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REPORT

International Conference on Buruli Ulcer

Control and Research

Yamoussoukro, Côte d'Ivoire 6-8 July 1998

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1. Introduction

In December 1997, on the occasion of his visit to Côte d'Ivoire, the then Director-General of the World Health Organization (WHO), Dr Hiroshi Nakajima, announced that the World Health Organization would take the lead to mobilize the world's expertise and resources to fight the emergence of Buruli ulcer as a serious public health problem. Since this announcement, WHO has set up the Global Buruli Ulcer Initiative (GBUI). The Global Tuberculosis Programme (GTB) of the WHO is coordinating this Initiative. In February this year, a Task Force consisting of some of the world's experts in the disease met in Geneva to discuss and recommend global strategy for control and research.

In recent years, Buruli ulcer has rapidly emerged as an increasingly important cause of human morbidity around the world. The disease has been reported in at least 25 countries in Africa, Western Pacific, Asia and South America. These countries are Angola, Australia, Benin, Bolivia, Cameroon, China, Congo, Côte d'Ivoire, Democratic Republic of Congo, French Guiana, Gabon, Ghana, Guinea, India, Indonesia, Liberia, Malaysia, Mexico, Nigeria, Papua New Guinea, Peru, Sierra Leone, Sri Lanka, Sudan, Surinam, Togo and Uganda. In West Africa in particular, there have been reports of an increasing number of cases, as well as geographical spread of the disease. In Benin and Côte d'Ivoire, it is believed that the reported number of cases could exceed those of tuberculosis and leprosy.

Buruli ulcer affects poor people in remote areas with limited access to health care. The disease starts as a painless nodule, which, if left untreated, often leads to massive skin ulceration followed by debilitating complications such as contracture deformities and loss of vital organs, e.g. the eye. In some cases amputation of limbs is necessary. With the current knowledge, surgery is the treatment of choice, but adequate surgical facilities are often scarce in endemic areas, and where such facilities are available, the cost of treatment is often too expensive for the poor to afford. Consequently, patients often present late and hospitalization is prolonged, averaging three months per patient, but up to 18 months in some cases.

With the increasing number of cases and the associated complications, given the current absence of clear control strategies, the long-term socioeconomic impact of Buruli ulcer on the rural economy could be substantial. Furthermore, this disease could seriously undermine the efficient use of the limited health resources in the endemic countries. Clearly, early diagnosis and better treatment would reduce some of the devastating complications associated with the disease.

2. Objectives of the Conference

In view of the growing public health importance of Buruli ulcer and the little attention given to the disease in past, the Conference was organized to bring together world experts in the disease and decision makers who could contribute to the fight against the disease.

The primary objectives of the Conference were:

1. to raise awareness of the significance of the disease globally;

2. to increase recognition by donor agencies, WHO partners, and NGOs of this disease, and to seek support for endemic countries to deal with the disease;
3. to review the current scientific knowledge on Buruli ulcer;
4. to gain consensus on WHO's proposed plan of work for control and research;
5. to adopt a declaration on Buruli ulcer.

3. Co-sponsors

The Conference was co-sponsored by the World Health Organization; the Government of Côte d'Ivoire; Sasakawa Memorial Health Foundation, Japan; Association Française Raoul Follereau (AFRF); Damién Foundation, Belgium and the Humanitarian Aid Relief Team, USA

4. Participants

The Conference was well attended attracting over 200 participants from more 20 countries. Among the participants were the Presidents Henri Konan Bedié of Côte d'Ivoire, Jerry Rawlings of Ghana and Mathieu Kerékou of Benin; the then Director-General of WHO, Dr Hiroshi Nakajima; the WHO Regional Director for Africa, Dr Ebrahim Samba; WHO Representatives from Côte d'Ivoire, Ghana, Togo and Benin; WHO Secretariat; Mr Michel Récipon, President of AFRF; Ministers of Health; Members of the Diplomatic Corps; Representatives of other UN bodies in Côte d'Ivoire; representatives of donor agencies, NGOs and the private sector; Clinicians and Scientists, and the general public.

