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National Programme Managers for Leprosy Elimination

*Report of an Intercountry Meeting
Bangkok, Thailand, 15-17 May 2006*



**World Health
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1. Introduction

1.1 Background

The World Health Organization's South-East Asia (SEA) Region, which traditionally accounted for the highest burden of leprosy worldwide, achieved the goal of elimination of leprosy as a public health problem in December 2005. At the end of 2005, the leprosy prevalence rate (PR) stood at 0.87/10 000 population. India, which accounted for the highest burden of leprosy globally and regionally, also achieved the goal in December 2005. Thus nine of the 11 countries of the Region have achieved the goal of leprosy elimination at the national level. The two countries which are yet to achieve the same are Nepal and Timor-Leste.

Since the introduction of Multi-drug Therapy (MDT) in the early 1980s, more than 15 million people have been globally cured of leprosy with about 12.8 million of them in SEA Region.

The annual intercountry meeting of national programme managers has been useful in reviewing the progress, sharing experiences, identifying constraints and evolving measures to deal with the remaining challenges. With this background, an Intercountry Meeting of National Programme Managers for Leprosy Elimination was organized in Bangkok, Thailand, from 15-17 May 2006. Twenty four participants from 10 Member States, including the national programme managers from nine countries, attended the meeting. Representatives from the Sasakawa Memorial Health Foundation, Novartis Foundation, International Federation of Anti-Leprosy Associations, The Leprosy Mission Trust India, Damien Foundation India Trust, Netherlands Leprosy Relief, German Leprosy Relief Association, British Leprosy Relief Association and staff from WHO headquarters, the Regional Office, and WHO India, WHO Nepal and WHO Timor-Leste offices participated. The list of participants and the programme schedule are at Annex 1 and 2 respectively.

1.2 Objectives

The main objective of the meeting was to review the progress of leprosy elimination in the Region and discuss the sustainability of leprosy services and critical activities.

The specific objectives were to:

- (1) Follow up on the progress of implementation of leprosy elimination programme in the Member States during 2005-2006;
- (2) Review the national plans of action for the biennium 2006-2007 and identify constraints as well as technical needs towards achieving leprosy elimination in the remaining countries, and
- (3) Identify mechanisms for sustaining leprosy activities and further reducing the burden through quality services.

2. Opening session

The Regional Director of WHO South-East Asia Region, Dr Samlee Pliangbangchang, inaugurated the meeting. In his address, Dr Samlee recalled the 1991 World Health Assembly Resolution urging endemic countries to reduce leprosy prevalence rate to less than 1 case per 10 000 population and noted that the reduction of prevalence in all endemic countries had been commendable with 116 of the 122 endemic countries achieving the goal by 2005. He highlighted the following points:

- The achievements within countries have not been uniform and that there are still areas of high prevalence within some countries;
- Leprosy services need to be henceforth integrated within the general health systems, including leprosy surveillance, through integrated disease surveillance systems;
- Deformities due to leprosy need to be corrected and affected persons socially integrated and occupationally rehabilitated;
- Psychological and cultural determinants significantly contribute to the persistence of leprosy;

- Respect for the human rights of the leprosy affected will have to be promoted and ensured, and
- Basic, clinical, epidemiological and operational research is needed to better understand leprosy, particularly its epidemiology and pathogenesis. This understanding may lead to primary prevention that aims at tackling disease determinants and risk factors and improved programme development and management.

Dr Samlee thanked all the partners collaborating with WHO and particularly lauded the Nippon and Sasakawa Foundations of Japan for their indispensable assistance to the Global Leprosy Programme and to Novartis for the free supply of MDT drugs. He also informed participants about the relocation of the Global Leprosy Programme from WHO headquarters in Geneva to the Regional Office in New Delhi in order to ensure efficiency and effectiveness of WHO services. WHO will continue to work closely with all partners, nationally and internationally, and provide technical and technological knowhow for specific areas of programme interventions and assist the countries in progressing towards a leprosy-free society, he assured.

Dr Derek Lobo, Regional Adviser, Leprosy and Diseases Targeted for Elimination/Eradiation, WHO/SEARO, introduced the participants, temporary advisers, representatives from partner agencies and observers.

The Regional Director, with the unanimous approval of the participants, nominated Dr Krisada Mahotarn as chairperson of the meeting. Dr GPS Dhillon was nominated co-chairperson and Mr Umar Hassan rapporteur.

