Annexure – VII).**

(15) Total number of cases released as cured during 2009-10, thus comes to 133822 (90.64%) as against total deletion of 147644. This brings the total number of persons affected by Leprosy cured of the disease in the country with MDT from the beginning till date to 12.41 million.

(16) Treatment Completion Rate (TCR) for the reporting year 2008-09, based on New case cohorts of PB (2007-08) and MB (2006-07) were reported as PB – 94.68%, MB – 89.48%, Male – 92.07%, Female – 93.0%, Urban – 86.64%, Rural – 93.72% and Total – 92.43%.

Progress report on utilization of funds for the leprosy program (2010)

Introduction

In the year 2009 a total of USD 120,000 was granted by the Nippon Foundation / SMHF for activities to be undertaken by WHO India for the leprosy program. The activities were divided in to the following major heads:

(1) Support for the WHO Logistic and Program Officers and staff at WHO India office.

(2) Support to the Multi Drug Therapy (MDT) Cell at the office of the Deputy Director General (DDG) (Leprosy) Government of India

(3) Meetings of State Leprosy Officers and other partners

(4) Supplies and equipment maintenance

A summary of the activities undertaken in each head is described here.

Support to the WHO Logistic and Program Officers and staff and WCO

The WHO Logistic and Program Officers had been placed and were in position in 2009 at the central, state and sub-state levels to facilitate and support the planning, implementation and monitoring of the NLEP. There were one officer at the national level and three at the state and zonal levels. The National Professional Officer (NPO) is based at the WCO to provide support in formulating policies, strategies and work plans related to the NLEP functioned as planned. The technical persons also monitored the implementation of the program at the peripheral level by means of regular visits to the field, interactions with the various program partners and by Review Meetings at all levels. An additional consultant for dealing with medical and social rehabilitation was also provided for. Some administrative costs of WCO India were met out of these funds as well.

Similar to the central level, a set of technical personnel placed at the state head quarters and in groups of districts referred to as zones functioned in 2010. Though three state and zonal personnel were present, a gradual reduction in the number took place through the year in keeping with the policy of gradual withdrawal of WHO support for making the Government program self sufficient. The personnel supported the State and District Leprosy Officers in implementing the program by assisting in areas like formulation of Program Implementation Plans (PIP), training the general health care staff, supervising and monitoring special programs for case detection, treatment and management of deformities and ensuring regular program reporting.

Support to the MDT Cell at the DDG Office.

The supply of the essential medicines for the treatment of cases of leprosy referred to as Multi Drug Therapy (MDT) is undertaken by WHO through donations from M/s Novartis. The WHO HQ collects the information on requirements from various countries and directs the supplier regarding the amount and places of drug delivery. In order to ensure that the supplies are smooth and un- restricted, WHO supported consultants at the central level at the DDG office and in five state capitals. The function of these consultants were to estimate the requirement of MDT, help the DDG order for them and ensure that the drugs were received on time and distributed to the states. They also ensured that the MDT was forwarded onwards to the districts and PHCs. Ensuring the quality and optimum storage conditions were also monitored by the consultants. Consultants for assisting in the tasks of data collation and analysis, finance and accounting, planning of training programs, Behavior Change Communication and monitoring and evaluation were also supported.

Meeting of State Leprosy Officers and other partners

WHO supported the annual meeting of the State Leprosy Officers (SLO). This meeting is usually held in a different state capital each year as an advocacy exercise and to stress the importance of the program to the state Government. In 2009, the annual two-day

SLOs conference was held in Varanasi city of Uttarpradesh on the 6th and 7th of November. They were attended by the State Leprosy Officers / designates of most of the thirty five state and Union Territories of the country. Other program partners working in India such as the ILEP member organizations, The Leprosy Mission, German Leprosy Relief Association Swiss, Emmaus, AIFO, Netherlands Leprosy Relief, LEPRA India besides various experts, academics and other concerned officials.

Assessment

The funds from the Nippon Foundation were used judiciously, effectively and efficiently to support the country's leprosy program. The funds were used to provide strategic support in areas where the program itself required inputs for getting better results. Since all the supported activities were concluded successfully and satisfactorily, the funding for the year 2009 could be said to have achieved its goals.

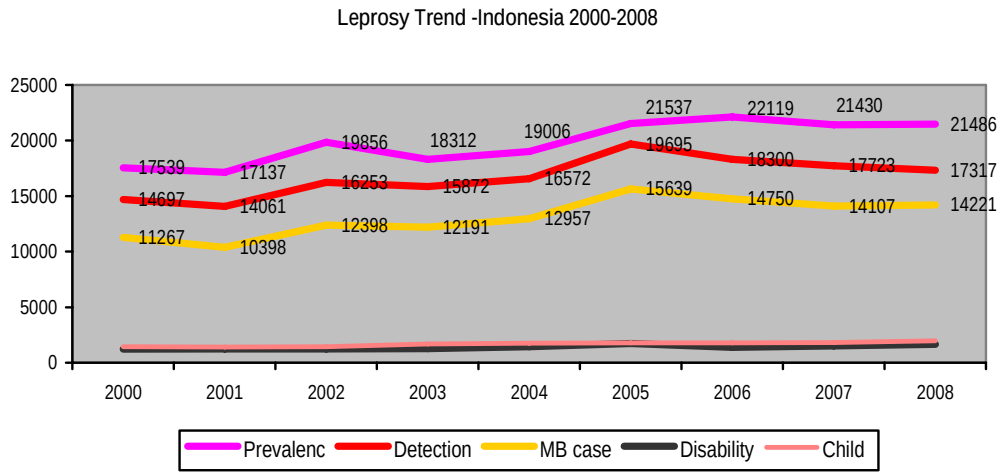
3.3 Indonesia

National Leprosy Control Programme (NLCP) central unit continued their efforts to sustain leprosy control activities to further reduce the disease burden in the decentralized health system in spite of the gradually dwindling internal and external funding. The programme promoted advocacy bodies at the national and district levels to sensitize policy decision makers in the decentralized system and to sustain political commitment to mobilize local resources. WHO, TNF/SMHF, NLR continued their financial and technical assistance. The Novartis Foundation continued uninterrupted supply of free MDT blisters through WHO. Since 2001, an additional 106,940 cases got cured by the end of 2008. At the end of December, 2009, 14 of the 33 provinces and 160 of the 460 districts still reported a prevalence rate of more than one per 10 000 population.

Trends in new case detection:

With the technical support of WHO, the national programme undertook retrospective analysis of trends in new case detection for all the provinces (1991-2009). This was undertaken to observe the long term trend in new case detection and to study the characteristics of cases such as multibacillary (MB) leprosy, child cases (<15 years) and cases with disability grade-2. This trend analysis assisted the programme to identify and prioritize key activities for further advocacy, resource mobilization and plan appropriate interventions to reduce the disease transmission and disability grade-2 among the new cases.

WHO supported the national programme in publishing the results of this analysis in the WHO-Weekly Epidemiological Records.



Timely case detection and management of leprosy cases in different health facilities is important. Indonesia as the third largest country reporting leprosy cases new leprosy case detection is the programmatic challenge. The prevalence and detection of new cases was significantly reduced during 1988 to 2000, however, after 2001 new leprosy case detection is in static stage. The strategic options for timely case detection and management focus on integrated public health services supported by trained health officers is current need. **An effective implementation of programme needs regular supervision, monitoring and evaluation with continued advocacy, social mobilization and effective communication.**

The main problem faced by the National Leprosy Elimination Programmes is of limited funding from the government and partners to intensify key activities as per the plan. This affected central and peripheral supervision and monitoring, MDT drug stock monitoring and flow of data from periphery to center as well as implementation of planned scaling up of IEC campaigns and case finding both in leprosy and yaws.

Summary of other activities during the review period:

World Leprosy Day 2010: World Leprosy Day, 2010" on 31 January, 2010 in Jakarta participated by the Minister of Health and several Officials of MOH as well people affected by leprosy and many NGOs. The main focus was on Socio-Economic issues related to people affected by leprosy, stigma, discrimination and empowerment. This advocacy is expected to enhance political commitment to leprosy control activities in the country as well as increased confidence of those affected by leprosy in the NLCP. The Center and WHO need to follow up with MOH officials to advocate them on socio-medical aspects of leprosy disease.

Media coverage on World Leprosy Day, 2010 was sufficient and media people are conveying more and more facts about leprosy. The news value of this celebration of World Leprosy Day was much higher. The programme at the center, province and district levels should use print media like news papers to convey about scientific facts about leprosy, the programme achievement, availability of MDT blisters at health centers and hospitals at

frequent intervals. This will increase public awareness about people to report for early diagnosis and treatment instead of once year during the World Leprosy Day.

