LEPROSY IN THE WHO AFRICAN REGION

D. Daumerie

The prevalence of leprosy in the WHO African Region is the second highest in the world, with 0.92 per 1 000. The total number of registered cases in this region (482 669) represents 13% of the world total. In the 1960s, leprosy control was based on vertical programmes and mass treatment with sulfones. The need to use multidrug therapy (MDT) because of the emergence of dapsone resistance, and the integration of health-service activities according to the primary health care approach, have modified strategies for leprosy control.

All countries of the region have adopted MDT as their official treatment strategy, but they sometimes encounter difficulties in implementing it. The interregional conference on leprosy control in Africa held in Brazzaville in November 1989 has provided much information to review the current situation and to see what progress has been made in implementing MDT in Africa: how to overcome the difficulties, if any, of implementing MDT within primary health care (PHC), how to control leprosy through MDT under varying conditions; how to build national capabilities; and how to identify ways of coordinating leprosy control through MDT with the participating funding agencies.

Leprosy situation and MDT progress

Situation analysis

The distribution of leprosy cases is uneven among the countries of the region, and even within individual countries. At the end of 1990, out of a population of about 500 million, 482 669 patients were registered for treatment, representing a global prevalence rate of about 1 case per 1 000 population and a detection rate of 8 per 100 000. About 40% of patients in the African Region are found in Nigeria alone. Available data on the distribution of patients according to age, sex or type of leprosy are very limited. The results of some surveys and programmes, however, provide the following information:

- proportion of children <15 among new cases—9%;
- proportion of multibacillary (MB) patients among new cases—5-20%;
- proportion of patients with physical disabilities among new cases—10%;
- proportion of patients with physical disabilities among total registered cases—25-40%.

The distribution by country of leprosy cases in the WHO African Region, and the proportion of registered cases treated with MDT, are given in Annex Table I, p. 11. Fig. 1 shows MDT coverage by subregion.

Leprosy control

All countries of the region have reoriented their strategies and introduced MDT, but less than 20% of the known patients are being treated with MDT, and coverage varies considerably from country to country. About 103 000 patients had completed treatment up to 1989.

Subregion I, which comprises 18 countries situated in the north-west and west, has a prevalence rate that is twice as high as that of other subregions, with a total of about 320 000 patients.

The prevalence of the disease has, however, declined considerably over the past 20 years. This drop can be explained by various factors such as effectiveness of programmes based on dapsone; high population increase; decline in the incidence of the disease; updating of available data; reduction in detection activities.

Leprosy control has normally been carried out by specialized staff. But special efforts are now being made for patients to be treated with MDT in general health units. A number of obstacles still remain in moving from a vertical specialized system to an integrated one; these probably explain the low MDT coverage in the subregion.

Subregion II, which comprises 13 countries situated in the centre and east, has for a long time been considered as a very high prevalence area. Prevalence has declined considerably in recent years, to reach the present level of about 0.7 per 1 000. Most of the programmes are based on vertical structures and the introduction of MDT is progressing very slowly, except in Ethiopia.

In Subregion III, which comprises 16 countries situated in the southern part of the continent, the leprosy problem has declined considerably in recent years. The general MDT coverage of Subregion III is higher than that of the other subregions.

Classification of countries according to the current leprosy situation

In order to set targets, it would be useful to classify the countries according to leprosy endemnicity and leprosy control (Box 1). In this way, guidelines to enable countries to progress from one level to the next can be more readily prepared. However, there are many biases in such a classification: the total number of registered cases could be far from the number of estimated cases; MDT coverage is a global indicator which does not take into account the performance of detection or treatment activities.

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*This article is based on a presentation made at the WHO interregional conference on leprosy control in Africa, Brazzaville, 6-10 November 1989.

1 Leprosy Unit, World Health Organization, Geneva.

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Level I. The prevalence of leprosy is very low (<1 per 10,000), and very few new cases are diagnosed annually (<1 per 100,000). Leprosy is not a public health problem. Newly-detected cases are managed by the general health services and all existing cases receive MDT.

Level II A. The prevalence of leprosy is medium, from 1 per 10,000 to 10 per 10,000. Nationwide MDT coverage is more than 75% of registered cases and prevalence has declined over the past 5 years.