3. Technical session 1: Global and regional situation

3.1 Current global situation 2006

Dr Vijay Kumar Pannikar, Team Leader, Global Leprosy Programme, said in his presentation that as per reports received from 91 endemic countries for the year 2005, a total of 222 367 leprosy cases were globally registered at the beginning of 2006 and 295 816 new cases were detected in 2005. Of the 122 countries originally considered as leprosy endemic in 1985, only six were yet to reach elimination – Brazil, DR Congo, Madagascar,

Mozambique, Nepal and Tanzania. The list does not include island countries with a population of less than one million such as Timor-Leste in the SEA Region. Only 18 countries detect more than 1000 cases and eight countries report more than 5000 cases.

The number of new cases globally detected has steadily declined in the last three years from 513 793 in 2003 to 407 791 in 2004 and down to 295 816 in 2005. The SEA Region accounted for 79% of all new cases in 2003, 73% in 2004 and 71% in 2005. With 169 709 new cases detected in 2005, India remains the country with the highest disease burden though it has attained the goal of leprosy elimination as a public health problem. Brazil with 38 410 new cases and Indonesia with 19 695 new cases have the second and third highest burden of leprosy. The profile of new cases in relation to PB/MB proportion, child rate, disability rate and male/female rate varies widely between regions/countries. Over the 20-year period between 1985-2005, more than 15 million persons have been cured of leprosy. It is estimated that about four million leprosy disabilities would have been averted. The number of relapses reported remain low at less than one case per 1000 patients per year and no drug resistance following MDT has yet been reported.

3.2 Regional progress of leprosy elimination

In his presentation, Dr Derek Lobo mentioned that as a Region, SEAR achieved the goal of elimination of leprosy as a public health problem in 2005. India which traditionally accounted for the highest burden of leprosy, globally and regionally, also achieved the elimination goal as of December 2005. The Region continues to bear the highest burden of leprosy with 71% of the global prevalence and 76% of the global new cases in 2005. India, Indonesia, Bangladesh and Nepal feature among the 10 top countries in terms of annual new cases detected in 2005. The Regional prevalence has steadily declined from 4.6/10 000 population in 1996 to 0.87/10 000 population in 2005 and the Regional new case detections have declined from a peak of 47.76/100 000 population in 1998 to 12.49/100 000 population in 2005.

The disability rate among new cases has declined from 6.5% in 1995 to 2.4% in 2005 and the child rate has declined from a peak of 17.9% in 2000 to 12.6% in 2005. Nine of the 11 countries have achieved the leprosy elimination goal. Nepal and Timor-Leste are yet to achieve the goal but are

making concerted efforts to reach the goal as early as possible, and of the more than 15 million persons globally cured, around 12.8 million are from SEAR, with 11.8 million from India alone. Thus the Region has made substantial contribution to the global achievements.

In line with the Global Strategy for further reducing the leprosy burden and sustaining leprosy activities, a Bi-Regional "Strategy to Sustain Leprosy Services following Elimination in Asia and the Pacific" and a "Regional Strategy for further reducing the burden of leprosy: 2006-2010" were developed focusing on the future areas of priority. The emphasis will be on sustaining quality of leprosy services within the general health systems.

4. Technical session 2: Country presentations

4.1 Bangladesh

In her presentation Dr A.N. Maksuda highlighted that Bangladesh had achieved the leprosy elimination goal at the national level in 1998 and has since sustained it. The prevalence rate as of December 2005 was 0.45/10 000 population and 7883 new cases were recorded in 2005. Five districts and two metros, Dhaka and Chittagong, are yet to achieve elimination. These areas are receiving extra focus and priority. Prevalence as well as annual new case detection show a declining trend since achieving elimination in 1998. However, the child rate is static between 10-13% for the past five years. A Leprosy Elimination Monitoring (LEM) exercise is planned in 2006, and the country is aiming at reducing deformity rate to less than five per cent and district-level elimination by 2007. The main challenges are the high rate of rural/urban migration, improving quality of services and minimization of 'operational factors', especially in certain NGO areas.

4.2 Bhutan

Mr Kaka Tshering informed that the country has reported less than 30 cases annually since the last five years. In 2005 15 cases were reported, of which 14 were of the multi-bacillary (MB) type. As per the national policy, MB cases receive 24 doses of MDT and the main challenge is timely detection of cases through improved surveillance and referral systems.