Log Frame Workshop on Strengthening National Leprosy Control Programme was held in Bandung, March, 8-10, 2010 where stakeholders from the various programmes of the Government, religious organizations, medical professional organizations and leprosy programme partners (including organizations of people affected by leprosy –PerMata, YTLI) participated. Series of discussions were held with the national programmes regarding developing **MDT drug resistance surveillance in leprosy, developing guidelines for sero-surveillance in yaws programmes**, **compilation of update of the treatment registers,** planning of sero-surveillance in yaws selected districts *etc*. This workshop was planned to incorporate the Enhanced Global Strategy 2011-2015 Plan ((WHO) in to the log frame of the leprosy programme.

Strengthening participation of persons affected by leprosy in leprosy services for implementing the enhanced global strategy is important. Further an initiative need to be taken by WHO, disease control progamme and NGO/INGOs e.g. Nippon Foundation/Sasakawa Foundation. People affected by leprosy will able to bring valuable experiences and also specific expertise and their involvement could lead to reduce stigmatization. Transformation from individual patient approach to group approach in participating leprosy control services is essential.

Socializing Enhanced Global Strategy for further reducing the disease burden due to Leprosy Plan 2011-2015: The programme would like to organize a workshop on sensitization of the national and provincial health officials to socialize Enhanced Global Strategy for leprosy in 2010 with WHO funds. WHO supplied copies of the Global Strategy documents to the Sub-Directorate for further distribution. The Sub-Directorate will translate these documents in Indonesian language.

It was emphasized that mobilizing resources within the country by advocating national and local governments should be accorded priority to new global target of reducing disability grade-2 by 35% by 2015 among the new cases (Base line comparison of disability rate/100 000 and proportion at the end of 2010). This emphasizes on focusing on IEC campaigns and promoting early case finding without grade-2 disabilities.

Monitoring of WHO collaborative activities (Leprosy, Yaws)

The proposals on drug resistance sentinel surveillance in leprosy, stakeholder's meeting, workshop on low endemic provinces, intensified case finding in leprosy and yaws from Sub-Directorate (LEP) under WHO Assessed Contribution (AC) and voluntary contribution (VC) need to be developed. The programme will implement WHO collaborative activities in course of time once already activities under NLR support are completed.

The bring a change in the static epidemiological and social stigma situation in the country, the national programme has developed a broad plan to intensify IEC activities to promote early case finding in the high burden districts to reduce disability grade-2 and reduce the disease transmission.

3.4 Nepal

Programme updates during the review period:

The trend of the national prevalence rate (PR) and new case detection rate (NCDR) over 5 years show steady decline and Nepal achieved the goal of elimination of leprosy as a public health problem during December 2009. At the end of the Nepali calendar year (2009/2010) that ended in June 2010, a total of 2104 cases on MDT treatment were reported with the national PR of 0.77 per 10, 000 population.

Administratively, Nepal is divided into five developmental regions. However, there are three ecologically distinct regions in the country; namely, Mountain region (35 % of land mass), Hilly region (42 %) and Plains or Terai region (23 %). Nearly half (48.4 %) of the country's population live in Plains or Terai region wherein 85 % of new cases were detected during 2009/2010. At the District level, there are 62 districts with the PR of below 1 per 10,000 population and the PR is above 2 in one district. Detail analysis of district-level data for the Nepali calendar year (2009/2010) that ended in June 2010 will soon be available.

New case finding activities were strengthened during the current fiscal year. Active case detection activity was integrated into the national strategy as part of the house hold contact screening and is supported by the Nepal government and WHO. To further reduce the burden of disease sub district pockets were identified and specific intervention involving local community is ongoing. House to house activity, School Health Program, "teacher's orientation", advocacy of the program in socially marginalized community, skin and disability camps, intensified IEC campaign were planned and carried out during the year. Involvement of the media and IEC activities involving local FM and journalists, high turn out at the World Leprosy Day celebration at district levels and center contributed to further acceptance of people affected by leprosy and reduction of stigma in the society. Additional leprosy service sentinel site was started with support from the partners and is functional in Chandanigahapur of Rautahat and Dhanusha DPHO to improve access to quality care for people living in endemic communities.

The Ministry of Health and Population decided to celebrate the achievement of elimination of leprosy as a public health problem in collaboration of the partners with an objective to continue advocacy for the program and sustain the achievement and partnerships to further reduce the disease burden and focus on rehabilitation of people affected by leprosy.

As a result of the above mentioned activities, 3157 new cases of leprosy were detected during the fiscal year 2009/2010. The Leprosy Control Program has been working closely with the community; community based organizations and strengthened partnership with journalist and media. Through their advocacy hidden cases in the community are seeking treatment.

The program believes in incorporating the country best practices into the 2011-2015 strategic plans. To sustain leprosy elimination and to further reduce the disease burden household contact screening of leprosy cases has been adopted by the country program. To sustain the activity, advocacy to the high level official of the MOHP, Planning Commission and the Ministry of Finance by the programme is ongoing. Similarly the program wants to scale up the network of self care and help groups, especially, in the mid and far west region with a vision to use services of the leprosy affected people to identify new cases and maximize their potential for improvement of the socio economic conditions of endemic

villages as a whole. Similarly, the program plans to reach the urban poor residing in the slums by partnership with stakeholders and actively involving people residing in the slum.

The national programme acknowledges the contribution of all partners and the impact of Nepal visits by Mr. Yohei Sasakawa, WHO-Goodwill Ambassador for Elimination of Leprosy in generating political commitment by advocating for the support of the programme amongst high level leaders and officials.

3.5 Timor-Leste

Intensified activities were undertaken in collaboration with partner (TLMI) and WHO Country Office, focusing on awareness campaigns at district levels, review of cases on treatment and updating the patients' registry. Following the national case validation, a total of 113 cases were under treatment as on June 30, 2010 with the PR of 0.98 per 10,000 population.

Case validation results by district as on 30 June 2010 in Timor-Leste:

Districts	No of cases Before		Completed treatment	Duplicate registered cases	Incorrecty diagnosed	Dropped out	New Cases Detected		No of Cases		Total cases Jun-10
	PB	MB					PB	MB	PB	MB	
Liquica	0	2	1	0	0	0	0	3	0	4	4
Bobonaro	0	10	6	0	0	0	0	0	0	4	4
Ermera	1	14	14	0	1	0	0	0	1	4	5
Dili	3	55	19	11	3	9	3	7	3	23	26
Aileu	0	0	0	0	0	0	0	0	0	0	0
Suai	0	5	0	0	0	0	0	0	0	4	4
Manufahi	0	0	0	0	0	0	0	1	0	2	2
Ainaro	0	0	0	0	0	0	0	0	0	0	0
Manatuto	4	5	1	1	0	1	0	0	2	4	6
Baucau	0	20	3	7	0	0	1	3	0	14	14
Viqueque	1	12	1	0	2	1	0	0	1	8	9
Ocusee	10	34	13	0	1	0	1	7	9	29	38
Lautem	1	0	0	0	0	0	0	0	1	0	1
Total	20	157	58	19	7	11	5	21	17	96	113

3.6 Bangladesh, Bhutan, Maldives, Myanmar, Sri Lanka and Thailand

These countries have achieved and sustained the elimination at the national level and further reduced prevalence. However, there are a number of high endemic areas within these countries. These countries need continued support and adequate resources to consolidate the gains made and to further reduce the burden of leprosy.

DPR Korea does not report any leprosy cases in the country.

Conclusion

All countries of the Region have integrated leprosy services into the general health services and are taking measures to further strengthen integration. Countries which have achieved elimination at the national level are concentrating on efforts to further reduce the burden of leprosy. Timor-Leste is intensifying the activities to achieve elimination at the end of 2010. Continued support to leprosy elimination has contributed to improve public perception on the disease, thereby reducing stigma and discrimination in the communities.

4. Financial Statement TNF/SMHF Funds during 2010 and proposed budget for 2011 (the approved budget for 2010 includes roll-over from 2009)

S. No.	Regional office and countries	Total proposed budget for 2011 in US $	Expected roll over by end December 2010 in US $	Additional amount proposed for 2011 in US $	Approved amount during Advisory Board meeting for 2011 in US $
1.	SEARO Regional Office	190 000	10 000	180 000	
2.	Bangladesh	62 000	0	62 000	
3.	Bhutan	20 000	0	20 000	
4.	India and WRO India	154 018	4 018	150 000	
5.	Indonesia	326 900	11 900	315 000	
6.	Maldives	20 000	0	20 000	
7.	Myanmar	56 798	1 798	55 000	
8.	Nepal	225 349	10 349	215 000	
9.	Sri Lanka	38 000	0	38 000	
10.	Thailand	20 000	0	20 000	
11.	Timor-Leste	37 000	2 000	35 000	
	TOTAL	**1 150 065**	**40 065**	**1 110 000**	

5. Provisional Budget Projection for 2011

5.1 Proposed budget for the Regional Office for January to December 2011:

S. No.	Activity	Expected Contribution	Budget for 2011 (US$)
1	Administrative support: secretary	Improved coordination and administrative services	30 000
2	National Leprosy Programme Managers meeting to review implementation of leprosy activities.	Enhanced technical support to further reduce leprosy among the member countries.	60 000
3	Regional meeting of the persons affected by leprosy focusing on their self-help initiatives.	Developed modules on capacity building based on GLP guidelines to strengthen involvement of persons affected by leprosy in leprosy service among the member countries.	50 000
4	Regular/periodic monitoring and supervision from the Regional office.	Technical support in improving programme performance.	20 000
5	Operational research on leprosy control activities	To contribute in reducing operational factors in implementing leprosy activities.	20 000
6	Regional annual publication on leprosy	Annual activity report distributed to the member-states	10 000
		TOTAL	**190 000**

5.2 Bangladesh

The table below shows the planned activities during 2010-11 for which funds have not yet been identified. These activities would be proposed for the next funding cycle of TNF. They should all be completed before the end of 2011.