5. Highlights of the Conference

The Yamoussoukro Declaration on Buruli ulcer

The signing of *The Yamoussoukro Declaration on Buruli ulcer* by the Presidents of Côte d'Ivoire, Ghana, and Benin, and the Director-General of WHO served to stimulate all the participants and to spawn hope that such proclamations will be followed by meaningful actions. The declaration also served to back WHO's efforts to address the disease. The speeches of the three Presidents emphasized the important link between health and overall development. The DG's speech stressed the need to simultaneously address traditional diseases such as malaria and tuberculosis, as well as emerging diseases like Buruli ulcer, if international efforts to control communicable diseases in general are to have any significant impact in the 21st century. The final resolution of the Conference is shown in Annex 2.

NGO Activities

1. Association Française Raoul Follereau's President, Mr Michel Récipon pledged the commitment of the AFRF to collaborate with WHO GBUI in the control of Buruli ulcer in Côte d'Ivoire and Benin.
2. MSF Luxembourg announced that it has already started a Buruli ulcer project in Benin.
3. HART presented its activities in Ghana.

Overview of GBUI

Dr Kingsley Asiedu outlined the background and policy objectives of the Initiative. The objectives include: 1. advocacy strategies to raise awareness about the disease; 2. development of partnerships with NGOs and other interested parties to directly assist endemic countries to deal with the disease; and 3. support to research in critical areas such as surveillance, vaccine and drug development, toxin and immunotherapy. The GBUI has already established a Task Force to serve as an advisory group. It is also in the process of establishing a working group to be called International *Mycobacterium ulcerans* Study Team (IMuST) to co-ordinate control and research activities and International Reference Laboratories to support research activities.

Presentations from endemic countries

The presentations by health workers from Ghana, Benin, Togo, French Guyana and Côte d'Ivoire served to focus attention on both their common and specific problems. These presentations also served to introduce these workers to the participants---a most important outcome. Following this introduction, scientists, clinicians, and other health professionals were more readily able to discuss their ideas with personnel from the field.

Scientific papers

The report by Dr John Foulds, WHO Consultant, outlining the possibility of vaccine development, is presented in Annex 3. Scientific abstracts presented at the Conference by participants are presented in Annex 4.

Recommendations of working groups

On the third day of the Conference, 8 July 1998, working groups were formed to discuss and make recommendations on clinical management, laboratory support, surveillance, control programme development and research. The recommendations are presented in Annex 5.

Agenda and List of Participants

The final conference agenda and the list of participants are shown in Annexes 6 and 7 respectively.

6. The Future of the Initiative

Funding

The future of the GBUI is unclear. The lack of assured funds for future activities made hollow many of the recommendations for actions. This is especially true for the critical field research and control efforts that are based upon programmes within endemic areas. Also, sustained funding will be needed for implementation of ambitious plans for future activities of the International *Mycobacterium ulcerans* Study Team (IMuST) and to support the planned WHO support for the Buruli ulcer research community [strain bank and tissue specimen banks]. Without substantial funding to implement the recommendations, continue planned surveillance, and support research activities, the WHO GBUI will quickly expire.

Annex 1

The Yamoussoukro Declaration on Buruli ulcer

CONFERENCE ON BURULI ULCER CONTROL AND RESEARCH

6-8 July 1998, Yamoussoukro, Côte d'Ivoire

THE YAMOUSSOUKRO DECLARATION ON BURULI ULCER

1. We, the participants at the Conference on Buruli Ulcer Control and Research, recognize that Buruli ulcer (also called Bairnsdale ulcer in Australia), the third most common mycobacterial disease after tuberculosis and leprosy, is a foremost cause of human suffering. In West Africa, in particular, the disease is rapidly emerging as a serious public health problem.

2. Buruli ulcer affects, primarily, poor communities, and especially children and women with limited access to health care. We are concerned that with the increasing number of cases and the associated health complications, Buruli ulcer could hinder efforts to improve the economic and social development of the communities most affected.

3. We are deeply concerned that very little is known about this disease. We believe that multidisciplinary research, including vaccine and drug development, could result in minimal noninvasive treatment of the disease. We recognize that early detection and early surgical treatment before ulceration are curative and avoid the complications currently associated with the disease.

4. We further recognize that, because the people most affected have limited access to health care and usually seek help at an advanced stage of the disease, when complications are devastating, hospitalization is often prolonged and hence costly to the health services, the patients and their families.

5. We, the participants at the Conference on Buruli Ulcer Control and Research, and more especially, Heads of State and government representatives from the most affected countries, are committed to mobilize the resources needed to establish, as soon as possible, effective action to control Buruli ulcer as an integral part of primary health care.