Level II B. The prevalence of leprosy is medium, from 1 per 10,000 to 10 per 10,000. Nation wide MDT coverage is less than 75% of registered cases and prevalence has not declined over the past 5 years.

Level III A. Leprosy remains a major public health problem with a prevalence rate >10 per 10,000 but MDT has been introduced and covers at least one-third of existing and new cases.

Level III B. Leprosy is a serious public health problem with a prevalence rate of >10 per 10,000 and MDT has been partly implemented, or covers less than one-third of new and existing cases.

Box 1. Classification of countries according to endemicity level and multidrug therapy (MDT) coverage, WHO African Region

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<tr>
<th>Level I</th>
<th>Level II A</th>
<th>Level II B</th>
<th>Level III A</th>
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<tr>
<td>Low endemicity/High MDT coverage</td>
<td>Medium endemicity/MDT coverage &gt;75%</td>
<td>Medium endemicity/MDT coverage ≤75%</td>
<td>High endemicity/MDT coverage &gt;33%</td>
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*World health statist. quart., 44 (1991)*
Leprosy situation in African countries by level of endemicity

Level I

In these countries, leprosy prevalence is close to zero, and leprosy patients are treated with MDT by the general health services. The goal of leprosy control is to eliminate leprosy. The main objectives are: to integrate leprosy control into general health services; to diagnose new cases early; to maintain health personnel awareness of leprosy; and to diagnose relapses.

**Algeria**
- 18 cases
- Prevalence rate: 0.01 per 10 000
- MDT coverage: 55.6%

Leprosy is not a public health problem in Algeria. Patients are treated with MDT in hospitals and dermatology clinics.

**Botswana**
- 100 cases – 65 MB; 35 PB
- Prevalence rate: 8 per 10 000
- Detection rate: 0.1 per 10 000
- MDT coverage: 100%

Leprosy is not a major public health problem and all registered and new cases are treated with MDT. Leprosy control (including case detection) has to be continued in order to ensure that prevalence continues to decline.

**Burundi**
- 75 cases – 75 MB
- Prevalence rate: 0.10 per 10 000
- Detection rate: 0.21 per 10 000
- MDT coverage: 100%

Since 1976, the leprosy control programme is integrated into the general health structure. Four mobile teams are responsible for the supervision of activities. At the national level, the programme has been combined with tuberculosis control since 1984. MDT was introduced in the country in 1981, and the regimens used are different from those recommended by WHO. The short duration of the regimen used, especially for MB patients, could explain that the detection rate is higher than the prevalence rate. However, low endemicity in this area and efficacy of regimens have to be confirmed by further studies.

**Mauritius**
- 26 cases
- Prevalence rate: 0.20 per 10 000
- Detection rate: 0.03 per 10 000
- MDT coverage: 100%

**Namibia**
- 26 cases
- Prevalence rate: 0.10 per 10 000
- Detection rate: 0.17 per 10 000
- MDT coverage: unknown

**South Africa**
- 962 cases
- Prevalence rate: 0.30 per 10 000
- Detection rate: 0.04 per 10 000
- MDT coverage: 52.6%

**Zimbabwe**
- 369 cases
- Prevalence rate: 0.40 per 10 000
- Detection rate: 0.14 per 10 000
- MDT coverage: 87.8%

The leprosy control programme has been established since 1983, and is now in the process of integration within the general health structure. Integration has become a priority because of the rapid decrease in prevalence.

Level IIA

Level IIA includes countries where leprosy endemicity is medium and leprosy control provides MDT to more than 75% of known patients.

In these countries, the goal is to reduce within 5 years the endemicity level of the disease by treating all known cases with MDT. The main objectives are: to extend MDT coverage; to improve early case finding; and to prepare integration of leprosy control where leprosy control is specialized.

**Angola**
- 4 046 cases – 2 429 PB;
- 1 478 MB; 109 NK
- Prevalence rate: 4 per 10 000
- Detection rate: 0.3 per 10 000
- MDT coverage: 84.3%

The country is divided into 18 provinces and leprosy control is combined with tuberculosis control. MDT was introduced in 1987.