Activities planned and for which funds still have to be identified

Serial Number	Activity description	Mechanism	Amount requested (in US$)
1.	Development of post-elimination strategy	DFC	10 000
2.	Workshop with core group of leprosy workers at district level on the global strategy and operational guideline implementation	DFC	15 000
3.	External review of NLEP	APW	21 000
4.	Development of core group on POD and control infection in leprotic ulcer	DFC	6 000
5.	Advocacy to amend Lepers' Act (1898) and further reduce stigma	DFC	10000
		TOTAL	**62 000**

5.3 Bhutan

S.No.	Activity	Amount requested (in US$)
1	National advocacy and workshop on the new Operational Guidelines and Protocols for 2011 – 2015	10,000
2	Joint monitoring and supervision at the district and health centre levels by MoH and WHO country office staff	10,000
	TOTAL	**20 000**

5.4 India

Introduction

The WHO Country Office for India proposes to continue to support the country's National Leprosy Eradication Program (NLEP) in the year 2011. It is planned that the support will mainly be in the areas of technical assistance for the activities of the program with a view to achieve a reduction in the rate of new cases with Grade 2 disabilities by at least 35% by 2015, in keeping with ***Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy: 2011-2015***.

Budget for the WHO/GOI Collaborative National Leprosy Eradication Programme (US$)

No.	Activity	Expected Contribution	Funding received for 2010 (USD)	Proposed Sasakawa Funding for 2011
1	Technical support to program coordination, monitoring and MDT management in the high endemic states through WHO Programme and Logistic Consultants at state and sub-state level, to ensure timely detection and early treatment of hidden cases of leprosy at the grassroot level, leading to a real reduction in the case load of the disease	Improved program coordination, monitoring and drug supply and logistic management coordination leading to enhanced case detection and early treatment Improved drug supply and management to ensure prompt and complete treatment at sub-national levels	80,000	80,000
2	WHO NLEP Coordinators		20,000	
3	Support to the Central Leprosy Division, Ministry of Health & Family Welfare, to better manage the programme data and management information system for efficient and effective programme coordination. The evidence based MIS reporting will further strengthen the Government's informed decision making process.	Support Central level planning, monitoring and programme data compilation and analysis for evidence based MIS	20 000	20 000

No.	Activity	Expected Contribution	Funding received for 2010 (USD)	Proposed Sasakawa Funding for 2011
4	Training programs for state and sub state level government programme management staff for advocacy and to retain technical competence in the newer incumbents who are being placed in the programme.	Improved technical competence of program staff		20 000
5.	**WR India:** Technical support to the WCO India to technically support the policy making planning, implementing monitoring and evaluation functions of the NLEP This is expected to lead to better coordination between WHO Regional and country office, Central Leprosy Division, GLP and other stakeholders.	Improved planning, implementation & monitoring	30 000	30 000
6.	Management and operations	Effective implementation and operations		
Total including PSC			**150 000***	**150 000**

Justification for proposed activities for 2011

(1) Technical support to Program Coordination and Monitoring

Program monitoring is perceived as one of the areas that need strengthening in the states. In is perceived that this activity will lead to the early diagnosis of hidden cases and immediate treatment. This would lead to the true reduction in the number of cases being detected. WHO India will continue to support the program monitoring and coordination at the state and zonal levels by means of field visits and review meetings at state and sub state levels.

The program management in the state and sub-state level is a function of the State Governments. Since the priority accorded to leprosy and the availability of manpower is not equal in every state there is a requirement to support the

program management in some of the states. This is intended to be done through placing trained personnel to support the program management. Since the availability of MDT at the peripheral level is a constraint for the program the Officers will also look in to the logistics and supply of the drugs in the periphery.

(2) WHO NLEP Coordinators – funding not requested for 2011.

(3) Support to Central Leprosy Division.

The WHO has supported the MDT Cell at the office of the DDG (Lep) Central Leprosy Division. This has resulted in the efficient monitoring and planning of program activities besides a strengthened data reporting and analyzing system. Since these are vital areas for the efficient management of the national program, it is proposed that the support remain as in 2010.

(4) Trainings in Leprosy:

Program management functions at the state and district level require a level of experience and expertise in the disease control activity. However, more and more states and are having to make do with officers who do not have previous exposure to the leprosy program. WHO intends to support long term training program of a select group of program personnel on a pilot basis.

WHO has supported the program review component of NLEP. This has been by means of holding national level meetings of the program managers (State Leprosy Officers), other program partners like ILEP and NGOs. This serves to review the activities in the recent past and plan for activities in the coming years. This is also an advocacy exercise. There is a continued requirement of the activity and support for this is proposed in 2011.

(5 & 6) WCO India and Management / operations

In order to coordinate the work at the WHO Country Office for India it is proposed to continue the posts of the Temporary National Professional and Administrative Assistant. This is expected to contribute to improved planning, implementation and monitoring of the program besides strengthened support to the disability and social aspects of leprosy which are included in the definition of the burden of leprosy. In order to streamline and professionalize the administration of the activities, the administration has been outsourced. So the cost of this is also included.

5.5 Indonesia

Proposed major activities and brief budget summary January 2011– December 2011

S.No	Proposed Activities	Proposed Budget for 2011 (US$)
1	Intensified leprosy case finding through awareness campaigns in 4 consistently high endemic districts in Eastern Indonesia (Papua and Maluku Provinces)	40 000
2	Capacity building to be coupled with and to promote early case detection, treatment including updating the patients' registry in high burden districts for reducing disability grade-2 and social stigma as per Enhanced Global strategies (2011-2015)	60 000
3	One day Partners Meeting in Jakarta	20 000
4	Capacity building workshop for the low burden provincial leprosy officials including leprosy officers of urban health centers and difficult to reach areas	40 000
5	Two national consultants to support the national leprosy elimination initiatives	40 000
6	a. Two advocacy and orientation meetings for the national and provincial health officials on Enhanced Global Strategies to reduce leprosy disease burden plan 2011-2015; b. To fight against leprosy by celebrating World Leprosy Day on Sunday, January 30, 2011	40 000 10 000
7	a. Review of the national leprosy control programme in Indonesia in collaboration with the ILEP partners (similar to an external evaluation of the national program); b. Operational research to support the leprosy elimination implementation programme and to evaluate the value of household contact survey in the case detection of leprosy at a low endemic situation districts in Indonesia	30 000 25 000
8	Travel expenses for WHO staff to provide with technical support to the provinces	10 000
9	General operating cost	4 000
	TOTAL	**315 000**

Justification for activity support for the year 2010 under TNF/SMHF grant:

Activity 1& 2: The issues of static leprosy situation in terms of new cases, disability grade-2, MB and child cases as well as static social stigma are the concerns to the MOH officials and partners. This was discussed in the two day brain-storming workshop in Jakarta. To address these issues, the program is planning to undertake this activity using community volunteers, caders, people affected by leprosy and community leaders to promote IEC activities, rapid contact examination and rapid village screening in high endemic pockets. Community volunteers, cadres, people affected by leprosy will be trained in suspecting leprosy and referring to health centers for diagnosis and treatment. District health officials will be advocated to support education through radio and TV spots and support such activities.

Activity 3: One day Partners Meeting in Jakarta: The individual partners, Ministry of Health, Community based organization, NGOs, private sectors, international agencies, professional associations (dermatologists etc) and group of persons affected by leprosy will be invited to participate this meeting. Partnership will help to raising the profile of the programme and in advocating for an augmented national response in mobilizing resources.

Activity 4: Workshop on low burden situation including urban leprosy: Building of capacity of different categories of heath staff, a focused, need based approach in low leprosy endemic areas will be required. At the same time care should be taken to ensure that service points are strategically located for easy accessibility. The case detection strategy need to be modified from the one adopted in high burden situation. This will be equally important to focus our attention in lower endemic areas to define the number of leprosy cases and nature of leprosy in coming years. Utilization of services of the persons affected by leprosy in difficult to access areas will be equally important.

