

# FOR THE ELIMINATION OF LEPROSY

Leprosy is Curable.

Free Treatment is Available.

Social Discrimination has  
no Place.

## A MESSAGE FROM THE SPECIAL AMBASSADOR Africa's Political Commitment



Meeting with the president of Nigeria, H.E. Olusegun Obasanjo

**M**any countries in Africa have had to deal with debilitating problems, ranging from a heavy debt burden to poverty, hunger, epidemics and civil wars. Of the 54 countries in Africa, nine are leprosy endemic, with three (Madagascar, Mozambique and Angola) having a prevalence rate of more than three per 10,000 inhabitants. In my position as special ambassador for the elimination of leprosy, I visited these three countries during the past year to meet with the top leaders and discuss the leprosy situation there. I was also able to meet the leaders of six African countries while they were in Japan for the Third Tokyo International Conference on African Development (TICAD III), held in late September.

In the meetings I had with these leaders, I urged each of them to strengthen leprosy elimination measures in their countries, promoting educational and medical efforts. They pointed out the fear people have regarding the disease and the resulting discrimination. They reassured me of their commitment to further devote their efforts toward the removal of such stigma and the reintegration of those affected by leprosy into society. The role played by these political leaders is vital in generating social movement for the elimination of the disease and the stigma associated with it.

Yohei Sasakawa  
WHO Special Ambassador  
President, The Nippon Foundation

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*A Street in Toamasina Province, Madagascar*

## REPORT ON AFRICA

# Leprosy Elimination Progress in the WHO Africa Region

By Dr. Bidé Landry, Regional Adviser, Leprosy Elimination Programme, AFRO (WHO - Regional Office for Africa)

## Trends and the Current Situation

In the WHO Africa Region (composed of 46 countries with more than 700 million inhabitants), substantial progress has been made toward eliminating leprosy since the 1990s. All member states have realized that elimination is tied in with poverty alleviation and in each country a high political commitment is evident in the high priority placed on the elimination of this stigmatizing disease.

In 1994, when the ministers of health adopted resolution AFR/RC44/R5 to eliminate leprosy as a public health problem on a regional level, 42 countries were highly endemic. More than two-thirds of them had prevalence rates of more than two cases per 10,000 inhabitants.

Today, only nine countries have a prevalence rate of more than one in 10,000 and only three have worryingly high rates. All other countries have made dramatic reductions.

With the intensification of leprosy elimination activities, more countries are beginning to reveal their true conditions. Tanzania is one of these countries. The leprosy programs in the Republic of the Congo, Sierra Leone and Liberia have been disrupted by war and social conflicts, leading to fluctuating prevalence rates. The magnitude of leprosy prevalence in DR Congo and the Central African Republic is still not fully known despite the low prevalence rates they have been showing for years.

**Prevalence Trends Since 1996** — Each country in the region has organized national leprosy elimination programs with corresponding systems to collect information on leprosy cases. In 1999, the average

prevalence rate for the region was 1/10,000. Seven countries had prevalence rates of more than 2/10,000 and were classified as priority countries by the Global Alliance for the Elimination of Leprosy.

In 2002, three years after the 1999 global evaluation of the elimination effort, only three countries were still considered highly endemic and at risk of not reaching the elimination goal.

**Detection Trends Since 1996** — In the early nineties, WHO recommended that all countries implement special actions to detect and treat the backlog of hidden leprosy cases throughout the region. The resulting interventions were successful. But an important aspect was often overlooked: the stigma of the disease. Since 1999, “social mobilization activities” have been developed and encouraged by WHO, aiming toward better knowledge of the disease and a reduction of its negative cultural and social impact. This initiative has assisted the implementation of special projects and facilitated case detection activities.

## The Current Regional Situation

The current regional situation is very encouraging. In spite of many emerging and re-emerging diseases and various complications, countries have maintained leprosy elimination as a national priority.

The number of countries that have reached the elimination goal has risen from 32 in 2002 to 37. Nevertheless, most of these 37 countries are looking for further support toward strengthening leprosy elimination efforts — a post-elimination program based on integration, early case detection, treatment and integrated surveillance of the disease.

