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REPORT OF THE

CONSULTATIVE MEETING

ON

CUTANEOUS LEISHMANIASIS

Geneva, WHO Headquarters, 30 April to 2 May 2007

Neglected Tropical Diseases

Innovative and Intensified Disease Management
Leishmaniasis Control Programme

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1. Background

Leishmaniasis is a parasitic disease transmitted by the bite of blood suckling insects, sandflies, which have previously fed on an infected reservoir host. There are two basic clinical presentations: visceral leishmaniasis (VL) or "kala-azar" and cutaneous leishmaniasis (CL). VL is the most severe and is fatal in almost all cases if left untreated, while CL is associated with a strong tendency toward spontaneous resolution but causes important social and psychological stigma.

Leishmaniasis is prevalent in 88 countries, affecting an estimated 12 million people with approximately 2 million new cases per year, 500 000 of which are VL and l 500 000 CL (90% of them in Afghanistan, Algeria, Brazil, the Islamic Republic of Iran, Peru, Saudi Arabia and Sudan). The disease burden is calculated at 2 356 000 disability-adjusted life years (DALYs): 946 000 in men and 1 410 000 in women, representing a significant rank among communicable diseases. A third of the global figure (770 000 DALYs) is attributable to CL. Given the importance of leishmaniasis, the 60th meeting of the World Health Assembly approved a resolution for "The Control of Leishmaniasis".

In general, CL has a tendency to heal spontaneously leaving scars which, depending on the species of *Leishmania* responsible, may evolve into recidivans CL, which is difficult to treat, and leaves extensive scars. In the Americas, CL may develop into one of two possible forms, depending on the species of *Leishmania* responsible: (1) diffuse CL, which occurs in patients with a weakened immune system who fail to heal spontaneously and relapse after treatment, with disastrous aesthetic consequences for the patient; or (2) muco-cutaneous leishmaniasis (known as "espundia" in South America), characterized by the destruction of the mucous membranes and cartilage of the mouth and pharynx followed by the facial tissue.

CL is a public health, as well as social problem, in many countries. CL is endemic in 82 out of the 88 countries where leishmaniasis is transmitted. The disease affects poor and deprived populations and has an important impact on the propagation of poverty, since treatment is expensive and therefore either unaffordable or involves a great a loss of wages. The cost of treatment and implementation of prevention strategies needs sizeable investments (financial and human resources) especially for vector and reservoir control. CL is re-emerging in many settings and in different countries with a variable number of cases and outbreaks occurring in urban areas or refugee camps, especially the internally displaced populations.

Operational research is required in multiple areas for evidence-based decisions. Public sector reporting of leishmaniasis only accounts for 20% of cases. The disease burden is therefore underestimated and real figures may be 4-5 times higher than what is being reported. Since CL is not fatal, it has received little attention with respect to improving its control at the individual or social level. CL therefore continues to be disregarded among the neglected diseases, and requires enhanced support for the implementation of effective prevention and control strategies.

Middle East and Maghreb countries harbour around 15% of the global leishmaniasis burden, which is almost exclusively attributable to CL. To aid the launch of a control programme aimed at reducing the incidence of CL in the aforementioned areas, WHO arranged a consultative meeting in Geneva from 30 April till 2 May 2007, which forms the basis of this report.

2. Meeting minutes

2.1 Opening Session

Dr Lorenzo Savioli, Director, Department of Control of Neglected Tropical Diseases, WHO Headquarters, Geneva, welcomed the participants of the meeting. In his opening remarks he highlighted the importance of leishmaniasis at global and regional levels. In particular, he mentioned the WHO commitment for the control of neglected diseases, which include leishmaniasis as one of the tropical diseases of public health importance. He highlighted important parts of the speech of the Director General, WHO, on the control of neglected diseases and emphasized the aim to reinvigorate the whole area of specific disease-related strategies, especially in poor and displaced populations where it is recognized that vector-borne diseases affect the poor and marginalized with variable levels of morbidity and mortality.

