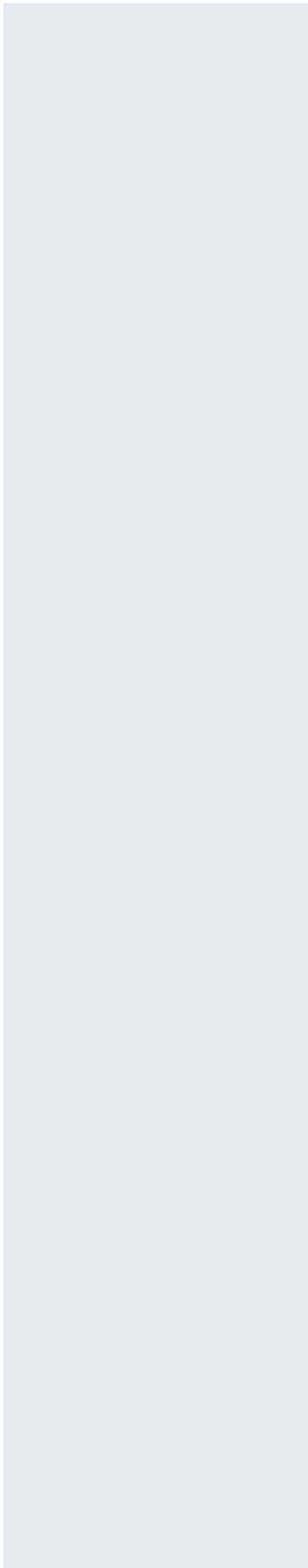


Annex 5

Country assessment reports



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Background

At the first meeting of the WHO Task Force on Buruli Ulcer in February 1998, at WHO headquarters in Geneva, one of the recommendations was that WHO should conduct a rapid assessment of the Buruli ulcer situation in selected countries in order to have a better understanding of the problem. As a result, a team of WHO consultants visited Benin, Côte d'Ivoire, Ghana and Togo between March and July 1998 with the following objectives:

1. to determine the scale of the Buruli ulcer problem in Benin, Côte d'Ivoire, Ghana and Togo;
2. to assess the resources currently available and the additional resources required to develop an effective control programme for the disease; and
3. to discuss with the government authorities the importance of the disease as a public health problem in those countries.

The summary and recommendations for each country are presented below.

Côte d'Ivoire

Summary

The first case of Buruli ulcer was reported in 1978. Between 1988 and 1997, over 10,000 cases have been recorded with more than half between 1995 and 1997 (see Fig. A5.1). In addition, there has also been increasing geographical spread of the disease. Five Centres currently treating Buruli ulcer patients were visited during the mission in order to assess the situation. These were the Dermatology Centre of Treichville University Hospital, Abidjan; the Kongouanou Centre in Yamoussoukro region; St Michael's Health Centre at Zoukougbeu in Daloa region; the Raoul Follereau Institutes at Manikro, Bouaké region and Adzopé, Abidjan region. The Kongouanou and Zoukougbeu Centres have no surgical facilities, hence the only treatment available was wound dressing. The average period of hospitalization in all these Centres was in excess of 6 months, and the average cost of treatment per patient was between US\$800 and US\$1500. Inadequate resources to control the disease has hampered the effective implementation of the programme's activities.

Recommendations

- The government of Côte d'Ivoire must commit itself to an effective programme to control the disease.
- Buruli ulcer should be considered a social disease like leprosy and tuberculosis, and those afflicted by the disease should be treated free of charge.
- The Raoul Follereau Institutes in Adzopé and Manikro should be supported and used for the treatment for Buruli ulcer.
- The Dermatology Centre at Treichville University Hospital, Abidjan should be brought up to standard to allow for better management of patients.
- The national programme should establish a better surveillance system for the disease.