## Conditions in the Most Endemic Countries

**Angola** is one of the most leprosy endemic countries in the WHO Africa Region, with a prevalence rate of 3.64 cases per 10,000 inhabitants and many highly endemic and difficult to access provinces. The general populations in these areas have little awareness of leprosy, which contributes to maintaining the stigma attached to the disease.

Several factors would help in achieving the goal of elimination, including the end of civil strife, greater government involvement in reconstruction and development efforts — including improved technical training of human resources in the health sector and greater financial input toward control and elimination of diseases.



*Children in Camakupa, Bie Province, Angola*

The most remarkable achievement in Angola is the geographic coverage of the program. In 1999, this coverage was less than 25 percent due to war and the absence of political commitment. Within two years, the program has accomplished a great deal, training all health staff at provincial and municipal levels, and organizing leprosy case-management activities at all public and private health facilities.

The first concrete result of this achievement has been an increase in detection, from 1,840 in 1999, to 4,272 new cases in 2002, resulting in a detection rate of 29.63/100,000.

**Madagascar** has some of the most difficult to access areas in the WHO Africa Region. Some 60 percent of the country remains relatively isolated due to mountains, an absence of roads and the rainy season.

The health system is built around 2,500 peripheral health centers, which are divided among 111 health districts.

The program was largely suspended for four years due to difficulties in collaborating with the Ministry of Health. Despite the presence of NGOs during this period, little progress has been achieved.

With the resumption of collaboration with WHO,

an appropriate plan for the elimination of leprosy has been established. Priority is given to human resources and clarification of the leprosy situation in the country. Much has been done in the past year in terms of the clearing of leprosy registers, training of health workers and reorganization of case management activities and reports.

**Mozambique** is the third most endemic country in the WHO Africa Region. At the end of 2002, the prevalence rate was 3.63/10,000.

In the provinces, MDT (Multi-Drug Therapy) coverage is low, primarily due to the lack of general health system coverage.

Mozambique will likely achieve elimination in time if higher priority is given to case management activities. The high level of political commitment the program benefited from last year must be maintained.

Mozambique registered a relapse-rate of 63 percent last year. This situation needs more assessment. The experience of village health workers who deal with leprosy needs to be evaluated and the way forward defined in order to improve the implementation of leprosy elimination activities in highly-endemic areas.

**Perspective** — The elimination of leprosy at a national level in all countries throughout the WHO African Region is achievable by the year 2005. The recent visits to Angola and Madagascar jointly organized by the WHO Regional Director, Yohei Sasakawa, and the president of the Association Francaise Raoul Follereau have been very helpful in strengthening the political commitment to the elimination effort.

Better coordination among partners to boost isolated efforts will speed the achievement of the elimination of leprosy. □



*Many public buildings lay in ruins in the aftermath of Angola's civil war. (Kuito City, Bie Province)*

# Leprosy Elimination Program in Madagascar

By Dr. Vololoarinosinjatovo Marie Monique, Leprosy Elimination Programme, Ministry of Health, Madagascar



My job is not only to elaborate and to plan, but also to go out in the field for supervision and training, supporting regional and district programs. This can be a difficult task, since 60 percent of our Basic Health Centers (BHC) are mainly inaccessible during the six-month rainy season.

During the past six months, I have visited a number of BHC, as well as health districts. I have also participated in staff-level training in support of those responsible for provincial programs. It is increasingly apparent that we still have a lot to do. Even though we have achieved some good results since implementing the leprosy elimination program, many problems remain and must be solved if we are to reach the goal of elimination.

In addition to the problem of accessibility and the lack of transportation, the major problems I have experienced are:

1) Insufficient ability of health workers to diagnose and treat leprosy cases correctly, or to properly use the leprosy program information supports. This contributes to a number of diagnostic errors and results in unreliable data.

2) The poor awareness of the availability of free treatment, contributing to fear of leprosy and a deep social stigma. Most of the population, even people living in towns, do not know the early signs of leprosy and do not know that treatment is freely available at health centers. This is one of the reasons why there are still undetected cases in communities.

I have witnessed insufficient health worker training in more than 75 percent of the BHC I have visited, which seems to be due to a lack of supervision, lack of training and a high health staff turnover.