4.3 India

India: National overview

Dr GPS Dhillon in his presentation mentioned that India had achieved the goal of leprosy elimination as of December 2005, with a reported prevalence of 0.95/10 000 population. This had further reduced to 0.84/10 000 population by March 2006. As many as 22 of the 29 states and four of the six Union Territories (UTs) have achieved the elimination goal. The states/UTs that are yet to achieve elimination were Bihar, Chandigarh (UT), Chattisgarh, Dadra & Nagar Haveli (UT), Delhi, Jharkhand, Orissa, Uttar Pradesh and West Bengal. These states/UTs are expected to attain the elimination target by 2007. There has also been a dramatic decline in prevalence and new case detections during the last three years. This can be explained by three factors:

- (1) The five nationwide Leprosy Elimination Campaigns were able to detect the majority of the backlog cases;
- (2) Setting case detection targets to workers was discontinued, and
- (3) Concerted efforts were made to minimize 'operational factors' which were influencing the indicators.

State of Bihar

Dr N.K. Bhimsaria said Bihar is one of the high endemic states in the country. MDT was initiated in phases in the mid-1980s and statewide coverage was completed only in 1996. The PR has reduced from 52/10 000 population in 1985 to 1.3/10 000 as of March 2006. There were 12 166 cases registered by March 2006, and 10 of the 38 districts had a reported prevalence of <1/10 000 population with the remaining 28 having a prevalence between 1-2/10 000 population. There has been a uniform decline in leprosy prevalence all over the state, he observed.

State of Orissa

In his presentation, Dr P.K.B. Patnaik rated Orissa as one of the high endemic states of India. MDT was initiated in the mid-1980s and statewide coverage completed in the early 1990s. PR has reduced from 23.3/10 000 in 1997-98 to 1.05/10 000 population as of March 2006. The state is

expected to achieve elimination in the second half of 2006. Of the 30 districts, 20 have a prevalence $<1/10\ 000$, six between $1-2/10\ 000$ and four between $2-5/10\ 000$ population. The maximum attention is being focused on the four high-endemic districts, and there has been a significant decline in new case detections during the five LECs and sustained decline in routine case detection.

State of West Bengal

Dr Aniruddha Kar informed that state-wise MDT coverage in West Bengal was completed in 1994-1995. The prevalence rate declined from $16.98/10\ 000$ population in 1994 to $1.24/10\ 000$ population as of March 2006. Of the 19 districts, nine have a prevalence of $<1/10\ 000$ population, four have between one and two per $10\ 000$ population, three between two and three for every $10\ 000$ population and three show figures of $3-5/10\ 000$ population. Maximum attention is being given to the six high endemic districts and future focus will be on strong surveillance, improved registration practices, improved data monitoring, community involvement, prevention/care of disabilities, rehabilitation and participation of medical colleges.

4.4 Indonesia

Dr Hernani informed that Indonesia had achieved the leprosy elimination goal at the national level in 2000 and sustained it. However, the prevalence has been fluctuating between $0.85 - 0.98/10\ 000$ population and the annual new case detections are showing an increasing trend over the past five years. The country follows a three-tier approach: In areas with prevalence of $>1/10\ 000$ population, an accelerated approach through advocacy and IEC is followed. In areas with a prevalence of $<1/10\ 000$ population but new case detection of $>0.5/10\ 000$ population, all health facilities will continue existing leprosy services. In areas with prevalence $<1/10\ 000$ population and new case detection rate $<0.5/10\ 000$ population for five years, leprosy services will be reduced to between one and three health centres per district while other centres will refer suspect cases to select centres. A plan to execute case validation and updating of registers in select districts has been developed.

4.5 Nepal

Nepal: National overview

In her presentation, Dr Bimala Ojha stated that Nepal is yet to achieve the leprosy elimination goal. This is partly on account of the difficult situation in the country. The objectives of the NLEP are (1) to reduce registered leprosy prevalence to less than 1/10 000 population; (2) to reduce disability due to leprosy, and (3) to reduce stigma. The national prevalence rate stood at 1.81/10 000 population as of March 2006 with 35 of the 75 districts having achieved the elimination goal. The prevalence has declined from a peak of 5.4/10 000 population in 2001-2002 to 1.8/10 000 population in 2004-2005. A total of 6150 new cases were detected during 2005. Ten terai districts account for 90% of the new cases detected. The decline in prevalence rate has occurred in all the five Developmental Regions of the country. Nepal has fully integrated leprosy into the general health services. It has a vast pool of trained manpower, an effective referral system and a well-functioning partnership between the NLEP and national/international NGOs.

Eastern Developmental Region of Nepal

In his presentation, Dr M.N. Mishra mentioned that the Eastern Developmental Region consists of five terai, eight hill and three mountainous districts. The province accounts for the second highest burden of leprosy among the five regions of the country. A total of 1175 cases are presently registered, giving a prevalence rate of 1.99/10 000 population. The five terai districts account for 93% of the registered cases. The modes of new case detection are voluntary presentation, health education at the household level and examination of contacts.

