

***Opening Address by***

***Dr Samlee Plianbangchang  
Regional Director, WHO South-East Asia***

***At the***

***Regional Meeting of National Leprosy Programme  
Managers***

***27-29 July 2011,  
Yangon, Myanmar***

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Dr U Ko Ko, WHO Regional Director (Emeritus); Director-General, Department of Health; Director of Medical Sciences; Director, Medical Research; distinguished country participants; honourable partners; colleagues and guests; ladies and gentlemen,

It is my pleasure to warmly welcome you all to this Regional Meeting of National Leprosy Programme Managers. First of all, I thank the Government of the Republic of the Union of Myanmar for agreeing to host the meeting. And, I thank all country participants, partners and colleagues for their interest and time in attending the meeting.

Ladies and gentlemen,

All countries in the South-East Asia Region have achieved their national targets for leprosy elimination. That means the national average of leprosy prevalence rate in the Region is now less than 1 per 10,000 population. In fact, the regional prevalence rate at the beginning of this year was 0.63 per

10,000 population. And leprosy is, therefore, no more a problem of public health importance in the Region. In spite of this achievement, during 2010, 67% of the total global new cases of leprosy were detected in the South-East Asia Region. It should be placed on record, however, that during the last two decades, a remarkable reduction of leprosy cases has been witnessed worldwide. This reduction has been possible due to the introduction of “multidrug therapy” (MDT); and WHO has promoted since the early 1980s the “fixed duration treatment” of leprosy cases with MDT. Nevertheless, the reduction in prevalence rate in individual countries, especially the big countries, is not uniform. There are still pockets or areas where the rates are more than 1 per 10,000 population. More work is needed to ensure uniform reduction of leprosy prevalence rate throughout individual countries.

We need to keep in mind also that after achieving the elimination target, leprosy still exists, but at the low level of prevalence. And, if our control programme becomes weak due to any reasons, leprosy will have a chance to come back to be a problem of public health importance again. We must be alert; and we must always keep vigilance to ensure the basic awareness on leprosy among people in the community; and we must continue working towards sustaining skills of peripheral health workers in providing “quality leprosy services”; the services which importantly include “detecting leprosy cases” early, and refer them for prompt treatment.

Ladies and gentlemen,

After elimination, we need a “strategic plan” that can help us effectively in further reducing the disease burden of leprosy; the burden in all aspects of leprosy problem; medical, social and economic. That strategic plan is already with us; that is, the “Enhanced Global Leprosy Control Strategy (2011-2015)”, including the “Operational Guidelines” for its implementation; the strategy and the guidelines were developed at a meeting of the Global Leprosy Programme Managers held in Delhi in 2009. In this meeting leprosy programme managers and a wide-range of partners participated. To introduce this new strategy for implementation, several Member States in the Region have undertaken high-level advocacy. This has been done in collaboration with the relevant partners and other stakeholders. I am glad to note that this Regional Meeting of National Programme Managers will review the various elements of the Enhanced Global Leprosy Strategy; and in this connection “country specific road-maps” for implementing the strategy in individual countries will be chalked out.

Ladies and gentlemen,

After elimination, we come to another challenging phase of leprosy control. Maintaining the “gains” from leprosy elimination is among the current key issues. We should not be the victims of our own success story; and we should safeguard against any complacency; the complacency that may lead

to the possible weakness of our leprosy control programme; and subsequently to the return of leprosy. Furthermore, the prevalence rate of leprosy must be further reduced as reflected in the Global Strategy. Work after elimination will be more difficult when the prevalence rate becomes lower and lower.

Colleagues,

If this process of “progressive reduction” of leprosy burden is to be achieved, more efforts are required for this challenging task - the efforts in terms of clinical, epidemiological, and operational research; as well as in terms of improved programme development and management. Our future efforts may not require large amount of funds for programme operation.

In view of the fact that leprosy is a “disease of poverty”; that has a strong link with social and economic determinants; we have to tackle these related determinants in a more systematic and vigorous manner; and we will have to go further to reach the hard-to-reach or to reach the unreached. We need a stronger and sensitive surveillance system for consistent and sustained vigilance. We need better and more powerful drugs for treatment. We also need an “improved treatment regimen” that is more convenient for the patients to follow.

Complete integration of leprosy services into general health services is another daunting challenge. We need to further reduce or even eliminate

social stigma of leprosy - affected people. We have to detect the case early enough so that after cure there will be no residue of physical deformity. This achievement in early diagnosis and prompt treatment can significantly contribute to reducing stigma and discrimination; and the achievement will help facilitate the integration of leprosy services into general health services; and the achievement can help facilitate “social integration” of leprosy-affected people. This is not easy since, among other things, leprosy has a long incubation period; many cases of leprosy are expected to be detected during the years to come. A solution should be found to shorten this long period before the cases are detected. This is an area for research.

Leprosy needs to be better known epidemiologically so that more effective “preventive measures” against it can be developed. An attempt should be made towards “an effective primary prevention” of leprosy. Development and management of leprosy control programmes need further improvement through operational research. This is in order to ensure effective implementation of the “Enhanced Global Leprosy Control Strategy”; the strategy that targets the reduction of grade 2 disabilities by 35% among new cases; to 1 per one million population by 2020. The only key to such reduction of grade 2 disability is to detect cases and treat them with MDT in a very timely manner.

Ladies and gentlemen,

Some people are talking about a “leprosy-free world”. “Leprosy-free-world” may still be a very long way to reach. However, we should keep this idea in mind as our aspirational goal. At the same time, “leprosy-free countries” may be achievable. These are especially “small island countries”. If well documented in a systematic manner, leprosy control could be used as a model for other disease elimination.

Now, let us look at some of the immediate actions that are required for the effective implementation of the “Enhanced Global Leprosy Control Strategy”. Among other important things, we need to continue exerting particular efforts in advocacy for maintaining political commitment; importantly, to ensure adequate investment for further reduction of the disease burden of leprosy. We need to advocate for more attention and more actions from all stakeholders and partners. Without their support, future work on leprosy will be extremely difficult.

Colleagues,

In addition, WHO has recently published a set of “Guidelines for strengthening the involvement of “People Affected by Leprosy” in leprosy services. These guidelines were developed by the ‘leprosy - affected people’ themselves from all over the world. SEAR is the first WHO Region to

implement these guidelines. The national leprosy programme managers at their annual meeting regularly discuss the enhanced involvement of people affected by leprosy in the advocacy towards detecting new cases early, and treating them with MDT in a timely manner.

I am confident that the “country-based road maps” for implementing the Global Leprosy Strategy in SEAR will be successfully developed during the course of this meeting; and with the synchronous and complementary efforts of all partners and stakeholders, including the essential contribution from people affected by leprosy; the targets set in the “Enhanced Global Leprosy Control Strategy” will be successfully achieved on the target date.

In addition to solving leprosy problems in the Region; and in view of the fact that 68% of global leprosy cases are in South-East Asia; the effective implementation of our country-specific road maps will also be an important contribution to the global leprosy control efforts. At this point in time, we should also view our work in leprosy control as an important lesson for future control of other “diseases of poverty”.

With these words, ladies and gentlemen, I wish the meeting all success.