Figure A5.1a. Buruli ulcer situation in Côte d'Ivoire

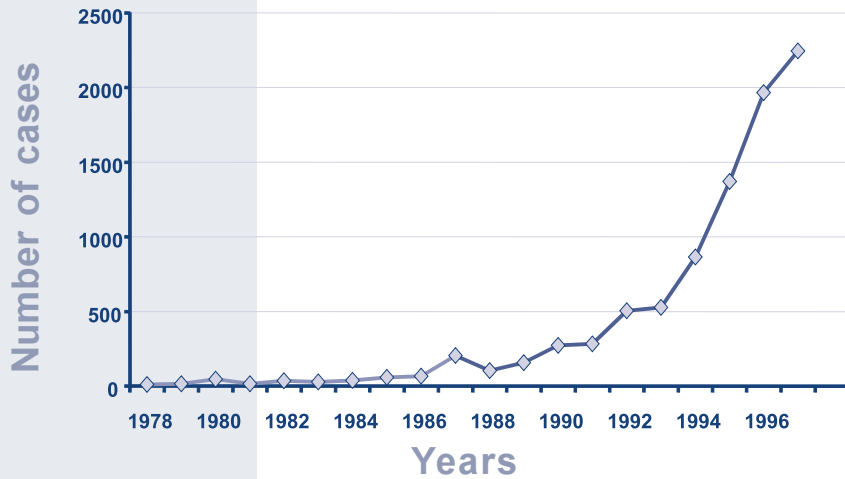


Figure A5.1b. Map of Côte d'Ivoire showing the geographical distribution of Buruli ulcer in 1989.

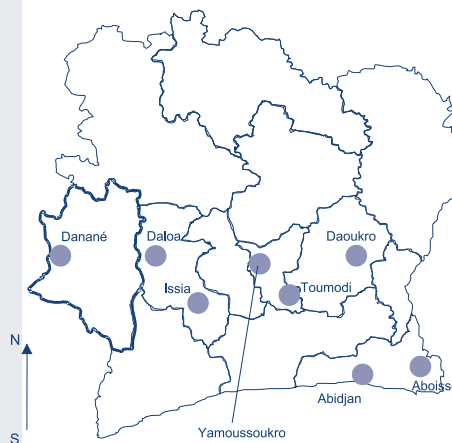
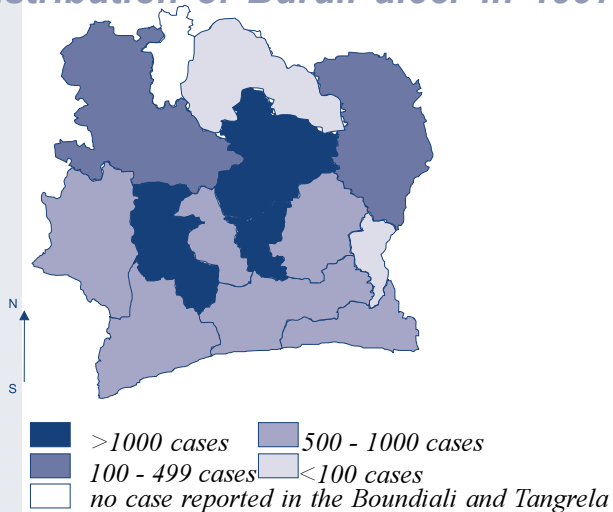


Figure A5.1c. Map of Côte d'Ivoire showing the geographical distribution of Buruli ulcer in 1997.



Benin

Summary

Since 1988, approximately 2300 cases have been reported, most of them as a result of passive detection. Four of the six regions (Atlantic, Mono, Ouémé and Zou) have been affected and the trends in the disease are shown in Fig. A5.2. In response to the growing problem, the Government of Benin has drawn up a national strategic plan to deal with the disease. This plan is yet to be approved by the Ministry of Health and implemented. The Health Centre at Lalo, the Leprosy Centre at Davougon and Zangnanado Nutritional Centre were visited. In all there were many patients with Buruli ulcer. Zangnanado Nutritional Centre is currently the centre treating the majority of patients in Benin. The median length of hospitalization at this centre is 2 months. Some endemic villages were visited, where large numbers of people with active disease spontaneously presented. It was concluded that Buruli ulcer was indeed a public health problem in Benin. However, given the resources currently available, effective control may be difficult unless additional ones are mobilized.