Activity 5: National consultants will provide technical support to the national leprosy control initiatives as there is a need of experts in the areas of early case detection, quality of diagnosis and case management, access to quality of services, providing essential leprosy services to underserved population groups, urban areas, scaling up activities of prevention and control of disabilities and community based rehabilitation.

Activity 6: Advocacy and orientation meetings with the national and provincial health officials on Enhanced Global Strategies (2011-2015) to reduce leprosy disease burden at the sub-national levels is crucial, especially, in a big country like Indonesia. The national program, with WHO support, would like to sensitize all the MOH officials and 33 provincial health officials to this new global strategy document issued by WHO. This will be the basis for further revising national guidelines and national action plan to implement activities in the districts to further reduce disability grade-2, number of new cases as well as in reducing social stigma. Like previous years the World Leprosy Day will be celebrated on, January 30, 2011 to continue fight against leprosy.

Activity 7a: Review of the national leprosy control programme in Indonesia in collaboration with the ILEP partners (similar to an external evaluation of the national program):

Nation-wide leprosy programme review has not been undertaken during recent years by the external experts after achieving elimination of leprosy as a public health problem, except, the evaluation of NLR supported provinces by NLR experts. Such review of the

national leprosy control program in Indonesia in collaboration with the ILEP partners' will benefit the programme to advocate higher level MOH officials to accord priority and allocate budget as per the recommendation by the external review/evaluation teams. This will also assist the programme to develop social marketing tools to advocate provincial and district decision makers to enhance the political commitment for leprosy control activities.

Activity 7b: National level operational research will be supported in the areas of integration, quality, epidemiological, operational and patient management. A review of the impact of household contact survey in the case detection of leprosy at low endemic districts in Indonesia will also be important for assessing its usefulness in future programme implementation.

5.6 Maldives

S.No.	Activity	Budget for 2011
1	National advocacy and workshop on the new Operational Guidelines and Protocols for 2011 – 2015	10 000
2	Joint monitoring and supervision at the district and health centre levels by MOH and WHO country office staff	10 000
	TOTAL	**20 000**

5.7 Myamnar

S. No.	Activity	Budget for 2011
1	Ensuring supportive supervision and monitoring of leprosy control programme through national consultants	10 000
2	Meetings of partners for Myanmar National Leprosy Control Programme	10 000
3	Programme Review and Coordination meetings at central, state/divisional and regional levels	15 000
4	Monitoring and supervision for sustaining leprosy services at all levels	20 000
	TOTAL	**55 000**

5.8 Nepal

S No	Activity	Output	Proposed amount in US $
1	NPO and Secretarial assistant support	Enhanced technical support towards achieving elimination	55 000
2	Screening for leprosy in urban slums and household contact screening activity	Provision of MDT service to cases not having access to leprosy services	40 000
3	Review of the leprosy program and capacity building of HW in high-endemic districts	Improved knowledge, programme management skills and motivation of staff	25 000
5	Review of the program and capacity building of HW in low-endemic districts	Sustain leprosy elimination	25 000
6	IEC support to the national program	Sustain leprosy elimination	15 000
7	Advocacy of the program amongst hard to reach areas, support to community based organizations working with socially marginalized group	Reduction of stigma and rehabilitation of leprosy patients.	20 000
8	Expanding the network of Self Help and Self Care groups in the districts of Western and Midwestern Development Regions of Nepal	Disability reduction and social rehabilitation	25 000
9	Participation in international meetings and seminars and supervisory visits by Central, Regional and district programme managers	Improved supervision, monitoring and increased staff motivation.	10 000
		TOTAL	**215 000**

5.9 Sri Lanka

S. No.	Activity	Budget for 2011
1	Development of National Operational Guidelines and Protocols for 2011 - 2015 based on Enhanced Global Strategy and Operational Guidelines	5 000
2	National Workshop on the new Operational Guidelines and Protocols for 2011 – 2015	10 000
3	Programme Review and Coordination meetings at central and district levels	10 000
4	Supporting IEC/advocacy activities in order to further increase awareness on leprosy, and further reduce the stigma associated with the disease	5 000
5	Conduct training programmes on self-care for leprosy	8 000
	TOTAL	**38 000**

5.10 Thailand

S.No.	Activity	Budget for 2011
1	National advocacy and workshop on the new Operational Guidelines and Protocols for 2011 – 2015	10 000
2	Joint monitoring and supervision at the district and health centre levels by MOH and WHO country office staff	10 000
	TOTAL	**20 000**

5.11 Timor-Leste

S.No.	Activity	Budget for 2011
1	National advocacy and workshop on the new Operational Guidelines and Protocols for 2011 – 2015	15 000
2	Joint monitoring and supervision at the district and health centre levels by MOH and WHO country office staff	15 000
3	Reproduction of leprosy educational materials the local language for distribution at the district and health centre levels	5 000
	TOTAL	**35 000**

Eastern-Mediterranean (EMRO)

1. Regional situation

The regional situation is nearly the same as the last few years. There are three groups of countries that can be identified:

(5) countries where leprosy is at very low levels and is not registered among local population and this group includes: Djibouti, Iraq, Jordan, Kuwait, Lebanon, Libya, Oman, Palestine, Qatar, Syria, Tunisia and United Arab Emirates.

(6) countries where leprosy burden is declining as a result of well developed strategies and high coverage of population with leprosy control activities and this group includes Egypt, Iran, Morocco, Pakistan, Saudi Arabia, Sudan and Yemen.

(7) countries where leprosy control is affected by difficulties resulting from past or current emergency situations and this group includes: Afghanistan, Somalia and Sudan.

By the end of 2009, and according to reporting from EMR countries to EMRO 4026 new leprosy cases were detected which is nearly the same as 2008 (3938 cases). Sudan, and especially its southern part, remains as one of the countries reporting more than 1000 or more new cases every year. As mentioned in the Enhanced Global Strategy for further Reducing the Disease Burden due to Leprosy 2011–2015 the increase in reported cases in Sudan along the past years is due to more data coming from the southern part of the country since 2007, mainly associated to improvements of the reporting system and strengthened operational coordination between the national program and implementing partners, such as NGOs.

The proportion of MB among new leprosy cases ranged from 100 percent in countries having very small reported numbers (Bahrain, Iraq, Kuwait, Lebanon, Oman and Tunisia), to zero percent in Libya. Countries with high numbers of reported cases had relatively high MB as north Sudan (87.35%), south Sudan (81.65%), Pakistan (80.64%), etc. New cases with G2 disability ranged from 100 percent in Kuwait (only one new cases of leprosy reported in 2009), and 34.38 in Iran to zero percent in several countries (Bahrain, Djibouti, Iraq, Libya, Oman, Qatar, Saudi Arabia and Tunisia). The female proportion among the newly detected cases ranged from 100 percent in Djibouti and Tunisia (newly reported leprosy cases in 2009 were two cases and one case in Djibouti and Tunisia respectively) and 42.88 percent in Pakistan to zero percent in several countries (Bahrain, Iraq, Kuwait, Lebanon and Libya). The child proportion in the Eastern Mediterranean Region ranged from 100 percent in Kuwait and 16.54 in Yemen to zero percent in several countries (Bahrain, Djibouti, Iran, Iraq, Lebanon, Libya, Syria and Tunisia). All illustrated data are summarized as follows in table 1.

Table 1: *Selected indicators for leprosy in EMR countries in 2009*

Country or territory	No. of new cases detected, 2009	No. of new cases of MB leprosy 2009	No. of new cases with G 2 D 2009	No. of new cases among children 2009	No. of female leprosy cases 2009	No. of cases registered for treatment at the end of 2009	No. of relapses, 2009	Cure rate (%) PB 2009	Cure rate (%) MB 2009
Afghanistan	52.	37	6	5	21	52	0	na	na
Bahrain	1	1	0	0	0	0	0	na	na
Djibouti	2	9	0	0	2	10	0	8.5	91.5
Egypt	700	616	42	48	265	912	5	82	83
Iran	32	29	11	0	11	81	5	100	86
Iraq	1	1	0	0	0	1	0	0	100
Jordan	0	0	0	0	0	0	0	0	0
Kuwait	1	1	1	1	0	1	0	na	na
Lebanon	3	3	1	0	0	3	0	100	100
Libya	5	2	0	0	0	9	1	na	na
Morocco	41	29	6	1	16	72	0	100	100
Oman	2	2	0	0	1	2	0	100	100
Pakistan	527	425	91	27	226	865	11	98	95
Palestine	0	0	0	0	0	0	0	na	na
Qatar	46	6	0	0	1	34	0	100	100
Saudi Arabia	15	1	0	0	4	5	0	100	100
Somalia	109	63	7	18	25	49	0	na	na
Sudan (north)	814	711	132	13	295	1127	2	88.3	72.1
Sudan (south)	1286	1050	284	85	668	4843	18	85	86.6
Syria	4	3	1	0	1	4	1	75	75
Tunisia	1	1	0	0	1	1	2	na	na
United Arab Emirates	0	0	0	0	0	0	0	na	na
Yemen	387	246	26	64	120	424	6	94.6	90.5
Total	4026	3234	608	257	1657	8071	51		

na: not available

2. Reporting on expenditure statements of years 2007, 2008, 2009 & 2010 (as of end of August 2010)

2.1 Expenditure statement of year 2007

The amount granted to EMRO by The Nippon Foundation (TNF) in 2007 was 40000 USD. (table 2). The amount was allotted in allotment EM/ICP/CPC/600/ST/06Q. Most of this amount was used in holding the annual regional meeting, in training activities and in production of advocacy materials, in addition to the programme support cost.