Those two problems need further consideration, because free MDT is available in more than 85 percent of the BHC. I am convinced that if we manage to solve

those two main problems, we will see a rapid improvement in our current situation.

In what ways should we focus our activities in the coming years?

1) Training of peripheral health workers for proper leprosy case handling, including correct diagnosis and correct use of national leprosy program supports. This training should provide well-trained leprosy people at the district level, beginning with highly endemic districts. Staff support at the national level should be made as available as necessary.

2) Strengthening of IEC (Information, Education and Communication) activities with strong community involvement.

3) Updating registers. This is already one of our main activities, but its success is contingent on improving basic health worker skills.

Before I began working in the leprosy program (during my medical studies), leprosy did not interest me, but since I started working on this program, I have learned more about it and little by little I have become deeply interested in the leprosy elimination program. It

began when I went into the field for the first time. I was deeply moved when I met many kinds of disabled people, especially young people and children who were beginning to develop disabilities. Since I knew that it could have been avoided, I felt that I must do what I could to help the situation.

Leprosy has been eliminated in many

countries, so why not in Madagascar? We still have a lot to do and maybe it will take more time, but it is not impossible.

I think the most important thing is to detect all leprosy cases when the very first symptoms appear and get them properly cured before disabilities develop. With the determination and the commitment of those responsible, we can succeed. □



Meeting patients at a Basic Health Centre in Toamasina Province, Madagascar (together with Dr. E.M. Samba and Health Minister Professor Rasamindrakotroka)

# Leprosy in Angola

By Dr. Yo Yuasa, Executive and Medical Director, Sasakawa Memorial Health Foundation

The Republic of Angola, a former Portuguese colony, has, since independence, suffered from a series of lengthy civil conflicts and has had a relatively poor healthcare system in general, compared to the countries in the southern part of Africa, a majority of which were either British or French colonies before their independence.

As a result, Angola is one of only six remaining leprosy-endemic countries in the world.

The latest official number of registered cases was 5,245, making the national prevalence rate 3.54/10,000. This indicates some

improvement, since in 1973 it was reported to be 5.2/10,000, yet progress has been very slow, casting some doubt on the potential to lower it to less than 1/10,000. Additionally, the deformity rate among newly detected cases was a relatively high 13 percent, indicating some delay in case detection. The child rate among new cases was 11.9 percent. Again this is somewhat high, but considering the young demographic profile of the country, it is perhaps not overly high, though it certainly indicates existing active leprosy transmission.

It was only in 1994, much later than in most other countries, that MDT was introduced. It then became available in all provinces by 1998. At present, 75% of existing health units are reported to have implemented MDT.

One notable phenomenon is the recent increase of case detection. This does not indicate an actual increase of new cases, but is a reflection of an increase in field activities. This resulted in a case detection rate of 12.49/100,000 in 1998, 17.62/100,000 in 2001 and 28.83/100,000 in 2002. This trend will hopefully lead in the near future to the detection of all backlogged cases, resulting in a case detection rate closer to the actual incidence rate which in turn should be much lower than the current figures.

According to the ministry of health's three-year strategic plan for leprosy (2003-2005), three main areas

need to be tackled.

1) Training of health staff, so that all health units can implement MDT, improve the efficiency of case detection, and achieve higher accuracy in diagnosis and classification. Maintenance of more up-to-date case records and implementation of an efficient reporting system is also vital.

2) Strengthening social mobilization with better IEC material, so that people will have more interest and a better understanding of leprosy.

3) Improving POID (Prevention of Impairment and Deformities) and "care after cure" activities so that fewer patients will suffer from residual physical or social problems.

The ministry would like to accomplish the

above through the following methods:

- Integration of all leprosy control activities into the general health services to improve accessibility to patients, as well as attain sustainability of leprosy activities.
- Better coordination of all potential partners, especially in view of the existence of the long and committed involvement of NGOs.

While there are several excellent medical and social programs being run in Angola by NGOs, in some other areas, armed conflict has nearly destroyed whatever they had in the past, and large numbers of refugees have created additional problems.