**Comoros**
- 83 cases – 25 PB; 58 MB
- Prevalence rate: 1.6 per 10 000
- Detection rate: 2.1 per 10 000
- MDT coverage: 84.3%

**Equatorial Guinea**
- 47 cases
- Prevalence rate: 1.1 per 10 000
- Detection rate: 0.8 per 10 000
- MDT coverage: 91.5%

**Gambia**
- 440 cases – 117 PB; 323 MB
- Prevalence rate: 5.1 per 10 000
- Detection rate: 0.3 per 10 000
- MDT coverage: 100%

The leprosy control programme is combined with the tuberculosis programme at the national, regional and district levels, but is integrated into PHC at the peripheral level. MDT was introduced in 1984 and since the start of the programme, prevalence has shown a sharp decline.

**Malawi**
- 1 895 cases – 662 PB; 1 233 MB
- Prevalence rate: 2.2 per 10 000
- Detection rate: 1.2 per 10 000
- MDT coverage: 100%

The country is divided into 24 districts. The leprosy control programme is fully vertical, with at least one leprosy worker per district. MDT was introduced in 1983, and because of the dramatic decline in prevalence, the country has decided to combine leprosy with a skin-disease programme.

**United Republic of Tanzania**
- 5 840 cases
- Prevalence rate: 2.1 per 10 000
- Detection rate: 1.4 per 10 000
- MDT coverage: 90.7%

The country is divided into 25 regions with 3-7 districts each. The leprosy control programme is combined with tuberculosis control, both fully integrated into the PHC structure. MDT was introduced in 1982 and the regimens used are different from those recommended by WHO. Introduction of MDT has resulted in a rapid reduction of prevalence, but not in the detection rate, which has remained more stable.

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1 MB: multibacillary; PB: paucibacillary; NK: classification not specific.
Zambia

The country is divided into 9 provinces and the leprosy control programme is combined with the tuberculosis programme at national level, but is fully integrated into the general health services and the PHC system. MDT was introduced in 1983 and total coverage is planned for 1991.

Level IIIB

Level IIIB includes countries where leprosy endemicity is medium and leprosy control provides MDT to <75% of known patients.

In these countries, the goal is to reduce within 5 years the endemicity level of the disease. The main objectives are: to extend the existing MDT coverage to at least 75% of known cases; to improve early case finding; and to prepare integration of leprosy control where leprosy control is specialized.

Ethiopia

Leprosy is considered to be one of the major public health problems in Ethiopia. The programme is partly integrated, and there are plans to improve detection activities and to implement progressive decentralization. MDT was introduced in 1983 and after 5 years, prevalence has been reduced to 75%.

Ghana

The country is divided into 10 administrative regions and 110 districts. The leprosy control programme is vertical, based on leprosy workers at the district level. MDT started in 1984, and with the constant reduction in prevalence, it is planned to review the present control strategy with a view to integrating it into the PHC system.

Kenya

The country is divided into 7 departments and leprosy control activities are vertically organized and based, in each department, on one mobile team responsible for the control of endemic diseases and immunization. MDT was introduced in 1983 and progress in coverage is very slow, owing to the immensity of the country and the dispersed population.

Reunion

Leprosy control activities are partly integrated into the general health services, under the supervision of mobile specialized teams. MDT was introduced in 1981 and at this time, the regimens adopted were different from those recommended by WHO. Since 1988, the programme provides the WHO MDT regimens and it is planned to develop a combined leprosy-tuberculosis programme.

Seychelles

Sierra Leone

The country is divided into 4 regions, and the leprosy control programme is vertically organized. With the introduction of MDT and the shorter duration of treatment, prevalence has fallen rapidly, and compliance and follow-up of patients have improved, but the workload of health personnel has remained the same or even increased.

Swaziland

Uganda

The country is divided into 10 regions and 33 districts. Leprosy control activities are partly integrated into the general health structure. MDT was introduced in 1983, and in some areas the programme has been interrupted because of social instability. From 1988, plans were initiated to develop a combined leprosy-tuberculosis programme.

Zaire

The country is divided into 9 provinces, the leprosy control programme is combined with the tuberculosis programme at national level, but is fully integrated into the general health services and the PHC system. MDT was introduced in 1983, using different regimens to those recommended by WHO. Since 1988, the programme delivers WHO regimens and is being progressively started in the districts. Total coverage is planned for 1991.
Level IIIA

Level IIIA includes countries where leprosy endemicity is high and leprosy control provides MDT to at least 33% of known patients.