The amount carried over to the biennium 2008/2009 was 3074 USD and was allotted to allotment EM/ICP/AAC/600/ST/08N. This amount was totally used by contributing to the costs of the Regional Leprosy Meeting 2009. (table 6)

Table 2: *Budget requirements for the year 2007 (allotment EM/ICP/CPC/600/ST/06Q)*

Main areas of intervention	Planned Cost USD (+PSC)	Expenditure	Balance of funds
Monitoring Leprosy Elimination at National and Regional Levels			
Regional Meeting of National Managers on progress in leprosy control	18,000	23628	-5628
Strengthening PHC Staff Training on Leprosy			
Training of PHC staff in Egypt, Pakistan, Sudan and Yemen on leprosy diagnosis, MDT treatment and disability prevention	20,000	5646	14354
Advocacy and health education materials	2,000	3050	-1050
PSC	0	4602	-4602
Total Budget Requirements for 2007	**40,000**	**36926**	**3074**

2.2 Expenditure statement of year 2008

The amount granted to EMRO by TNF in 2008 was 40000 USD. (table 3). The amount was allotted to the allotment EM/ICP/AAC/600/ST/08N. Most of the amount was used in 2008 in organizing the Regional Leprosy Meeting in addition to the programme support cost.

The amount carried over to 2009 was 8282 USD and continued in 2009 as the same allotment EM/ICP/AAC/600/ST/08N, as the WHO financial biennium included both 2008 and 2009. This amount was used totally in 2009, with a deficit of 1125 USD. It supported two regional missions for attending meetings as well as translation of technical documents into Arabic.(table 6)

Table 3: *Budget requirements for the year 2008 (allotment ICP/AAC/600/ST/08N)*

Main areas of intervention - 2008	Planned Cost USD (+PSC)	Expenditure	Balance of funds
Monitoring Leprosy Elimination at National and Regional Levels			
Regional Meeting of National Managers on progress in leprosy control	23,000	27116	-4116
Strengthening PHC Staff Training on Leprosy			
Training of PHC staff in Islamic Republic of Iran, Pakistan and Sudan on leprosy diagnosis, MDT treatment and disability prevention	10,000		10000
Advocacy and health education materials	7,000		7000
PSC	0	4602	-4602
Total Budget Requirements for 2008	**40,000**	**31718**	**8282**

2.3 Expenditure statement of year 2009

The amount granted by TNF in 2009 was 40000 USD.(table 4) The amount was allotted to the allotment EM/ICP/AAC/410/XA/08. Most of the amount was used in 2009 in holding the Regional Leprosy Meeting in addition to the programme support cost.

The carried over amount in 2010 was 8210 USD and continued in 2010 as award 55070. This amount was used totally in 2010 with a deficit of 108 USD. It supported translation of two technical documents into Arabic at the regional level, re-printing of training guidelines in Pakistan and attendance of one EMR staff of a technical meeting.

Table 4: *Budget requirements for the year 2009 (allotment ICP/AAC/410/XA/08)*

Main areas of intervention – 2009 Plan	Planned Cost USD (+PSC)	Expenditure	Balance of funds
Monitoring Leprosy Elimination at regional levels	*		
Regional Meeting of National Managers on progress in leprosy control – requested funds for 2009*	10,900	27188	-16288
Strengthening PHC Staff Training on Leprosy			
Training of PHC staff on leprosy diagnosis, MDT treatment and disability prevention.	12,000		12000
Advocacy and health education materials	4,000		4000
PCH strengthening and rehabilitation			
Supporting PHC rehabilitation for leprosy cases mgmt	10,000		10000
Monitoring, supervision at Country level			
Country mission for coordination and follow up with leprosy programme managers and focal points	3,100		3100
PSC	0	4602	-4602
Total Budget Requirements for 2009	**40,000**	**31790**	**8210**

2.4 Expenditure statement of year 2010

The amount granted by TNF in 2010 was 50000 USD with an increase of 10000 USD than the last three years. (table 5). Part of the amount is obligated / used for training activities is four countries: Sudan, Yemen, Afghanistan and Egypt. The greater amount will be used to hold the Regional Leprosy Meeting (December 2010), where the estimated cost is 45 000 USD. If we add the programme support cost there will be an expected deficit of more than 14000 USD.

Table 5: *Budget requirements for the year 2010 (award 56267)*

Main areas of intervention – 2010	Cost USD (+PSC)	Expenditure in USD	Balance in USD
Monitoring Leprosy Elimination at regional levels			
Regional Meeting of National Managers on progress in leprosy control	30,000	45000 (estimated costing)	-15000 (expected deficit)
Strengthening capacity building			
Support to training of PHC workers, including associated supervision activities to the operational site in Yemen, Sudan and Egypt	14,250	13500 (trainings during 2010 in Afghanistan, Egypt, Yemen & Sudan)	750
Programme support cost			
Support for operational needs of the program	5,750	**5752**	**-2**
Total	**50,000**	**59252**	**- 14252 (expected deficit)**

2.5 Summary of the carried over funds in years 2007, 2008 & 2009

Noting that the TNF granted funds are valid in the year following the year of receiving the funds, EMRO usually uses most of the amount in the first year, and uses the remaining small part of the funds to cover activities in the next year. The total amounts carried over were 19566 USD for the three years 2007, 2008 and 2009 (3074 USD, 8282 USD and 8210 USD respectively). The amounts disbursed were 20779 USD for the three years (3068 USD, 9413 USD and 8318 USD respectively), with a total deficit of 1233 USD. (table 6)

As shown in table 6, and as outlined in the expenditure statements (2.1, 2.2 & 2.3 above), all the amounts that were carried over were used totally in the following years in important activities that were usually planned in the approved work-plans. Table 6 shows precisely the amounts carried over in years 2007, 2008 & 2009 and the different activities they supported.

Table 6: *Amounts carried over and their status of disbursement in years 2007, 2008 & 2009*

Original year	Amount carried over in USD	Year(s) of disburse-ment	Amounts disbursed in the following year (s) in USD	Balance after disburse-ment in USD	amounts disbursed in USD by stickers or registration /TR numbers	Areas of intervention	remarks
2007	3074	2008-9	3068	6	1557 EM09628734 1511 EM09634223	Regional leprosy meeting	Amount carried over from 2007 to 2008/2009 as allotment EM/ICP/AAC/600/ST/08N
2008	8282	2009	9413	-1131 (deficit covered from other sources in 2009)	2507 EM09653199	Travel	Amount continued in 2009 as same allotment EM/ICP/AAC/600/ST/08N
					2921 EM09653221	Travel	
					3985 EM09789585	Translation of documents	
2009	8210	2010	8318	-108	1728 TR157639	Travel	Amount carried over from 2009 to 2010 as award 55070
					1107 2010/79968	Printing in Pakistan	
					1399 2010/79968	Printing in Pakistan	
					873 TR157639	Travel	
					2192 2010/69384	Printing in Pakistan	
					883 2010/86579	Translation of documents	
					136 TR157639	travel	
total	19566		20799	-1233	20799		All carried over amounts disbursed with deficit of 1233 USD

3. Reporting on 2nd part of 2009 & 2010 activities (as of end of August 2010)

During the last few months of 2009 and during 2010 EMRO supported or will support the EMR countries through the following activities.

(1) EMRO translated both "Enhanced Global Strategy for Further Reducing the Disease Burden Due To Leprosy (Plan Period: 2011–2015)" and its "Operational Guidelines (updated) into Arabic. The layout is done and the printing and distribution will take place before end of 2010.

(2) EMRO supported Pakistan to re-print WHO document titled "Guide to Eliminate Leprosy as a Public Health Problem". This document will be used as an excellent teaching material in leprosy training workshops for physicians, students, nurses and paramedical workers. This activity included re-printing 4000 copies in Urdu and 3000 copies in English.

(3) EMRO was represented by the regional leprosy focal point in the Meeting to Develop Guidelines to Strengthen Participation of Persons Affected by Leprosy in Leprosy Services, Manila, Philippines, 9–10 June 2010. During that meeting, the guidelines were endorsed and the final version will be prepared and circulated to the participants. When the guidelines are finalized EMRO will present them to the regional leprosy programmes for further steps at regional level.