As in most developing countries, leprosy is by no means the top priority health issue in Angola. However, because it is a chronic, non-lethal and deformity producing disease, it remains one of the more serious social burdens, which tends to hinder improvement of national living standards, far beyond the relatively small number of actual cases.

Angola is not a highly developed country, but that in itself should not prevent it from improving health care. With carefully chosen priorities and attention to logistic details, health services can improve. It is hoped that not only will the elimination of leprosy be achieved in time, but that improved health care for those in need will also be provided. □



IEC: Health Education Campaign in Angola

# THE SPECIAL AMBASSADOR'S JOURNAL

## Mozambique, Angola and Madagascar - the Political Will to Eliminate Leprosy

There are six countries in the world that have not achieved the elimination of leprosy. Three of these countries are in Africa: Angola, Mozambique and Madagascar. All three have had to deal with food shortages,

poverty, natural disasters and political unrest. However, leaders at the highest levels of government impressed me with the seriousness with which they are treating the push to eliminate leprosy by 2005. Priority is being

given to educational and health services, because these two areas have the greatest impact on elimination — both of the disease and of the stigma surrounding it. Reflecting on the efforts that I saw when I was there, I feel strongly that all three of these countries stand a very good chance of achieving elimination by the year 2005.



broader levels need to be just as strong if elimination is to be achieved. Mozambique has a prevalence rate of 3.63/10,000. However, as in India, there is a large imbalance between provinces, with a few areas in the north reaching numbers as high as 10 per 10,000. It is my belief that country-level elimination can be achieved if efforts are focused on these northern areas.

I began my journey in the capital city, Maputo, where I met Prime Minister Pascal Mocumbi. Being a medical doctor himself and former Health Minister, Prime Minister Mocumbi has a full understanding of the state of leprosy elimination in the country. He expressed to me his firm political commitment to the fight against the disease.

In Maputo, I was able to observe the way in which former patients are being rehabilitated. There were several self-help projects, under which people managed a well and sold water, manufactured blocks for construction, and made shoes for the physically disabled. Health Minister Songane explained, "It is in the Mozambique spirit to offer a constructive role in society to physically disabled people."

Then I proceeded to the northern provinces to meet with local political leaders and visit hospitals and health centers. In Pemba City in Cabodelgado Province, I was taken to another self-help facility, managed by an alliance known as ALEMO. This group is made up of physically handicapped people and those who have been affected by leprosy. There, I witnessed people being rehabilitated and producing rope as a way of generating income.

In Namaita Village, Nampula Province, about 1,300km from the capital, I took part in the launching ceremony of COMBI (Communication for Behavioral Impact). COMBI is an effort to educate people about leprosy and promote self-check activities among children and their family members, with assistance from volunteer village health workers. Several hundred people gathered for the ceremony. Among them were many school children wearing yellow T-shirts bearing the message, "Check your skin."

In Mozambique, it was gratifying to find such strong commitment, to both elimination and education, among the government leaders. However, I felt that the more basic components of the country's effort still need to be improved. It is hoped that political will can be translated into more effective activities at grass roots levels.

## Mozambique (September 14-21, 2002)



Mozambique Children Wearing Leprosy Campaign T-shirts saying "Check your skin"

My visit to Mozambique last year was very enlightening. It showed me that while political commitment is an absolutely vital base, efforts at much

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### Angola (July 29 - August 2, 2003)

In Angola, I visited Bie Province, about an hour and a half by air from Luanda, the capital. For years, the long Angolan civil war nearly stopped progress there in many ways. Not only did Bie see some of the fiercest fighting in the civil war, but it now also has one of the highest prevalence rates in the country — 5.83 as of 2002. We drove 80 kilometers from the city of Kuito to a hospital in a town called Camakupa. The hospital is understaffed and lacking in equipment, and I can only imagine how difficult it must be to work there.

Nevertheless, in spite of these conditions, it was encouraging to see a young volunteer doctor from overseas working diligently alongside the local staff.