Kailali district: Far-Western Development Region of Nepal

In his presentation Mr Shree Krishna Bhatta mentioned that Kailali district of the Far Western Region is one of the high endemic districts of the country with a prevalence rate of 3.69/10 000 population against the regional prevalence of 2.3/10 000 and national figures of 1.8/10 000. Case detection is being done through school health education and household awareness programmes and by promoting voluntary case detection.

4.6 Maldives

Mr Umar Hassan mentioned that Maldives reported only eight cases in 2005. The country has not reported grade-2 deformity for the last five years. The majority of the reported cases are single-lesion pauci-bacillary (PB) type, and the country is aiming at zero leprosy, he informed.

4.7 Myanmar

Dr Kyaw Myint stated that Myanmar had achieved the leprosy elimination goal at the national level in early 2003 and at the state/divisional level in 2004, and has since sustained it. Only 15 of the 324 townships recorded a prevalence of $>1/10\ 000$ population in 2005. As of 31 December 2005, there were 2679 registered cases giving a national prevalence was $0.48/10\ 000$ population. A total of 3499 new cases were detected in 2005, giving a new case detection of rate of $6.31/100\ 000$. There has been a steady fall in prevalence and new case detections over the last 10 years. A total of 267 059 cases have been cured in the country since the start of MDT till date and the future focus will be on sustaining quality leprosy services, including prevention of disabilities and rehabilitative services, strengthening monitoring/supervision, improving community participation and transferring ownership to the townships.

4.8 Sri Lanka

Dr Sunil Settinayake informed that Sri Lanka had initiated MDT in 1983 and was one of the first countries in the SEA Region to achieve countrywide MDT. It achieved elimination at the national level in 1995 and has sustained it. One of the key factors responsible for the early achievement of the goal was an effective social marketing campaign from 1990-1995. Leprosy services were integrated into the general health services in 2001. This led to some increase in prevalence and new case detections possibly due to insufficient capacity of GHS to correctly diagnose leprosy, and the prevalence and annual new case detections have remained more or less static during the last five years. This requires careful analysis.

4.9 Thailand

Dr Krisada Mahotarn informed that Thailand achieved the leprosy elimination goal in 1994, the first country in the Region to attain the goal. The current PR is 0.31/10 000 population, the least among the countries of the Region. A total of 75 of the 76 provinces and 892 of the 936 districts have a reported prevalence of <1/10 000 population. The deformity rate among new cases, at 10%, is high indicating delayed diagnosis. Steps are being taken to ensure early detection. There are approximately 20 000 leprosy disabled in the country. Four Leprosy Elimination Campaigns (LECs) have been conducted in the last 10 years. The first LEC from 1996-1998 was organized across the country, the second in 124 high endemic districts of 36 provinces and the third (2001-2002) in 93 districts of 32 provinces, while the fourth was organized in 2005 in 73 high endemic districts of 27 provinces. Thus there was a systematic attempt to detect all backlog cases. Leprosy Elimination Monitoring (LEM) was conducted twice, 1998-99 and in December 2004.

4.10 Timor-Leste

Mr Salvador Amaral informed that Timor-Leste is yet to achieve the elimination goal. There were 214 cases on treatment as of March 2006, giving a prevalence rate of 1.89/10 000 population. The country is piloting an integrated approach combining leprosy elimination with lymphatic filariasis, soil-transmitted helminthiasis and yaws control programmes.

5. Special presentations

5.1 Sustaining quality leprosy services within General Health Systems (GHS)

Dr P. Krishnamurthy, Director, Damien Foundation India Trust, said the achievement of the leprosy elimination goal by most countries and the integration of leprosy services into the General Health Systems requires planning for the future. The most important future requirements are sustainability and quality of services within the integrated set-up. This means that the person with leprosy has the same opportunity as those with other diseases to attend health services and that the health services are

sensitive and responsive to all their needs. The key steps required are the involvement of all major stakeholders in the formulation of policy, strategies and action plans, with clear assignment of activities and budget-sharing. The strategy should deal with the leprosy affected as a “person” and not as a “case to be diagnosed, treated and reported”. The strategy should be “target-free”. The external support should be limited to structural strengthening and key operational areas such as the training of trainers, tertiary care and research. Some critical areas for improvement include surveillance, referral systems, supervision/monitoring, information sharing and operational research. Leprosy should not be allowed to remain the protected domain of leprosy specialists, NGOs or the Health Ministry. Several other stakeholders should be coopted to support leprosy work.

