

A choir warms up delegates before the start of the African Leprosy Congress.



beings like anyone else. We are useful to the community.”

Cresenciano T. Rosello (IDEA) recalled how pen-pal letter writing campaigns began on Culion Island in the Philippines after World War II, requesting assistance for the many orphaned children living in what was once the world’s largest leprosy colony. Benefactors were forthcoming and conditions improved, encouraging others with more dubious claims to write as well. “Pen-pal letters became a cottage industry,” he said.

Now a couple of projects are helping prevent a new generation from resorting to begging letters by making them self reliant and self sustaining. “We intend to produce an economic miracle, transforming people from recipients of aid to givers of aid,” he said.

AFRICA’S PROGRESS

Africa’s remarkable progress, highlighted at the opening of the congress, was dealt with in more detail by Dr. Landry Bide (Regional Advisor, WHO/AFRO) in his state of the art lecture on Leprosy Elimination in Africa. In the 1980s, he said, there were over 1 million cases of leprosy in Africa alone. It was a serious problem, poorly managed. In 1990, 42 out of the 46 states comprising the WHO Africa Region were endemic, and the prevalence rate was above 1% of the population.

All that changed with the introduction of free treatment with MDT and the formation of national programs in every country, giving leprosy a new priority within the health sector. “It ceased to be a charity activity and began to be a policy,” he said.

Africa still grapples with some special problems, including those relating to geographical access (the size of the continent and difficulty of reaching people), cultural access (illiteracy, taboos and poor communication between different groups), financial access (low income levels and largely absent health insurance), and functional access (decrepit health

facilities, lack of trained health workers).

Above all, said Dr. Bide, the main constraint is war, which “destroys health facilities, scares off health workers and displaces populations.”

The symposium on Reaching the Unreached, moderated by Dr. K. Kawuma, noted that the bedrock of the leprosy elimination strategy was early detection and prompt treatment. Nonetheless, each year, new cases are occurring that are not being detected. Why? The answers, he suggested, included ignorance of the disease among both patient and healthcare worker (“some people look and do not see”), problems of distance and cost, and the matter of the diagnosis being “unwelcome.”

Dr. B. F. Njako (GLRA/NTLP) speaking of Tanzania’s experience, said that health workers can’t do everything, especially with the increasing demands made on them by TB and HIV/AIDS, and that it was essential to have greater community involvement in uncovering leprosy cases.

In the Democratic Republic of Congo, war has been a major contributor to poor infrastructure, said Dr. J.N. Mputu (Ministry of Health, DRC). Many health districts are not functional, and there is almost no community involvement, especially at village level, in leprosy detection activities. Volunteers were needed, they needed to be chosen by the local community, and they needed to be remunerated, he said.

In the last state of the art lecture, on Prevention of Disability in Leprosy-Affected Persons, Dr. H. Srinivasan said that while leprosy is no longer a medical problem or (in most countries) a public health problem, the “human problem” of leprosy continues because of impairment, which can lead to marginalization and social isolation.

Disability can occur even after a successful course of MDT, he said, but action can be taken to stop it from happening, and he called on persons affected by leprosy to become the “main actors” in practicing disability prevention. ■