In these countries, the goal is to reduce within 5 years the current prevalence to Level II by treating all known cases with MDT. The main objectives are: to extend the existing MDT coverage; to improve early case finding; and to prepare the integration of leprosy control after the workload has been reduced.

Cameroon

12 302 cases - 9 085 PB; 3 217 MB
Prevalence rate: 10.9 per 10 000
Detection rate: 0.96 per 10 000
MDT coverage: 35.3%

The country is divided into 10 provinces and leprosy control activities are completely integrated into the general health services. At the central and provincial levels, there is a combined programme for leprosy and tuberculosis.

Gabon

2 491 cases
Prevalence rate: 21.3 per 10 000
Detection rate: 1.3 per 10 000
MDT coverage: 52%

Guinea Bissau

1 179 cases - 618 PB; 418 MB; 143 NK
Prevalence rate: 11.9 per 10 000
Detection rate: 2.13 per 10 000
MDT coverage: 100%

The country is divided into 3 provinces, 8 regions and 37 districts. Since 1980, leprosy control is combined with tuberculosis and is being progressively integrated into the PHC system. MDT was introduced in 1986, with an intensive starting phase of daily rifampicin treatment for MB patients.

Madagascar

19 210 cases
Prevalence rate: 16 per 10 000
Detection rate: 1.6 per 10 000
MDT coverage: 12%

The country is divided into 6 provinces and about 200 medical districts. The leprosy control programme is integrated into the general health services. MDT was introduced in 1985 but is still limited to the pilot areas and private centres. A national plan of action has been designed, with implementation intended to start in 1990, aiming at the generalization of MDT over a period of 5 years.

Level IIIB

Level IIIB includes countries where leprosy endemicity is high and leprosy control provides MDT to less than 33% of known patients.

In these countries, the goal is to reduce within 5 years the endemicity level of the disease to Level II by treating at least 75% of all known cases with MDT. The main objectives are: to extend the existing MDT coverage to at least 75% of known cases; to improve early case finding; and to prepare the integration of leprosy control after the workload has been reduced.

Benin

5 655 cases - 1 825 MB; 2 221 PB
Prevalence rate: 11.9 per 10 000

Leprosy is considered to be the fifth most important health problem in the country. While there is a plan to progressively integrate leprosy control activities into PHC, at present the programme is still vertical. MDT was introduced in 1987 and covers 5 of the 6 provinces. The regularity of treatment is 87-90% for patients treated with MDT. It has been observed that the introduction of MDT is followed by a rapid drop in prevalence and an increase in the case-detection rate.

Burkina Faso

13 312 cases - 2 302 MB; 11 010 PB
Prevalence rate: 14.8 per 10 000
Detection rate: 1.85 per 10 000
MDT coverage: 8%

The country is divided into 30 provinces and 300 districts. Leprosy control is partly integrated, with specialized personnel at the intermediate level to organize and supervise activities. MDT has been introduced in 15 provinces in 1990 and should be generalized throughout the whole country within 3 years.

Cape Verde

491 cases
Prevalence rate: 12.9 per 10 000
Detection rate: 1 per 10 000
MDT coverage: 13%

Central African Republic

7 096 cases - 5 707 PB; 1 389 MB
Prevalence rate: 24.4 per 10 000
Detection rate: 1.5 per 10 000
MDT coverage: 29.4%

The country is divided into 5 regions and the leprosy control programme is combined with the tuberculosis and trypanosomiasis programmes at national level. MDT was adopted as the basis of the national leprosy control programme in 1986.

Chad

10 651 cases - 8 926 PB; 1 725 MB
Prevalence rate: 18.8 per 10 000
Detection rate: 0.9 per 10 000
MDT coverage: 6.3%

The country is divided into 14 prefectures and 6 health sectors. Leprosy control is partly integrated, but specialized mobile teams are responsible for detection activities. Complete integration into the general health structure is planned for 1990. MDT was introduced in 1984.

Congo

6 416 cases
Prevalence rate: 32.2 per 10 000
Detection rate: 1 per 10 000
MDT coverage: 3.8%

The country is divided into 10 health areas. The national leprosy control programme is partly integrated or still vertical and combined with other programmes (tuberculosis, trypanosomiasis, schistosomiasis, immunization). MDT was introduced in 1985.