5.2 Leprosy and human rights

In her presentation Mrs K. Yamaguchi, Executive Director, Sasakawa Memorial Health Foundation, highlighted that leprosy apart from being a medical and social problem also has a human rights dimension for many of those affected. Those involved in leprosy work prioritise the treatment and care but there are many issues beyond these, such as those issues related to family and community acceptance, provision of jobs and rehabilitation, and issues that infringe on equality and human rights. Therefore, the “knocking on the door” to prevent discrimination against leprosy victims and their families continues. A beginning was made by WHO Goodwill Ambassador Mr Yohei Sasakawa when he succeeded in prevailing upon the UN Human Rights Commission to take up the issue. This was followed by a global appeal signed by 11 internationally renowned and eminent persons to the UN Commission on Human Rights to take up the issue of discrimination against leprosy as an agenda item and a request to formulate guidelines to governments on eliminating discrimination against people affected by leprosy. The Human Rights Agenda is aimed as an instrument of change in the affected populations, in supporting stakeholders, and in the community as a whole.

5.3 Integration of care and services for disabled leprosy affected within GHS

Dr Atul Shah, Director, Novartis Comprehensive Health Care Project, Mumbai, India, said in his presentation that an estimated 1.5 million

persons in India are disabled due to leprosy. Each year about 10 000 newly disabled people are recorded. There is proof that MDT has reduced the disability burden worldwide. Prevention and care of disabilities should form an integral part of the leprosy elimination programme. Effective tools are available for disability care and services. Integration means defining disability care services for each level of the general health system and proper training of health staff in disability prevention/care. Disability prevention and care can be integrated into the GHS through on-the-job training of health staff and provision of simple products like footwear, protective splints, grip-aids at the peripheral level. Unfortunately, there is no mechanism to supply these to needy persons. All leprosy disabled should have the benefit of appropriate health education, physiotherapy, reconstructive surgery and supply of splints, footwear, and grip-aids in order to improve their quality of life and productivity. The Comprehensive Leprosy Care Project (CLCP) in Mumbai supported by the Novartis Foundation for Sustainable Development has developed a "self-care kit" and useful splints and grip-aids. The National Leprosy Programmes and NGOs should arrange to supply these tools to those in need.

5.4 Role of partners in reducing the burden of leprosy

Mr Douglas Souter, General Secretary, International Federation of Anti-Leprosy Agencies, said partnerships have been one of the key factors contributing towards the achievements of the worldwide leprosy programmes. Partnerships can be defined as "inter-organizational relationships involving activities aimed at achieving shared goals, with a commitment to shared objectives, mutual trust and respect, reciprocal obligations and accountability, and a willingness to 'give and take' to reach a consensus". Partnerships will be effective when objectives are clearly expressed and agreed upon; the role of each partner is defined and acknowledged, activities and problems are widely discussed and negotiated and all partners are involved in the planning, implementation and evaluation process. The 21 members of ILEP annually spend 65 million Euros on leprosy work, including E2.7 million on research and scientific support. The ILEP perspective for 2006-2010 includes a shift from numerical to quality targets and from prevalence to new case detection and treatment completion as the main indicators, continued focus on quality case detection, MDT, POD and rehabilitation and sustainable activities.

6. Technical session-6: Global, bi-regional and regional strategies

Dr V. Pannikar gave a briefing on the Global Strategy and Operational Guidelines for further reducing the leprosy burden and sustaining leprosy activities. He emphasized that the purpose of the operational guidelines is to help managers of national health services to implement the new Global Strategy in their countries, taking into consideration policies applicable to their own situation and revising their national manuals as needed. Leprosy services will be run through the general health services in all countries. A new emphasis is given to the need for an effective referral system. The procedures for establishing the diagnosis of leprosy remain the same but the accuracy of diagnosis must be monitored. Emphasis is given to prevention of disability, management of lepra reactions, rehabilitation and recording/reporting. Under programme management, priority is given to the running of integrated leprosy services, including supervision, MDT supply, training, partnerships and programme evaluation.

Dr S.K. Noordeen pointed out the similarities between the Global, Bi-regional and Regional Strategies saying that the Global Strategy 2006-2010 is broad-based and allows sufficient flexibility for individual countries to adapt the global strategy to suit their epidemiological situation. Availability of resources and capabilities within the existing system, sustainability, further reducing the leprosy burden and quality of services are the vital essentials of the Global as well as Regional Strategy. He said that from now on “targets” particularly for smaller geographical or population levels, should be avoided and the aim should be on “expected outcomes” monitored largely through case detection rates. Prevalence measurement may also be used for the purpose of making comparisons over a period of time.

