Dear Sir,

Leprosy had been a public health problem in Myanmar, for many years. The Government of Myanmar at various times, with the expertise and advice of the World Health Organization (WHO) and INGOs, had been fighting against the disease.\(^1\)

As the country had made a strong and clear decision to eliminate the leprosy as soon as possible, many bodies both internal and external came to join hand in hand to accelerate the efforts for leprosy elimination.\(^3\)

Myanmar achieved leprosy elimination in February 2003 and this fact had been officially declared at the Meeting of Third Global Alliance for Elimination of Leprosy held in Yangon. After achieving the goal of elimination, sustaining leprosy control services is still necessary for further reducing the leprosy burden.\(^3\)

The WHO Strategy for Further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities (2006-2010) and Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy (2011-2015) have been widely endorsed. Leprosy services have been integrated into the general health services and need for an effective referral system, as a part of integrated programme, has been recognised.\(^2\)

Our challenge is to sustain the quality of leprosy services and to ensure that all leprosy affected people, wherever they live, have an equal opportunity to be diagnosed and treated by competent health workers without unnecessary delays. Among the challenges, we are facing the yearly detection of child leprosy cases and Grade-2 disability cases among new cases; 3013 new leprosy cases were detected in 2012. Among the new cases, 155 were child leprosy cases and 503 cases had Grade-2 disability at diagnosis. Out of the 155 new child leprosy cases, 33 cases had Grade-2 disability. Therefore, we studied the cross sectional analysis of new child leprosy cases with Grade-2 disability during 2012 in Myanmar.\(^6\)

Characteristics of disabled child cases

Out of 33 new child leprosy cases with Grade-2 disability, the mean age was 11.15 years, and the median age was 12 years. There were 18 male child cases and 15 female cases. Amongst the 33 children, 12 cases were paucibacillary and 21 cases were multibacillary; 16 cases had
a history of contacts and 17 cases had no history of contacts. Only two cases were detected by active case detection and the majority (31) presented by voluntary reporting. Twenty-nine cases were diagnosed by leprosy control programme staff and only four cases were diagnosed by basic health staff. Regarding the duration of complaint, 24 cases had 1 year & above and nine cases had less than 1 year.4,5,6

Twenty-seven cases were permanent residents and six cases were migrants. Most of the cases were from Yangon Region and others were from Mandalay Region, Sagaing Region, Bago Region and Ayeyarwaddy Regions respectively.4

Thirty-one cases had a single lesion and 28 cases had nerve enlargement. No child had any eye disability, but 12 cases were found to have disability in a foot and 21 cases had disability in a hand.4

![Figure 1](image1.png)

**Figure 1.** Graph showing Prevalence Rate (PR) and New Case Detection Rate (NCDR) from 1991 to 2012 of Myanmar Leprosy Control Program.5

![Figure 2](image2.png)

**Figure 2.** Yearly detected new child leprosy cases from 2003 to 2012.6
Comment: it is noteworthy that most of the cases had a duration of complaint (1 year & above), suggesting the possibility of a preventable delay in diagnosis, although all the cases were detected in hyperendemic regions.

Recommendations

To promote leprosy awareness not only children but also among their families and communities.
To build up capacity of basic health staff for leprosy control.
To conduct the health education programme for early signs and symptoms, and stigma reduction among school children.
To enhance leprosy awareness campaign in hyperendemic areas.
To emphasise the contact survey and strengthen the integration into basic health services.

References