(4) EMRO will support the National Leprosy Programme in Afghanistan where a consultant will visit Afghanistan for two weeks (November 2010) to review leprosy activities and develop a national strategy in line with the Enhanced Strategy for Further Reducing the Disease Burden Due to Leprosy (2011–2015), and to prepare its plan of action. The consultant will facilitate a 2-day training workshop during his mission (activity number 7 below)

(5) The National Programme in Sudan was supported to conduct supervision activities and an international NGO working in Sudan was also supported to conduct leprosy services in Darfur. (activities are still going on till mid 2011)

(6) EMRO planned to hold the annual "Programme Managers Meeting on Leprosy Elimination" on 23–24 June 2010, however, it was decided to postpone it to 15-16 December 2010. This was decided based on the experiences from previous years where holding the meeting in summer (June-July) misses most of the planned activities of the participating National Program Managers and other implementing partners, that would take place in the second half of the year. Based on this observation, it was thought to hold the meeting toward the end of the year in order to give participants the chance to produce more results and implement more activities to report at the annual meeting. The objectives of the 2010 meeting are: a)- to review progress of national leprosy elimination programmes made during 2009/2010, b)- to discuss the implementation of the Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy 2011–2015 and its updated Operational Guidelines, and c)- to address the strategic and operational needs at the country level for 2010/2011 operational plan development.

(7) EMRO is supporting training activities in four countries: Sudan, Yemen, Egypt and Afghanistan to build capacities of health workers in leprosy management. These training activities will take place between September and November 2010.

4. Plan of action for 2011 with budget requirements

EMRO proposed activities for 2011, include three components: capacity building of national staff, monitor-ring leprosy elimination efforts in EMR countries and advocacy for new initiatives, and, follow up and supervision activities.

4.1 Capacity building of national staff

In February 2009, a training workshop on national programme management was held in Taiz, Yemen. It was a successful workshop and it is felt that a second one is needed to ensure national program managers and healthcare workers have the adequate skills and knowledge for case detection and treatment, and that they can lead and supervise activities of national programmes. The proposed workshop is supposed to be based on the methodology, learning process and approach of the previous one held last February 2009 in Taiz. This would ensure participation of those managers who could not take part to the 2009 training, including: Bahrain, Djibouti, Jordan, Libya, Oman, Qatar and Tunisia.

4.2 Monitoring leprosy elimination efforts in EMR countries and advocacy for new initiatives

As one of the important periodic events, EMRO stresses on the need to hold the annual regional meeting for national leprosy programme managers. The meeting is usually a two-day meeting that is held in one of the Member States.

The 2010 meeting, as mentioned was postponed and will be held on 15–16 December 2010 in Beirut, Lebanon. This will use the funds from last year which is already available for this activity.

The 2011 meeting will aim at following with EMR countries on the progress in implementation of the 2011–2015 Enhanced Global Strategy. The meeting will be a good opportunity to review the leprosy programme activities as well as challenges and need for help in different Member States. This meeting will also be a suitable occasion to introduce the Guidelines to Strengthen Participation of Persons Affected by Leprosy in Leprosy Services, which were endorsed in Manila, Philippines in the 9–10 June 2010 meeting. It is expected that by the time the Regional Meeting is held (tentatively mid-2011) the Guidelines would be in their final version. Therefore the regional meeting will enable WHO to work along with Member States to adapt these guidelines to specific regional or country needs. Moreover, being a regional meeting, it will be an important occasion to bring together different stakeholders relevant to the leprosy control, including donors and implementing partners.

4.3 Follow up and supervision activities:

This includes country visits to follow on activities especially in countries with high burden and those where WHO is providing support. Also this component will include representation of the regional staff in leprosy meetings or conferences which is an important step to be oriented with new initiatives, interventions and ideas related to leprosy control and their introduction into the Region.

4.4 Funds requested for 2011 operational year.

The total amount requested is 50000 USD. The amount is divided according to the three components mentioned above, with a total of 44250 USD for activities, while the programme support cost amounts to 5750 USD (table 9)

Table 9: *Summary of funds requested for 2011 operational year*

Main activities – 2011	Cost in USD
Strengthening capacity building: supporting training workshop (e.g. workshop in Yemen attended by staff from Sudan, Egypt, Oman, etc.)	10000
Regional Meeting of National Programme Managers	30000
Supervision activities/country visits/attending meetings	4250
Total for proposed activities	**44250**
Programme support cost	5750
Grand Total	**50000**

WHO-Western Pacific Region - Leprosy Elimination Programme Regional progress report of 2009 and the 1st half of 2010

The 2009 leprosy data have been submitted timely by all countries from the Western Pacific Region to WHO WPRO and are still in the process of being compiled. Thus the key leprosy data of 2008 are being presented here again.

LEPROSY SITUATION (END OF 2008)

Leprosy as a public health problem was eliminated in the Western Pacific Region in 1991, nine years before the global target date. Thirty-four of the 37 countries and areas in the Western Pacific Region have eliminated leprosy as a public health problem, covering 99.9% of the Region's population. The Federated States of Micronesia and Marshall Islands have not yet achieved elimination, while Kiribati failed to sustain the elimination status. Only two countries in the Region, the Philippines and China, have been reporting more than 1000 cases annually.

According to available data at the beginning of 2009 there were 9754 registered cases in the Region, with a prevalence rate of 0.055 per 10000 population. Even though the prevalence rate has declined by 85.6% compared to the 1991 rate, a slight increase was observed in 2008. A total of 5859 new cases were reported for 2008 with a new case detection rate of 0.333 per 100000 population. The new case detection rate has slightly decreased compared to 2007 and decreased by two thirds compared to that of 1991. Cambodia, China, Lao PDR, Malaysia, Philippines, PNG and Viet Nam contributed to 92% of the total prevalence and 95% of the new cases detected in the Region. The proportion of multibacillary leprosy and the proportion of children increased by 16% and 22% respectively while grade 2 disability proportion among new cases detected declined by 3% compared to 2007.

PROGRESS REPORT 2009

Technical and funding support was provided to PNG in May 2009 with the aim to: a) orient the provincial leprosy coordinators about the New Global Strategy Operational Guidelines; b) strengthen case and program management; c) conduct a program review and planning exercise; d) provide training to the provincial leprosy coordinators; and e) hold a leprosy partners meeting.

In June 2009 a consultative workshop was held in Shanghai, China for National Leprosy Programme Managers of countries with the highest burden of leprosy in the Western Pacific (Cambodia, China, Philippines, Lao PDR, Malaysia, PNG, and Viet Nam). The workshop aimed to: a) identify the current status of leprosy following the implementation of the bi-regional (SEAR and WPR) strategy since 2000 and the Global Strategy Operational Guidelines in 2006; b) provide leprosy updates and re-training to include prevention of disability and rehabilitation; c) determine strategic directions in the Region; d) identify country specific program needs; and, e) hold a partners meeting to identify areas for future collaboration.

Also in June 2009 in Shanghai, China a training workshop was held for national leprosy control staff of countries in the Western Pacific (Cambodia, China, Lao PDR, Malaysia, PNG, Philippines, Viet Nam, Kiribati, Marshall Islands, FSM, Vanuatu, Samoa and Solomon Islands. The meeting was organized with support from the Global Leprosy Programme and facilitated by ILEP consultants and had the theme 'From Global Strategy to National Action'.

A consultancy mission was organized to provide technical and funding support on leprosy elimination activities to the Federated States of Micronesia and Republic of Marshall Islands in July/August 2009. The mission focused on: a) leprosy program review; b) clinical and programme management training; and, c) strategic planning and identification of future directions.

In November/December a mission reviewed the leprosy control activities and the programme accomplishments in Kiribati and supported the development of the programme action plan for 2010/2011.

In December 2009 a mission reviewed the leprosy situation in provinces with a high prevalence of leprosy in China and provided recommendations with regard to sustaining leprosy services.

PROGRESS REPORT 1 JANUARY TO 15 AUGUST 2010

In January/February 2010 an external review of the Philippine National Leprosy Control Programme (NLCP) was done to assess the performance of the National Leprosy Programme for the last five-year period and give recommendations on how to improve the implementation of the "enhanced global strategy for further reducing the disease burden due to leprosy 2011-2015".The findings showed that the Philippine NLCP was well-conducted, infrastructure was in place, MDT drugs were well maintained and staff were motivated. Extensive capacity building activities have been ongoing leading to the majority of staff being trained on leprosy. However, while case detection activities were carried out by voluntary reporting, early neuritis and disability were mostly not assessed and reported. Supervision and follow-up visits were frequently missing. Recording and reporting was often incomplete and old and new cases were reported together leading to difficulties and unreliable reports.