These presentations were followed by a round table discussion on the implementation of strategy. The National Programme Managers of Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand provided valuable inputs during the discussion.

7. Group work

The participants were divided into four groups with the following topics for discussion:

Group-1: Leprosy and other neglected tropical diseases – An integrated approach.

Group-2: Sustaining leprosy services and further reducing the burden of leprosy in the Region.

Group-3: Prevention and care of disabilities and rehabilitative services.

Group-4: Human Rights and Leprosy.

Each group presented recommendations on the respective topics which were reflected in the conclusions and recommendations of the meeting. The main recommendations of the groups are mentioned below.

7.1 Group-1

- WHO should develop strategies for integration, support policy-making at the national level and assist in mobilizing funds/resources.
- The modalities for integration of activities and job responsibilities of all programme staff should be clearly defined.

7.2 Group-2

- Availability, accessibility and coverage of existing leprosy services should be enhanced by including private practitioners.
- MDT services should be supplemented with counselling wherever required.

7.3 Group-3

- Country-specific guidelines should be prepared to ensure that services/materials for disability prevention are provided within a specified time period. This can be achieved through referral and networking of agencies involved in such activities.
- Community-based rehabilitation of disabled persons should be ensured through integration with existing social rehabilitation programmes.

7.4 Group-4

- Discriminatory laws against the leprosy-affected should be identified and abolished.
- The community should be educated about the relevant facts on leprosy to invoke a strong response to fight discrimination.

8. Conclusions and recommendations

The meeting noted with happiness and satisfaction that the South-East Asia Region has achieved the goal of elimination of leprosy as a public health problem. It placed on record its appreciation to all the programme managers, health staff and partners involved.

The participants congratulated India on achieving the leprosy elimination goal at the national level and also noted that the two countries which have not achieved the same, Nepal and Timor-Leste are also making concerted efforts to reach the goal in the near future. It was also observed that all other countries have sustained elimination at the national level and that significant progress has been made to further reduce the burden of leprosy and its consequences.

The participants endorsed the WHO Global Operational Guidelines and agreed that these can be used to determine future policies and plans for national programmes.

It was taken into account that some large countries of the Region are aiming at sub-national elimination. It is recommended that the sub-national elimination goal should not be pursued through case detection targets.

In view of the declining leprosy burden, it is strongly recommended that the annual new case detection and cure rates be used as the primary indicators for monitoring the leprosy programme.

The programmes should accord high priority to sustainability and ensuring quality of services.

It was recognized that prevention, management and care of disabilities and rehabilitation are an integral part of leprosy services. This important component needs to be strengthened.

It was recommended that human rights issues related to leprosy should be brought to the attention of policy-makers and opinion makers, including the judiciary, media and civil society. Discriminatory laws that are still existing should be repealed.

There is need for increased research for better tools and intervention. WHO and partners have been urged to allocate adequate funds for research, including operational research.

9. Closing session

Dr P.T. Jayawikramarajah, Acting WHO Representative, Thailand, was the chief guest at the closing session. He thanked the National Programme Managers, partners and other participants for their valuable inputs and active involvement in the deliberations and expressed the hope that the recommendations of the meeting will lead to further reduction of the leprosy burden in the Region. The participants also expressed their appreciation and thanked the chairperson, co-chairperson and rapporteur. They also had a word of appreciation for the WHO Secretariat.

Annex 1

List of participants

Bangladesh

Dr A.N. Maksuda
Programme Manager Leprosy
TB & Leprosy Control Programme
Directorate-General of Health Services
Mohakhali
Dhaka

Dr Rafiq Ahmed
Medical Officer
Leprosy Control Institute and Hospital
Mohakhali
Dhaka

Bhutan

Mr Kaka Tshering
Sr Programme Officer
Leprosy Programme
Ministry of Health
Thimphu

India

Dr G.P.S. Dhillon
Deputy Director-General of Health
Services (Leprosy)
Ministry of Health & Family Welfare,
Government of India
342-A Wing, Nirman Bhawan
New Delhi 110 011

Dr Rajendra Sharma
Sr Specialist
Department of PMR (Physical Med and
Rehabilitation)
Safdarjung Hospital
New Delhi 100029

Dr T. Sreedhar
Chief Medical Officer (NFSG)
All India Institute of Physical Medicine and
Rehabilitation
K.K. Mar
Haji Ali Park
Mumbai 400034