Dr Jean Jannin, Coordinator, Innovative and Intensified Disease Management, WHO, Geneva, presented the objectives of the meeting. This was followed by the selection of the Chairperson:
Dr. Jaouad Mahjour, Director, Department of Communicable Diseases, WHO Regional Office for the Eastern Mediterranean (EMRO) was elected as the Chairperson for Session I. Professor Richard W. Ashford, Liverpool School of Tropical Medicine, and Dr C. M. Arif Munir, Pakistan Medical Research Council were elected Rapporteur.

Dr Jorge Alvar, Leishmaniasis Programme Manager, highlighted the global importance of leishmaniasis in his introductory remarks. He was concerned with the increasing incidence of CL in the Eastern Mediterranean region and emphasized the need for more urgent and sustained action to keep the disease under control. He stressed that, in addition to morbidity, the problem of social stigma attached to CL requires renewed efforts to review and refine the existing strategies and mobilize resources to prevent and control this very important disease. This demands serious commitment at the national and global level.

2.2 Meeting Objectives

The meeting objectives were: (i) to revisit the area-specific disease-related strategies for the control of CL, especially in poor and displaced settings, and (ii) to define and decide on common strategies for prevention and control of CL in the Eastern Mediterranean region.

The WHO guidance to the participants focussed on the following:

> Clear strategies are needed to move ahead.
> More emphasis is required on effective implementation of disease control interventions.
> Member countries need to define common strategies for the control of CL for the next five years (2007–2012).
> National programme managers should take the lead and move forward to control this very important disease. WHO would provide the maximum support in the areas of disease epidemiology, surveillance, implementation of control intervention, and research. WHO would also consider the different possibilities for strengthening the national disease control programmes.

2.3 Invited lecture

Dr Riadh Ben-Ismail, Regional Advisor, Control of Tropical Diseases, WHO, EMRO, presented the regional situation of CL (anthroponotic and zoonotic). He discussed in detail the disease epidemiology including vectors and reservoirs and emphasized the need for more organized, target-oriented and cost-effective disease prevention and control strategies. He reviewed old and existing tools and the development of new tools for wider implementation. He also highlighted the case containment strategies.

Session I: Epidemiological Review and National Programmes

Speakers from 11 countries (Afghanistan, Algeria, Iraq, the Islamic Republic of Iran, Jordan, Libya, Morocco, Pakistan, Saudi Arabia, the Syrian Arab Republic, and Tunisia) made presentations. In almost all countries anthroponotic and zoonotic CL are prevalent. At the end of the session, detailed discussions were held that helped the participants focus their attention during the working group discussions.

Session II: State of the Art

Five presentations made by the speakers (list attached) covered different topics ranging from a systematic review on the treatment of CL, drug resistance, vector and reservoir control, and control in displaced settings. These state of the art lectures provided the opportunity to share diverse experiences related to various disease control components. The presentations were followed by in-depth discussions, and the session was concluded with the identification of working groups.

Session III: Working Groups

Three working groups were formed:

Epidemiological information and policy
Cases management
Prevention (vector and reservoir control)

Prior to working groups, discussions were held to identify key areas requiring input from the working groups. At the end of the session, one member presented the findings of their group These findings were then discussed in a combined session, and recommendations were given.

3. Recommendations

3.1 To endorse all recommendations of the resolution for the "Control of Leishmaniasis", 60th World Health Assembly, May 2007.

3.2 To promote political commitment of national governments for:

Formulation of policies
Availability of appropriate allocation of resources
Intersectoral collaboration

Community mobilization
Co-ordination with neighbouring countries

3.3 To set up a network for CL for:

Sharing information and experiences
Harmonization of control measures
Capacity building
Drug access and resistance monitoring
Quality control
Sub-regional collaboration

Vote of thanks and closure of the meeting