Recommendations

- The Government of Benin should quickly finalize the national programme plan and implement it as soon as possible, starting with the resources currently available.
- The national programme should include surgeons to train staff, treat patients and ensure standardization of care.
- Based on the similarities between the problems encountered with leprosy and Buruli ulcer, the control of Buruli ulcer should be linked to the leprosy programme.
- Because of the lengthy hospitalization, the Government should contribute towards the cost of feeding patients, as is done for leprosy patients.
- The Zangnanado Centre should be improved and provided with more support, particularly in terms of medical staff.
- The draft agreement between MSF Luxembourg and the Republic of Benin should be finalized as quickly as possible to allow the Lalo Centre to manage Buruli ulcer cases.
- Peripheral centres at Tchi in Mono and Bonou in Ouémé should be equipped to manage simple cases (simple excisions) and wound dressing.

Figure A5.2a. Buruli ulcer situation in Benin. Distribution of new cases between 1989 and 1998 in Zangnanado

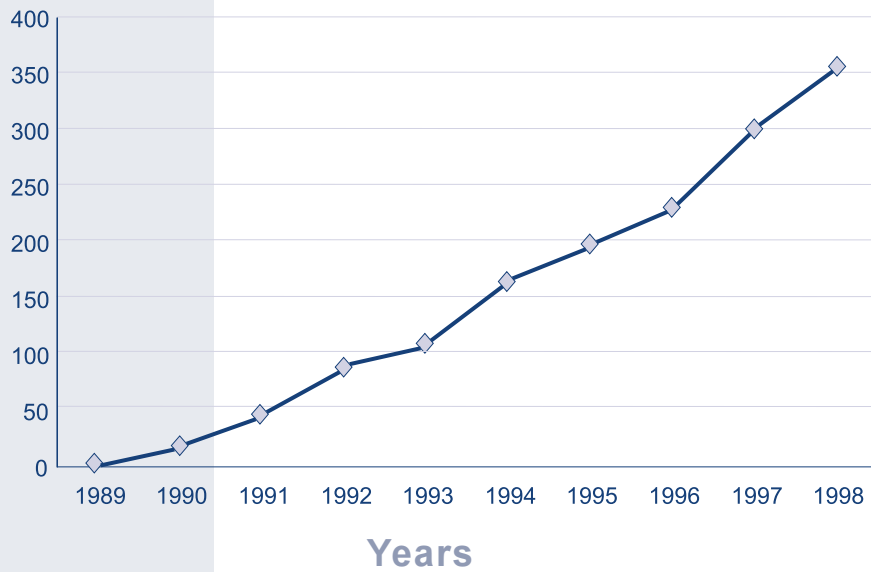


Figure A5.2b. Map of Benin showing the geographical distribution of Buruli ulcer in 1989.

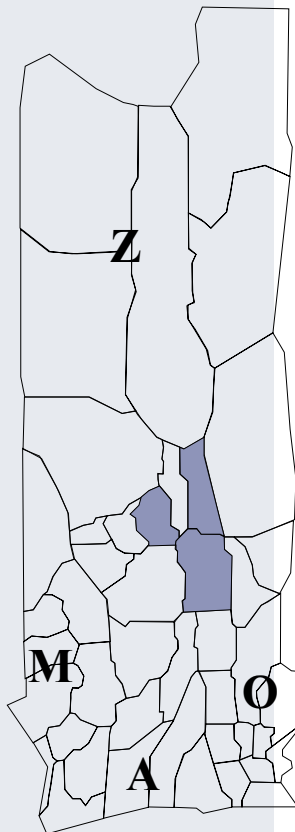
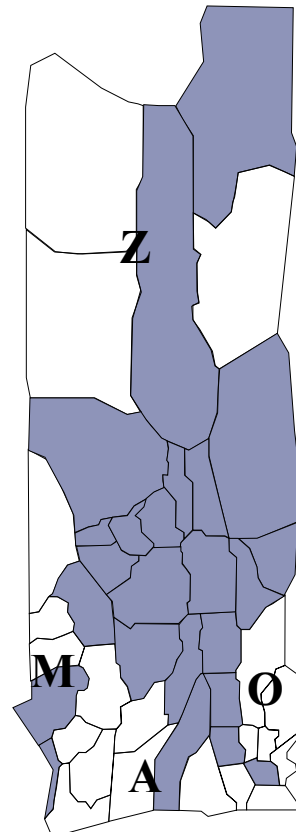