Dr N.K. Bhimsaria
State Leprosy Officer
Pariwar Kalyan Bhawan
Shekhpura
Patna

Dr B.S. Sarwa
State Leprosy Officer
Directorate Of Health Services
Raipur

Dr S.C. Nayak
State Leprosy Officer
Leprosy Research & Training Institute
Brambe
Ranchi 835 205

Dr K.S. Baghotia
State Leprosy Officer
Directorate of Health Services
Government of Delhi
Swasthya Sewa Bhawan
F-17 Karkardooma
New Delhi 110 032

Dr P.K.B. Patnaik
State Leprosy Officer
Directorate of Health Services
Heads of Department Building, Unit-5
Bhubaneswar

Dr Aniruddha Kar
State Leprosy Officer
Swasthya Bhawan, 2nd Floor, A Wing
Block G-N, Plot 29, Salt Lake City
Sector-5
Kolkata 700073

Indonesia

Dr Hernani
Head, Sub-Directorate of Leprosy
and Yaws Control
Directorate of VBDC
Directorate-General of DC & EH
Ministry of Health
R.I. Jakarta

Dr Husein Kausaha
Head of Provincial Health Office
North Maluku

Maldives

Mr Umar Hassan
Director Leprosy Control Programme
Department of Public Health
Ministry of Health
Male

Ms Fathimath Manal
Community Health Worker
Department of Public Health
Ministry of Health
Male

Myanmar

Dr Zaw Win
Assistant Director (Leprosy)
Department of Health
Ministry of Health
Yangon

Dr Khin Maung Lin
Team Leader
Leprosy Control Team
Shwebo
Sagaing Division

Nepal

Dr Bimala Ojha, Director
Leprosy Control Division
DHS/MoH&P/HMG of Nepal
Teku
Kathmandu

Dr Mahananda Mishra
Regional Director
Eastern Regional Health Directorate
Ministry of Health and Population
Dhankuta

Mr Shree Krishna Bhatta
Public Health Administrator
District Health Office
Dhangadhi

Sri Lanka

Dr Sunil Settinayake
Director, Anti Leprosy Campaign
Room 21, O.P.D
National Hospital of Sri Lanka
Colombo 08

Thailand

Dr Krisada Mahotarn
Senior Medical Officer
Raj Pracha Samasai Institute
Department of Disease Control
Ministry of Public Health
Bangkok

Timor-leste

Mr Jose Liu Fernandes
National Officer for Leprosy Programme
Ministry of Health
Dili

Donor/Non-governmental organizations

Sasakawa Memorial Health Foundation (SMHF)

Mrs K. Yamaguchi
Executive Director
Sasakawa Memorial Health Foundation
Nippon Zaidan Bldg.
1-2-2 Akasaka, Minatoku
Tokyo 107-0052
Japan

Novartis Foundation

Dr Atul Shah
Director
Novartis Comprehensive Leprosy Care
Association
Remi Bizcourt, C-01 Veera Desai Road
Andheri
Mumbai 400058
India

Mrs Neela Shah
Managing Director
Novartis Comprehensive Leprosy Care
Association
Remi Bizcourt, C-01 Veera Desai Road
Andheri
Mumbai 400058
India

International Federation of Anti-Leprosy Associations (ILEP)

Mr Douglas Soutar
General Secretary, ILEP
2324 Blythe Road
London W14 OHJ
United Kingdom
The Leprosy Mission Trust India

Dr G. Rajan Babu
CNI Bhawan
16, Pandit Pant Marg
New Delhi 110 001
India

Damien Foundation India Trust

Dr P. Krishnamurthy
Secretary DFIT
27 Venugopal Ave.
Spur Tank Road, Chetpet
Chennai 60003
India

Netherlands Leprosy Relief

Mr Rens Verstappen
Head Projects Department
Netherlands Leprosy Relief (NLR)
P.O. Box 95005
1090 HA Amsterdam
The Netherlands

German Leprosy Relief Association

Dr Thomas Abraham
Dy Director & Senior Medical/Technical
Adviser
GLRA/ALES-India
4 Gajapathy Street
Shenoy Nagar
Chennai 600030
India

British Leprosy Relief Association (LEPRA)

Dr P.V. Ranganadha Rao
PO Box 1518, Plot No.17
Krishnapuri Colony
West Marredpally
Secunderabad 500026
India

Temporary Advisers

Dr S.K. Noordeen
Leprosy Elimination Alliance
1-A K.G. Valencia
57 First Main Road
Gandhinagar
Chennai 60002
India