Côte d'Ivoire

24 291 cases - 20 669 PB; 3 622 MB
Prevalence rate: 19.3 per 10 000
Detection rate: 1.8 per 10 000
MDT coverage: 9.5%

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The country is divided into 26 rural health sectors and leprosy control is being integrated into the general health structure, particularly in the areas where MDT is used. MDT was introduced in 1983.

**Guinea**
- 15,918 cases - 1,871 PB; 376 MB; 13,571 NK
- Prevalence rate: 23 per 10,000
- Detection rate: 1.3 per 10,000
- MDT coverage: 14%

The country is divided into 4 regions. The leprosy control programme is based on the PHC approach. MDT was introduced in 1986 and a national plan of action aiming at the coverage of the whole country within 5 years started in 1989.

**Mali**
- 22,121 cases - 17,874 PB; 4,247 MB
- Prevalence rate: 23.6 per 10,000
- Detection rate: 1.7 per 10,000
- MDT coverage: 3.3%

Since 1985 leprosy control (considered as a priority by the government) has been integrated into PHC structures. In 1981 MDT was started in a specialized centre, and in 1987 became the basis of the country's leprosy-control programme.

**Mozambique**
- 24,338 cases - 830 PB; 731 MB; 22,777 NK
- Prevalence rate: 15.5 per 10,000
- Detection rate: 0.9 per 10,000
- MDT coverage: 6.4%

Leprosy control activities are combined with the tuberculosis programme and are partially integrated into the general health structure. MDT was introduced in 1984 but could only be implemented in the capital city of each province and in 9 districts, because of the political situation.

**Nigeria**
- 193,715 cases - 44,609 PB; 12,078 MB; 137,028 NK
- Prevalence rate: 17.1 per 10,000
- Detection rate: 0.5 per 10,000
- MDT coverage: 4.3%

More than 40% of registered cases in the WHO African Region are in Nigeria. The country is divided into 22 states. Leprosy and tuberculosis control are considered as priority programmes by the federal government. The leprosy-control programme is based on treatment with MDT through the PHC approach. MDT was introduced in 1985, but is limited to 11 states.

**Senegal**
- 11,554 cases - 7,580 PB; 3,974 MB
- Prevalence rate: 15.7 per 10,000
- Detection rate: 0.7 per 10,000
- MDT coverage: 12.6%

The country is divided into 10 administrative regions and 30 departments, and leprosy control is mainly vertical. MDT was introduced in 1982 in a pilot area, then expanded to 2 departments per year since 1986.

**Togo**
- 3,987 cases - 2,504 PB; 1,483 MB
- Prevalence rate: 11.5 per 10,000
- Detection rate: 1.3 per 10,000
- MDT coverage: 4.7%

Leprosy control activities are essentially vertical. MDT was introduced in a pilot area in 1986. A national programme plans to expand MDT throughout the whole territory by 1995, and to integrate activities into the general health structure.

**Future prospects**

Leprosy remains an important public health problem in Africa, and the countries of the western and central part of the continent notify very high prevalence and detection rates.

A majority of countries in the region have implemented the WHO-recommended MDT regimens as a basis for their leprosy control. However, MDT coverage is low and is increasing slowly as compared with other WHO regions. The reasons for such slow progress are numerous, and mainly related to the operational aspects of leprosy control in a difficult socioeconomic context.

However, with the increasing political commitment in many countries to control leprosy through MDT, and with the constant decline of leprosy prevalence (mainly due to the update of data during MDT implementation), a new interest has been shown for leprosy control in Africa. Consequently, high priority is now given to treat all registered cases with MDT, especially in level II and III countries. During this stage, efforts should be made to improve case detection by the PHC approach and community involvement.

The most important technical and operational constraints in leprosy control have been identified and discussed during the interregional conference on leprosy control in Africa, held in November 1989. The major recommendations of this conference were as follows:

- The great opportunity for bringing about major reductions in the prevalence of leprosy in the African countries as a result of the availability of effective MDT technology, as recommended by WHO, and the considerable resources available through national and international nongovernmental organizations (NGOs) and other agencies, should be fully utilized.