Figure A5.2c. Map of Benin showing the geographical distribution of Buruli ulcer in 1997.



A: ATLANTIQUE
M: MONO
O: OUÉMÉ
Z: ZOU

Togo

Summary

The first two cases were described by Meyers et al. in 1996, since when about 40 cases have been surgically treated at the St Jean Dieu Hospital, Afagnan. This hospital is well equipped and staffed to provide complete treatment for Buruli ulcer patients. The extent of Buruli ulcer as a public health problem in Togo is not yet clear. As such, no efforts are currently in place to address the disease. The disease exists in the southern part of the country (Tabligbo, Vogan and Aneho). The estimated average treatment cost per patient at St Jean Dieu Hospital was between 0.5 and 1 million CFA francs (US\$ 800–1600). This cost is covered by a charity called LILIANA.

Recommendations

- Buruli ulcer is not yet a public health problem in Togo and a national programme for this disease was not considered necessary.
- Prevalence studies should be carried out as soon as possible to determine the extent of the problem.
- The excellent infrastructure set up for leprosy could be used for these studies.
- Togo is situated between two countries (Benin and Ghana) where the disease is highly endemic. Since it seems that Buruli ulcer is not yet a major health problem in Togo, the government of this country should rapidly set up a surveillance system allowing early detection and treatment of cases.

Ghana

Summary

The first case of Buruli ulcer was reported in 1971. Between 1993 and 1997, nearly 2000 cases have been reported. Six of the 10 regions and 35 of the 110 districts of the country are affected. The exact magnitude of the problem is not known. The Ashanti region is the worst affected region in the country, accounting for about 60% of all reported cases. In response to the growing problem of Buruli ulcer, the Ministry of Health has set up a Buruli Ulcer Task Force to advise the Government on the control of and research on the disease. The assessment was conducted in the Ga district of the Greater Accra region, in the Asante Akim North and Amansie West districts of the Ashanti region, and in the Upper Denkyira district of the Central region. Except for the Ga district, all the other districts have equipped surgical facilities and basic laboratories for the management of patients. All the institutions visited emphasized the strain put on their limited resources by the increase in Buruli ulcer patients. Structural intervention for prevention of disabilities and for rehabilitation (e.g. physiotherapy) do not exist.

Recommendations

- The Government of Ghana should start to put into operation an effective programme to address the disease.
- Surveys should be conducted to assess the extent and distribution of the disease and set up ongoing surveillance.
- Resource gaps and needs (training, equipment and facilities for diagnosis, treatment, prevention and rehabilitation) should be identified. Community health workers should be trained and involved in early diagnosis.
- The treatment of the disease should be free of charge in accordance with the final resolution of the Yamoussoukro Conference, and patients and health care providers should be made aware of this.
- Treatment should be decentralized as much as possible, by providing to various levels of the health care system dressing materials and other logistics to ensure effective treatment of patients.
- A rehabilitation programme should be an integral part of a national control programme.
- A simple surgical facility should be provided at the Amasaman Health Centre to allow treatment of early lesions, and the laboratory should be equipped to allow the detection of acid-fast bacilli from ulcers.
- Agogo hospital should be used to teach the disease in the nursing school and to train doctors in the surgical management of the disease.
- The Noguchi Memorial Institute for Medical Research should be contacted for the possibility of collaborating with other centres in Buruli ulcer research activities.