

EDITORIAL

Leprosy in Africa: a contrasted picture

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There is no doubt that the goal of the Elimination of Leprosy as a public health problem, as adopted by the World Health Assembly in 1991, has had a very positive impact on the leprosy situation. Globally, more attention has been given to leprosy by political authorities and Ministries of Health during the last decades than ever before in history, and much progress has been achieved. This is also true for Africa: while a kind of routine had been prevailing for many years in often vertically organized leprosy services, a new impetus was given in all countries. The results of this are impressive.

According to official statistics, the number of leprosy cases registered for treatment in the African Region of WHO has decreased by more than 50% between 1995 and 2003, mainly thanks to the generalization of the use of the WHO MDT regimens. The registered prevalence rate is now 0.8 per 10,000 for the whole Region. It is above 1 per 10,000 in only seven of the 46 countries of the Region (Angola, Central African Republic, Comoros, DR Congo, Madagascar, Mozambique and Tanzania), of which three countries only (Angola, Madagascar and Mozambique) are officially recognized at risk of not achieving the Elimination goal by the end of the year 2005.¹ What is more, it has been reported from several countries where surveys have been carried out, that many registered patients should have long been discharged (patients having completed treatment, having disappeared or died who remain in the registers for years, . . .) or should not have been registered at all (re-registration of previously treated patients and cured patients, wrong diagnoses).²

The workload for the health staff has thus been significantly reduced during the last decade. This should make integration of leprosy into general health services easier; and at the same time it should permit the staff to concentrate more on issues such as the prevention of disabilities rather than on distributing MDT drugs only.

Information systems on leprosy have been strengthened and at the same time simplified. As a result of the validation of registers, statistics are now much more reliable.

In addition, significant progress has been made in a number of countries concerning decentralization and integration of leprosy into the general health services, making those services much more accessible to the population, and at the same time more sustainable. Following the campaigns that have been carried out in many places, awareness of the

population for leprosy, its early signs and the possibility of curing it has increased. Stigmatization of the patients is diminishing. These are all extremely positive signs.

However, in spite of the progress made, a critical analysis of available data gives a more contrasted picture. Official figures of registered prevalence may sometimes give an overoptimistic image of the situation: in a number of countries, coverage of the population by health services remains low.^{1,3,4} The main factors evoked are the poor socio-economic situation, populations living in hard to reach areas, civil unrest or a war situation. Even if the case detection rate decreased over time in the Region, the number of new patients detected was still slightly higher in 2003 as compared with 1994, and nine countries (the seven cited above plus Guinea and Sierra Leone) still had a case detection rate higher than 1 per 10,000 population in 2003.

In many countries that have officially eliminated leprosy as a public health problem, endemicity may remain high at provincial/state or district level.^{1,5} Reliability of data can go in two directions, over- or under-reporting. Data available at national level might be incomplete, particularly concerning war stricken or insecure areas. Another example of lack of reliability of data is the observation that in some countries, the number of patients registered by the end of the year is smaller than the number of MB cases detected during the year. The reliability of the leprosy diagnosis is also at times questionable.⁶

Reports from several leprosy elimination campaigns carried out in a number of countries during the last few years have shown that there remained in many places a backlog of undiagnosed leprosy cases.^{7,8} This may be due to poor coverage of the population by health services, lack of awareness of the early signs of the disease in the population, lack of training of health staff to suspect and diagnose leprosy. The disappearance of skin smears services may lead to a lack of specificity of the diagnosis for some patients, wrongly diagnosed as MB cases, but it could also lead to the under-diagnosis of true early MB cases.⁹

The proportion of newly detected patients with WHO grade 2 disabilities remains high (11.7% in average), signalling late detection. It is more than 10% in 23 countries of the Region. This has serious consequences for individual patients, and may also have a negative impact on the programmes (ongoing transmission, and possibly also continuing stigmatisation and fear in the population). The proportion of children among the newly detected patients remains also high, being at 10.1% for the Region and at more than 10% in 14 countries. Transmission is thus obviously still going on.

Not all the countries of the Region are able to report cure rates (or treatment completion rates) for patients put on treatment. This indicator, calculated through a cohort analysis is, however essential if one wants to assess the effectiveness of patient management. In most countries, leprosy control has been integrated to various degrees into general health services. In some countries, this process is still at an early stage: many health workers have not been trained yet, and case-finding and diagnosis often remain in the hands of specialized workers.

What are the main challenges for the coming years? Even in countries which have reached the elimination level, services have to be sustained, probably still for a long time. In most instances, decrease of incidence appears to be slow. New cases are likely to appear in significant numbers still for many years to come.

In countries where prevalence and/or detection figures have significantly decreased at national level, attention should focus on areas of suspected or known high endemicity. Intensification actions could still be organized in those areas, but they should not be a way back towards vertical services. On the contrary, they should be used to reinforce integration, particularly through training of general health staff for specific tasks. As the scarcity of

well-functioning general health services is also an obstacle to the coverage of the population by leprosy services, external donors interested in leprosy should accept that a sizeable part of their support goes into the strengthening of general health services.

Leprosy services have to be integrated into the general health services. This does not mean that every health worker, wherever he is working, should be able to perform all tasks related to leprosy. All health workers should be able at least to suspect leprosy with a very high sensitivity, and to collaborate in treatment delivery. Additional responsibilities will depend on several factors, and particularly on the degree of leprosy endemicity in the area (i.e. the probability for that particular health worker to see patients during his daily work), and on the level where he is working (peripheral health centre, referral level). The quality of integrated leprosy services has to be carefully monitored through supervision visits, particularly concerning the validity of the leprosy diagnosis and the effectiveness and actions for the prevention of disabilities. Logistics must follow, to ensure that drugs and other means are made available where they ought to be. In several countries, village volunteers and community members are used to raise community awareness, suspect leprosy cases and/or distribute drugs. These are certainly encouraging moves which should help to increase effective coverage of the population. The question that will undoubtedly have to be faced is how to ensure sustainability of their commitment.

One must avoid the situation where integration, though essential, would result in services of lesser quality. It should be well prepared and gain from the beginning the adhesion of the main stakeholders. Guidelines for facilitating the integration process have been recently produced, which propose stages and steps to be followed for optimising the chances of success.¹⁰

If leprosy has any importance, it is because it is a disabling disease. Prevention of disabilities should attract much more attention than what it receives now. Early detection of the disease and treatment with MDT are recognized as the most important measures, but they are not the only ones. Early detection and effective treatment of reactions and neuritis are also essential, and patients with insensitive limbs must be taught how to avoid further complications.

Finally (although this list is not limitative but only wants to insist on a number of crucial issues), health systems research should be encouraged to try and find locally appropriate solutions to locally identified problems.

Let us thus not rest half-way on the road to success.

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