In May 2010 WHO WPRO organized the 2nd Workshop on Sustaining Leprosy Services in Pacific island countries and areas (PICs) in Nadi, Fiji. This meeting brought together 25 participants from 12 PICs, technical experts, technical agencies and partners such as the Pacific Leprosy Foundation, and the Leprosy Mission International New Zealand. The participants reviewed the current leprosy situation in the PICs and the achievements and progress made to sustain leprosy services following the elimination of leprosy as a public health problem in most countries. The continuing detection of new cases under this low endemic situation in the PICs illustrates the need to sustain quality leprosy services to further reduce the burden of leprosy. The workshop provided a valuable forum for updating knowledge and skills in case and programme management as well as reviewing the WHO Enhanced Global Strategy of Sustaining Leprosy Services and Further Reduce Leprosy Burden. The workshop also identified significant organizational, policy, operational and administrative challenges in the PICs. Leprosy should be included in each national health agenda to secure sustainable and adequate funding for case detection, monitoring, supervision and evaluation, case holding and follow-up. The participants acknowledged the continuing commitment and support of the partners to further reduce the leprosy burden and ensure sustained delivery of quality leprosy services in the PICs. During the partners' meeting with technical agencies the need of continuous funding support and sustainability of leprosy services to further reduce the disease burden was highlighted.

In June 2010, WHO WPRO hosted the global leprosy "Meeting to develop guidelines to strengthen participation of persons affected by leprosy in leprosy services" in Manila. During this very successful meeting, the main topics of the guidelines were presented and discussed in detail.

As a result of the Partners' meeting, a joint mission to Kiribati, Samoa and Fiji took place in July/August 2010. The team was composed of a WHO consultant and the Pacific Leprosy Foundation to review the leprosy situation and to provide training in Samoa and Kiribati as well as to update the leprosy guidelines in Fiji.

Funding was provided for a surveillance workshop in China as well as for leprosy training in Cambodia in March and August 2010.

The 2009 data has been submitted timely by countries and is currently being compiled and analyzed before it will be published.

Table 1 provides an overview of the expenditures up to 15 August 2010 and the estimated costs of planned activities.

PLANNED ACTIVITES (REMAINING MONTHS OF 2010)

Due to insufficient funding for activities in 2010, most activities have already been completed by August 2010 with only few activities planned for the remaining part of the year.

Depending on the availability of funding, technical assistance for the elimination activities will be provided to the Federated States of Micronesia and the Republic of Marshall Islands through a monitoring and training mission (possibly jointly with partners) during the 4th quarter 2010.

Depending on the availability of funding, technical assistance will be provided to Papua New Guinea to support the programme review and completion of the national strategic leprosy plan.

The 2010 Leprosy Report will be finalized and published.

Latest notification of leprosy cases and monitoring indicators by countries 2008

Country	Population	Prevalence		New Case Detection									
	X 1 000	No.	Rate x 10 000	No.	Rate x 100 000	MB*		Dis Grade 2**		Child***		Female	
						No.	%	No.	%	No.	%	No.	%
American Samoa (2006)	66	NR		NR		NR		NR		NR		NR	
Australia (2006)	19921	0	-	11	0.0552	7	63.63	1	9.090	0	-	3	27.27
Brunei	380	0	-	2	0.5263	2	100	0	-	0	-	2	100
Cambodia	14453	242	0.1674	306	2.1172	219	71.56	40	13.07	21	6.862	85	27.77
China	1321290	3388	0.0256	1614	0.1221	1403	86.92	357	22.11	40	2.478	487	30.17
Hong Kong (2006)	7196	24	0.0333	5	0.0694	2	40	0	-	0	-	1	20
Macao	456	0	-	1	0.2192	1	100	0	-	0	-	1	100
Commonwealth of N. Mariana Island	80	2	0.25	0	-	0	-	0	-	0	-	0	-
Cook Islands(2006)	20	0	-	0	-	0	-	0	-	0	-	0	-
Fiji	868	7	0.0806	4	0.4608	0	-	0	-	0	-	2	50
French Polynesia (2006)	240	6	0.25	5	2.0833	2	40	1	20	1	20	3	60
Guam	158	16	1.0126	13	8.2278	12	92.30	1	7.692	3	23.07	5	38.46
Japan	127856	3	0.0002	3	0.0023	1	33.33	0	-	0	-	1	33.33
Kiribati	97	88	9.0721	42	43.2989	28	66.66	0	-	18	42.85	18	42.85
Republic of Korea	48004	332	0.0691	7	0.0145	6	85.71	3	42.85	0	-	6	85.71
Lao P.D.R.	5790	86	0.1485	93	1.6062	67	72.04	19	20.43	4	4.301	41	44.08
Malaysia	23821	696	0.2921	218	0.9151	162	74.31	9	4.128	6	2.752	73	33.48
Marshall Islands	63	54	8.5714	46	73.0158	25	54.34	0	-	11	23.91	20	43.47
Micronesia, F.S.	129	190	14.7286	124	96.1240	72	58.06	0	-	49	39.51	54	43.54
Mongolia	2617	0	-	0	-	0	-	0	-	0	-	0	-
Nauru	12	3	2.5	2	16.6666	1	50	0	-	2	100	0	-
New Caledonia	223	NR		NR		NR		NR		NR		NR	
New Zealand (2005)	3892	NR		NR		NR		NR		NR		NR	
Niue	2	0	-	0	-	0	-	0	-	0	-	0	-
Palau	21	5	2.3809	5	23.8095	5	100	0	-	0	-	0	-
Papua N. Guinea	6116	696	1.1379	422	6.8999	277	65.63	34	8.056	134	31.75	158	37.44
Philippines	86214	3338	0.3871	2373	2.7524	2142	90.26	45	1.896	110	4.635	285	12.01
Pitcairn Islands (2004)	0.046	NR		NR		NR		NR		NR		NR	
Samoa	184	5	0.2717	6	3.2608	5	83.33	0	-	2	33.33	2	33.33
Singapore	4325	18	0.0416	10	0.2312	5	50	0	-	0	-	0	-
Solomon Islands	496	14	0.2822	17	3.4274	14	82.35	0	-	3	17.64	5	29.41
Tokelau (2005)	2	0	-	0	-	0	-	0	-	0	-	0	-
Tonga	102	0	-	0	-	0	-	0	-	0	-	0	-
Tuvalu	11	1	0.9090	0	-	0	-	0	-	0	-	0	-
Vanuatu	220	0	-	0	-	0	-	0	-	0	-	0	-
Viet Nam	82345	540	0.0655	530	0.6436	378	71.32	82	15.47	18	3.396	202	38.11
Wallis & Futuna (2003)	15	0	-	0	-	0	-	0	-	0	-	0	-
WPRO	**1,757,685**	**9,754**	**0.0554**	**5859**	**0.3333**	**4836**	**82.53**	**592**	**10.10**	**422**	**7.202**	**1454**	**24.81**

*Proportion of MB cases

**Proportion of cases with grade 2 disability among new cases

***Proportion of children younger than 15 years among new cases

Figures in ( ) mean year of latest data

Work Plan Leprosy for 2011 – WHO Western Pacific Region

With intensified efforts and sustainable financial commitment it is feasible to achieve leprosy elimination as a public health problem in all countries of the Western Pacific Region in the next decade. As leprosy in the Western Pacific Region continues to decline, efforts need to be intensified to sustain the gains of elimination and to facilitate the integration of leprosy services into the general health services. Comprehensive and accessible leprosy services need to be available and provided for newly detected as well as for previously diagnosed and treated patients. This is also crucial as new cases will continue to occur for many years due to ongoing low levels of transmission of infection and the long incubation period of the disease. In addition, a considerable number of cured patients with disabilities will be relying on rehabilitative services.

A special focus should be put on those three Pacific island countries and areas which have not yet reached leprosy elimination as well as on those reporting more than 100 cases of leprosy annually. This includes Cambodia, China, the Lao People's Democratic Republic, Papua New Guinea, the Philippines and Viet Nam, as well as the Federated States of Micronesia, Republic of the Marshall Islands and Kiribati. It is also necessary to strengthen the decentralization efforts of integrating leprosy activities into the general health services by improving the referral system and networking in PICs reporting $\leq$10 cases annually.

WHO WPRO remains highly committed to continue to undertake the required activities to further reduce the leprosy burden and sustain quality leprosy services in the Region. WHO WPRO plans to continue to support countries in implementing the Enhanced Global Strategies, and planning, monitoring, evaluation and training missions are planned to take place in WPR countries. WHO WPRO will continue to work in close coordination with partners in the Region.

However, in 2010 WHO WPRO has not been provided with any additional funds and has been limited to using the remaining carry over funds from 2009. Without a funded focal person and secretarial assistance for leprosy in the Western Pacific Region and the unsecure funding for leprosy activities, addressing the above issues will be a major challenge for WHO WPRO. Depending on the availability of funding, further prioritization of activities is needed as WPRO may not be in a position to carry out activities. The WPRO workplan continues to engage all affected countries in the Region and includes technical assistance missions to priority countries. In order to address the above challenges, the following activities for 2011 are proposed as listed in table 2.