Meeting with Outpatients at a Hospital in Camakupa, Bie Province, Angola

During my visit, I also had a chance to attend a Partners' Meeting on Leprosy Elimination. It was apparent that there is a strong political will to achieve the elimination of leprosy by the end of 2005. I felt assured that progress, having been delayed for so long by the civil war, will now begin in earnest. When I attended the meeting, all partners were treated as equals, from the health minister, representatives of WHO and NGOs, to the people affected by leprosy. This is a good indication of the government's efforts to deal with the issue, both medically and socially. Progress must be made, not only in improving detection and treatment, but on the issue of discrimination as well.

### Madagascar (September 14-21, 2003)

In Madagascar, I accompanied Dr. E.M. Samba (regional director of WHO-AFRO), and Michel Recipon (president of the Association Francaise Raoul Follereau), as we looked at the state of elimination



Children at Foulpointe Basic Health Center in Toamasina Province, Madagascar

activities there. While in the country, the three of us exchanged views with representatives of the government and local medical personnel, encouraging them to make further progress.

We took a close look at the high prevalence rate in the northeast part of the country, visiting several villages in our efforts to promulgate accurate information about leprosy. We were welcomed in a village in Toamasina Province by around 300 villagers who performed educational songs and dances about the elimination of leprosy. When a group of more than 100 children was asked who knew that leprosy is curable, nearly all of them raised their hands.

During this trip, top leaders were able to meet and discuss issues. Both a thorough knowledge of leprosy and a high level of political commitment toward the problem were expressed. It was emphasized that the fight to eliminate the disease is connected with the fight to eliminate poverty.

Certainly, there are barriers to overcome in these three countries, from access problems in difficult areas to the need for better training for local health workers. However, having felt firsthand the political will to reach the elimination goals, I am convinced that the road to the elimination of leprosy is not such a long one. □



Children Performing Leprosy Educational Play at Antetezambaro Basic Health Center in Toamasina Province, Madagascar

## Meeting with African Leaders

*At the end of September and beginning of October 2003, Special Ambassador Yohei Sasakawa held meetings with the political leaders of six African countries who were in Japan to attend the Third Tokyo International Conference for African Development (TICAD III).*

*Responding to Mr. Sasakawa's request that more attention be paid to leprosy elimination, all of these leaders expressed concern and confirmed a strong commitment to the elimination efforts in their countries, and all showed an impressive grasp of the situation. Their remarks follow.*

### President of Burkina Faso, H.E. Blaise Compaoré



"In our country, we have an annual solidarity day for leprosy elimination. I myself attend the ceremonies every year, as my schedule permits. I would like to invite you, Mr. Sasakawa, to come to our country and participate in these Leprosy Day activities. I can accompany you into the field so that we can observe leprosy elimination activities together."

### President of Mozambique, H. E. Joaquim Chissano



"We can eliminate leprosy with systematic treatment. The current trend is for people to pay more attention to newly emerging diseases and to forget about the effort that they have spent on old diseases such as leprosy. This is not a healthy situation. We appreciate your unwavering commitment and work toward leprosy elimination."

### Prime Minister of Ethiopia, H.E. Meles Zenawi



"We are very grateful for your continuous efforts toward leprosy elimination. Leprosy has caused social discrimination in our country because many people have a fear of the disease. We must change the perception of the people and rehabilitate the patients. We will work together with you toward elimination."

### President of Nigeria, H.E. Olusegun Obasanjo



"Poverty has many faces. Leprosy is one of these. In order to eliminate leprosy, accessibility, availability and affordability of information regarding prevention, diagnosis and treatment are necessary. I will personally join in this crusade for a world without leprosy."

### President of Mali, H. E. Amadou Toumani Touré



"We have worked on leprosy elimination for many years together with AFRF (Association Française Raoul Follereau) and WHO. Mali has been a center of research on leprosy and I would like to refer you to the research data accumulated in our country. Leprosy patients suffer from both the disease and from poverty as well. It is important to organize social rehabilitation programs, particularly in rural agricultural villages."

### President of Senegal, H.E. Abdoulaye Wade



"In Senegal, AFRF has been working from the early stages of leprosy elimination activities. There still remain patients. The difficult thing is the social rehabilitation of former patients. At the moment, we are working to establish a social rehabilitation center for disabled people and patients of other diseases as well."

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