

LEISH



WHO BI-REGIONAL CONSULTATION ON THE
**STATUS OF LEISHMANIASIS CONTROL
AND SURVEILLANCE IN EAST AFRICA**

NAIROBI, KENYA
12–14 JUNE 2017



World Health
Organization

MANIASIS

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ABBREVIATIONS

AAU	Addis Ababa University
ALERT	Africa Leprosy Rehabilitation and Training Center
CFR	case fatality rate
CL	cutaneous leishmaniasis
DHIS	District Health Information System
DND <i>i</i>	Drugs for Neglected Diseases <i>initiative</i>
FIND	Foundation for Innovative New Diagnostics
HIV	human immunodeficiency virus
ICIPE	International Center of Insect Physiology and Ecology
IEC/BCC	information, education, communication/behaviour change communication
IMA	Interchurch Medical Assistance
IRS	indoor residual spraying
ITM	Institute of Tropical Medicine Antwerp
ITN	impregnated treated net
KAP	knowledge, attitude, practices
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Authority
LCL	localized cutaneous leishmaniasis
LLIN	long-lasting insecticidal net
LST	Leishmanin skin test
M&E	monitoring and evaluation
MSF	Médecins Sans Frontières
NTD	neglected tropical disease
PKDL	post-kala-azar dermal leishmaniasis
SOS	SOS Children's Villages International
SSG	sodium stibogluconate
UON	University of Nairobi
VL	visceral leishmaniasis
WHO	World Health Organization

1. INTRODUCTION

Both visceral and cutaneous leishmaniasis are endemic in East Africa. Visceral leishmaniasis (VL) is caused predominantly by infection with *Leishmania donovani*. It is transmitted mostly by *Phlebotomus orientalis* and *P. martini*. The disease is highly endemic. Some 11 000 new VL cases were reported to the World Health Organization (WHO) in 2016 from six countries (Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda).

Cutaneous leishmaniasis (CL) is mainly caused by infection with *L. major* and *L. aethiopica*. It is transmitted by *P. papatasi*, *P. duboscqi*, *P. pedifer*, *P. longipes* and *P. aculeatus*. Some 4000 new CL cases were reported to WHO in 2015 from Ethiopia, Kenya and Sudan.

A WHO Bi-regional consultation on the status of leishmaniasis control and surveillance in East Africa was organized by the WHO Global Leishmaniasis Programme in collaboration with the WHO Country Office for Kenya. The meeting was held in Nairobi, Kenya from 12 to 14 June 2017. Participants were from national programmes and the country offices of WHO's African and Eastern Mediterranean regions, namely Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda, as well as partners from the Drugs for Neglected Diseases initiative (DNDi), the Foundation for Innovative New Diagnostics (FIND), the International Center of Insect Physiology and Ecology (ICIPE), KalaCORE, the Kenya Medical Research Institute (KEMRI), Médecins Sans Frontières (MSF), the University of Nairobi, the University of Navarra and the University of Tunis. Annex 1 contains the meeting agenda and Annex 2 the list of participants.

The consultation was moderated by Dr Sultani Matendecheo, Head of NTDs (neglected tropical diseases) at the Kenyan Ministry of Health, Dr José A. Ruiz-Postigo, Head of the Global Leishmaniasis Programme at WHO headquarters, and Dr Adiele Nkasiobi Onyeze, Medical Officer at the WHO Regional Office for Africa. The rapporteur Dr Mercedes Herrero, WHO consultant, wrote this report jointly with Dr Ruiz-Postigo.

The welcome address by Dr Ruiz-Postigo acknowledged the contribution of partners to VL control, including the commitment of governments and partners to advancing the agendas for control and elimination of the leishmaniasis. Dr Onyeze noted that WHO headquarters and partners as well as the Regional Office for Africa have in place the platforms necessary to implement activities, that great efforts have been made against those NTDs amenable to preventive chemotherapy, and that similar progress is needed now on leishmaniasis. Data and surveillance gaps are a major concern, hence the need to prioritize leishmaniasis on global health agendas.