- The primary responsibility for control of leprosy should remain with the ministries of health, which should work in close collaboration with all parties participating in the programme. This coordination could best be achieved through the development of national coordinating committees under the leadership of the ministries of health, and tripartite agreements between governments, WHO, and supporting national and international NGOs and other agencies.

- Political commitment to leprosy control is extremely important for successful control of the disease, and this commitment should be translated into the development of national plans of action with clear targets for the implementation of MDT.

- Experience with MDT so far has demonstrated it to be effective, safe and practicable in a variety of situations. The operational problems of implementing MDT can be resolved in a cost-effective manner. Health systems research should be encouraged, with a view to solving several of the operational problems.

- Leprosy control through MDT should be carried out within integrated services. Integration means that leprosy control activities should be part of de-
centralized, comprehensive and permanent health services which are as close to the community as possible. Such integration is best achieved at the district level, based on the PHC approach, and should be carefully planned. Specialized technical (supervisory) support for leprosy control activities must remain available within the integrated programmes.

- Building national capabilities for leprosy control with particular emphasis on management is crucial for proper implementation of leprosy control through MDT. While external personnel are of value on a short-term basis, the long-term future of leprosy control depends entirely on the building of national capabilities. The appointment of a national leader is vital to the success of the programme.

- In integrated programmes, it is even more important that not only the general health services personnel and current leprosy workers are trained and retrained, but in addition, that leprosy control as a subject (including practical training) should be an integral part of the curricula for undergraduate medical training as well as for the training of para-medical personnel.

- Appropriate health and public education of patients, health workers and the community within the framework of general health promotion is important to gain the support of all concerned for leprosy control. Such support would help in removing the existing stigma and would aid case-finding and treatment compliance.

SUMMARY

The African Region has the second largest prevalence of leprosy among the WHO regions with about 1 per 1 000 population affected. With a very uneven distribution among countries, the region currently has a total of about 480 000 registered cases. The number of new cases detected per year is reported to be about 37 000. A high proportion (25-40%) of the registered cases are estimated to have significant physical disabilities. In spite of the introduction of multidrug therapy (MDT) in the early 1980s, currently only about 20% of the patients are benefitting from this improved treatment. The major problem in the low MDT coverage appears to be operational, against the background of a difficult socioeconomic situation. However, there have been favourable trends towards increased political commitment in several countries in recent years. The operational and technical constraints were discussed at an inter-regional conference in Brazzaville in 1989 which emphasized the need to make use of the opportunities to reduce disease prevalence through MDT; to coordinate various internal and external resources available for leprosy control; to increase political commitment and develop plans of action to build national capabilities for leprosy control; to integrate leprosy control within general health services; and to promote health education.

RÉSUMÉ

La lèpre dans la Région OMS de l’Afrique

La Région africaine, avec un taux d’environ 1 pour 1 000, se situe au deuxième rang des régions de l'OMS pour la prévalence de la lèpre. Le nombre total des cas enregistrés, très inégalement répartis entre les pays, est actuellement de l’ordre de 480 000. Environ 37 000 cas nouveaux seraient dépistés chaque année. On estime qu’une forte proportion (25-40%) des cas enregistrés est atteinte d’invalidités physiques importantes. Malgré l’introduction de la polychimiothérapie (PCT) au début des années 80, quelque 20% seulement des malades bénéficient actuellement de ce traitement amélioré. La faiblesse de la couverture par la PCT semble être due surtout à des problèmes opérationnels, liés à une situation socio-économique difficile. Depuis quelques années, cependant, une évolution se dessine dans plusieurs pays en faveur d’un engagement politique accru. Les obstacles opérationnels et techniques ont été examinés lors d’une conférence interrégionale qui a eu lieu en 1989 à Brazzaville, où a été soulignée la nécessité de saisir les occasions offertes par la PCT pour réduire la prévalence de la maladie, de coordonner les diverses ressources intérieures et extérieures disponibles pour la lutte antilépreuse; de renforcer l’engagement politique et d’élaborer des plans d’action en vue de doter les pays d’un potentiel pour la lutte antilépreuse; d’intégrer la lutte antilépreuse dans les services de santé généraux; et, enfin, de promouvoir l’éducation sanitaire.