Dr M.D. Gupte
Director
National Institute of Epidemiology(ICMR)
Mayor V.R. Ramanathan Road
Chetpet
Chennai 600 031
India

Observers

Dr Kowit Kampirapap
Senior Medical Officer
Raj Pracha Samasai Institute
Department of Disease Control
Ministry of Public Health
Bangkok
Thailand

Ms Budiarti Setiyaningsih, SKM, M.Kes
Sub-Directorate of Leprosy and Yaws Control
Directorate of VBDC
Directorate-General of CDC & EH
Ministry of Health
R.I. Jakarta
Indonesia

WHO Secretariat

WHO/SEARO

Dr Derek Lobo
Regional Adviser
Leprosy & Diseases Targeted for
Elimination/Eradication

Dr V. Pannikar
Team Leader
Global Leprosy Programme

Dr Myo Thet Htoon
Medical Officer
Global Leprosy Programme

WCO, India

Dr Indranath Banerjee
NPO (Leprosy)
WHO India, New Delhi

WCO, Nepal

Mr Sushil Kumar Bhattarai
M.A. MPH
National Coordinating Officer
National Leprosy Elimination Programme

WCO, Timor-Leste

Mrs Asy Angelina Juliana
NPO
Special Disease Control, Eradication and
Elimination
WHO Dili

Mr Salvador Amaral, Leprosy Assistant
WHO Dili, Timor-Leste

Mr Cipriano Pinto, Leprosy Assistant
WHO Dili

Annex 2

Programme

Day 1: 15 May 2006

- 08:30-09:00 Registration
- 09:00-09:30 Inaugural session
- Inaugural address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region
 - Introduction of participants
 - Nomination of chair, co-chair and rapporteurs
 - Group photograph
- 10:00-11:00 Technical session-1: Global and Regional review
- Global review and future plan – Dr V. Pannikar, Team Leader, Global Leprosy Programme
 - Regional review and future plan – Dr Derek Lobo, Regional Adviser, Leprosy & Diseases Targeted for Elimination/Eradication, WHO/SEARO
- 11:00-13:00 Technical session-2: Country presentations
- India - National (20 minutes)
 - India - 3 states (10 minutes each)
 - Nepal - National (20 minutes)
 - Nepal - 2 regions (10 minutes each)
- Discussions
- 14:00-15:30 Technical session-3: Country presentations (15 minutes each)
- Bangladesh
 - Indonesia
 - Myanmar
 - Sri Lanka
 - Thailand

- 16:00-16:30 Technical session-4: Country presentations (10 minutes each)
- Bhutan
 - Maldives
 - Timor Leste
- 16:30-17:00 Discussions
- Day 2: 16 May 2006**
- 09:00-10:30 Technical session-5: Special presentations (10 minutes each)
- Sustaining quality leprosy services within the GHS – Dr P. Krishnamurthy, Director, Damien Foundation India Trust
 - Human rights and health, with particular reference to Leprosy – Ms K. Yamaguchi, Executive Director, Sasakawa Memorial Health Foundation, Japan
 - Integration of care & services for disabled leprosy affected within GHS – Dr Atul Shah, Director, Novartis Comprehensive Health Care Project, Mumbai, India
 - Role of partners in further reducing the burden of leprosy – Mr Douglas Soutar, General Secretary, ILEP, UK
- Discussions
- 11:00-12:30 Technical session-6: Global & bi-regional (SEARO-WPRO) strategies for further reducing the leprosy burden and sustaining leprosy services
- Briefing on the Global Strategy & Operational Guidelines – Dr V. Pannikar, Team Leader, Global Leprosy Programme
 - Briefing on linkage between the Global & Bi-Regional Strategy – Dr S.K. Noordeen, Chair Regional TAG for Leprosy Elimination
 - Round table discussion on implementation of strategy
- 14:00-15:30 Group activity
- Group-1: Leprosy and other neglected tropical diseases - An integrated approach
- Group-2: Sustainable leprosy services and further reducing the burden of leprosy in the Region
- Group-3: Care of leprosy disabilities and rehabilitation services
- Group-4: Human rights & leprosy
- 16:00-17:30 Group activity continued

Day 3: 17 May 2006

09:00-09:30	Presentation of recommendations of 8 th TAG meeting, Aberdeen, UK – Dr M.D. Gupte, Member, WHO TAG
09:30-10:30	Preparation of draft group reports & group recommendations
11:00-12:00	Presentation of group reports and recommendations/Discussion on recommendations
12:00-13:00	Preparation of final report and recommendations
14:00-15:00	Presentation of final report and adoption of recommendations
15:00-15:30	Closing session