Major challenges and opportunities in the Region

The Western Pacific Region is in a position to achieve leprosy elimination as a public health threat in the remaining three PICs (Federated States of Micronesia, Republic of the Marshall Islands, Kiribati) within the next decade and to sustain leprosy elimination overall as well as in all countries that have already eliminated leprosy. In order to further reduce the burden of leprosy in all countries, sub-national approaches based on the new Global Operational Guidelines should be implemented.

However, as the burden of leprosy is decreasing, severe challenges remain:

- Many countries are faced with a decrease of well-trained staff with sufficient knowledge on leprosy, leading to patients remaining undetected for extended periods of time.
- The integration of leprosy services into the general health services is often lagging behind.
- Access to healthcare, especially in the widely spread out PICs.
- Endemic pockets and risk groups need to be identified as well as contact tracing and screening efforts intensified to strengthen case detection.

- The recording and reporting system needs to be validated and strengthened in many countries as the level of underreporting remains unclear.
- Furthermore monitoring, supervision and evaluation activities need to be enhanced as well as regular follow-up of patients.

Regional Objectives

1. Further reduce the burden of leprosy in the Western Pacific Region:
    - Elimination of leprosy as a public health problem in Federated States of Micronesia, Marshall Islands and Kiribati;
    - Further reducing leprosy burden in Cambodia, China, Lao PDR, Malaysia, PNG, Philippines and Viet Nam through sub-national approaches based on the new Global Operational Guidelines
2. Sustain quality leprosy services in the peripheral health centers to ensure timely diagnosis and prompt MDT treatment
3. Strengthen the integration of leprosy services into general health services and establish a referral system to improve coverage and accessibility for diagnosis and treatment particularly in Cambodia; China, Lao PDR, Malaysia, PNG, Philippines, Viet Nam and in the PICs
4. Increase knowledge and skills through training based on task of appropriate peripheral and key general health staff on the diagnosis of leprosy, MDT treatment, management of complications and prevention of disabilities (POD)
5. Continue to prioritize POD, strengthen rehabilitation activities and enable and promote self-care
6. Reduce/end stigma and discrimination against people affected by leprosy and their families
7. Improve quality of data and reports through regular supervision and training of intermediate and peripheral health staff
8. Orient Member States in the Region on the New Enhanced Global Operational Guidelines 2011 – 2015 which targets a reduction of incidence of grade 2 disability in the population
9. Support Member States to implement pilot testing of the “new guidelines to strengthen participation of persons affected by leprosy in leprosy services” once finalized and endorsed
10. Provide technical assistance through supervision, monitoring and evaluation of leprosy control activities in the context of the Global Operational Guidelines objectives and strategies
11. Sustain political commitment and provision of adequate financial, human and material resources to support leprosy control activities in countries in the Region

In order to face the challenges and to achieve the objectives as outlined above, WHO WPRO needs to continue to support Member States in good collaboration.

In particular WHO needs to:

- provide technical support to national leprosy programmes of Member States through programme reviews and development of national action plans
- conduct training in leprosy managerial and clinical skills
- update country staff on recent developments and policy changes

To effectively continue those leprosy activities in the Region adequate funding for activities and for a focal person for leprosy needs to be urgently secured.

Table 1:
Overview Leprosy Expenditures WHO WPRO 2010 (15 August 2010)

Activities	Expenditures and Encumbrances
Available funds (carryover from 2009)	*USD 134,946*
Funds received 2010	*USD 4,200*
Total funds available	***USD 139,146***
1. Assessment of the Philippine National Leprosy Control Program by the Royal Tropical Institute (KIT), Jan-Feb 2010	USD 25,000
2. Second Workshop on Sustaining Leprosy Services in the PICs, 10-12 May 2010, Nadi, Fiji	USD 51,445
3. Technical support, monitoring and duty travel for leprosy activities in • Republic of Kiribati • Samoa • Fiji	USD 18,256
4. Support to countries to further reduce the leprosy burden and sustain leprosy services, advocacy and training • Cambodia • China	USD 19,159
5. Technical support in the compilation and analysis of the 2009 leprosy data received from the countries	USD 5,250
Total Expenditures & Encumbrances:	***USD 119,110***
REMAINING BALANCE 15 AUGUST 2010	**USD 20,036**
Planned Activities until 31 December 2010	
6. Technical support, monitoring and duty travel for leprosy activities in • Federated States of Micronesia • Republic of the Marshall Islands • Papua New Guinea	USD 30,000
7. Participation in the annual Global Leprosy Meeting and drug resistance in Leprosy, Tokyo, Japan in November 2010	USD 10,000
8. Printing of annual Leprosy report 2010	USD 5,000
Funding needs until end of 2010	***USD 45,000***
FUNDING GAP 2010	**USD 24,964**

These costs do not include funding for WPRO positions

Table 2: OPERATIONAL BUDGET 2011 (based on 2010 figures)

ACTIVITIES	BUDGET REQUIRED
1. Pacific Island countries and areas training workshop on Leprosy Program Management under low endemic situation • Decentralization • Integration of Leprosy Activities into the General Health Services / Referral System • Partners meeting	USD 60,000
2. Development of Standard Operation procedures - Sustaining leprosy under Low endemic situation in Pacific island countries and areas* • task based training, • role/ function identification at different levels (Primary Health Care system and structure), • establishing/strengthening of referral system	USD 20,000
3. Technical support to the three countries that still have to achieve the elimination target: • Federated States of Micronesia • Republic of Marshall Islands • Republic of Kiribati	USD 30,000
4. Technical support and funding support for leprosy activities: • National program review – external review in Papua New Guinea • Leprosy seminar and training - Cambodia	USD 60,000
5. Training workshop for Cambodia, China, Lao PDR, Malaysia, PNG, Philippines, Viet Nam on • New Enhanced Global Operational Guidelines 2011-2015 • Rifampicin Surveillance in the Region • New guidelines on participation of people affected by leprosy / Pilot Testing	USD 50,000
6. Operational costs and annual publication of regional leprosy report	USD 20,000
Total activities:	***USD 240,000***
7. Secretary WPR	USD 20,000
8. Medical Officer WPR P5	USD 204,000
Total staff	***USD 224,000***
TOTAL FUNDS REQUESTED	**USD 464,000**

* One outcome of the proposed workshop for the PIC's will be the development of practical SOP's on how to address the challenges in the PIC's like decentralizationof leprosy activities and strengthening of the referral system. This generic document will be based on the concept of primary health care and focus on tasks, roles and functions. It will incorporate the basic elements of the Enhanced Global strategy. Pacific island countries may want to further adjust it to their own needs.

Overview Leprosy Expenditures WHO WPRO 2007

Activities	Expenditures and Encumbrances
Available funds (carryover from 2006) *Funds received 2007* ***Total funds available***	*USD 90,000* *USD 210,000* ***USD 300,000***
1. Salaries, Medical Officer for Leprosy (until July 2007)	USD 151,190
2. Regional Leprosy Meeting for the PICs	USD 51,170
3. Technical assistance • Micronesia • China • Review of the leprosy situation in the Region and preparation of Regional leprosy report • -Regional Adviser, WHO/WPRO	USD 30,499
4. Leprosy elimination activities • Cambodia • China	USD 20,427
5. Operational costs and technical support in review of the leprosy situation, preparation of the regional leprosy report and publication	USD 14,714
Total Expenditures:	***USD 268,000***
REMAINING BALANCE 31 DECEMBER 2007	**USD 32,000**

Overview Leprosy Expenditures WHO WPRO 2008-2009

Activities	Expenditures and Encumbrances
Available funds (carryover from 2007)	*USD 32,000*
Funds received 2008	*USD 183,000*
Total SMHF funds	***USD 215,000***
Old Nippon Funds	*USD 44,000*
Total funds available	***USD 259,000***
1. Training and Partners Meeting, Cebu, Philippines	USD 31,100
2. Technical assistance • China • Consultative meeting on TNF funding, New Delhi, India • Leprosy TAG meeting, Cairo, Egypt	USD 27,885
3. Leprosy elimination activities and trainings • Cambodia • Viet Nam • China	USD 48,000
4. Operational costs and technical support in data gathering, compilation and analysis of leprosy data received from the countries	USD 17,500
Total Expenditures:	***USD 124,485***
REMAINING BALANCE 31 DECEMBER 2009	**USD 134,515***
Remaining balance 2009 SMHF	***USD 94,698***
Remaining balance 2009 old Nippon	***USD 40,248***

**Most activities in 2009 were funded from other awards (mainly regular budget). The remaining balances do not fully match as some activities (e.g. leprosy workshop Shanghai, China, TA mission Kiribati) were co-funded from several awards and the figures shown resemble the best possible distribution*