On behalf of the WHO Representative for Kenya, Dr Iheoma Ukachi Onuekwusi helped to explain how the discussions would assist in advancing control of the leishmaniasis and reiterated WHO's continuing support to the Ministry of Health of Kenya.

The address by Dr Jackson Kioko, Director of Medical Services, Ministry of Health of Kenya, emphasized the high attendance of leishmaniasis partners and their commitment to overcoming the disease. Kenya is significantly affected by NTDs, but VL and CL are marginalized. The Ministry of Health has prepared the second strategic plan for NTDs 2016–2020 and is finalizing the revised national guidelines on leishmaniasis. The guidelines recommend combination therapy as a first-line treatment; this major step will have an impact on lowering the cost of treatment compared with that of sodium stibogluconate (SSG) monotherapy. Management of NTDs should be integrated into regular health systems to ensure that diagnostics and treatment are available. A recent (first case on 16 May 2017) outbreak in Kenya shows why programmes should be owned from the first line at grass roots and why the responsibility for investigation and response must be with the local staff and communities. In his final message to affected countries Dr Kioko said that “*they need to put in place functional surveillance systems and integrated methods for control ... there is a need to develop a common strategy at regional level as it [leishmaniasis] is one of the most endemic [diseases] in the world*”.

2. MEETING OBJECTIVES

The objectives of the meeting were:

- (i) to review the progress and challenges made in leishmaniasis control activities and strategies in the past year (2016), specifically in control of CL; and
- (ii) to elaborate an action plan for 2017 and identify the role of each partner, including the WHO AmBisome donation programme and the roll out of the leishmaniasis online surveillance system.

3. PRESENTATIONS



Dr J. A. Ruiz Postigo
WHO HQ

3.1 Leishmaniasis control and surveillance: progress and perspectives

Dr Ruiz-Postigo, WHO headquarter

The main points of the presentation are summarized below.

Surveillance and country profiles

<http://www.who.int/leishmaniasis/burden/endemic-priority-alphabetical/en/>

As part of a WHO-led effort to update the empirical evidence base for the leishmaniasis, country profiles on the 25 most endemic countries from each WHO region were updated in July 2016. However, the data were available only for 2014, hence the need to improve data collection and the reporting system in order to obtain more updated data from countries in a timely manner. The new country profiles summarize information collected for 18 indicators for VL and 12 indicators for CL on epidemiology, control and surveillance, diagnosis and treatment outcome (http://www.who.int/leishmaniasis/burden/Country_profiles/en/). The 2015 country profiles are almost final and data are available online for countries and partners through the WHO Global Health Observatory (http://www.who.int/gho/neglected_diseases/leishmaniasis/en/).

Progress on real-time online surveillance

WHO has been supporting VL endemic countries to set up the health management online information system for leishmaniasis based on the DHIS2 (District Health Information System) software. Health ministries in countries that have chosen to use DHIS2 as the health information system are supported by WHO to gain expertise and become users of this friendly system. For countries where the health ministry uses another tool to collect or gather data, WHO has developed an application to easily import data from Excel to the online platform. In addition to the routine aggregate data collected every month, the district hospitals can use the DHIS2 tracker module or event capture to capture case-based data from inpatient admissions and deaths, enabling more accurate morbidity and mortality statistics and data analysis.

The DHIS2 platform has been set up or is in progress in several countries for VL surveillance (Bangladesh, India, Kenya, Nepal, Somalia, Sudan and Uganda). Training workshops were conducted in more than 12 countries in 2016, with over 60 participants.

AmBisome donation

http://www.who.int/neglected_diseases/news/WHO_and_Gilead_Sciences_extend_collaboration/en/

In September 2016, WHO and Gilead Sciences signed a new agreement for the donation through WHO of an **additional 380 400 vials** of AmBisome (liposomal amphotericin B for injection), extending their previous agreement to 2021. The donation will benefit key endemic countries in South-East Asia, where the medicine is used as first-line treatment (Bangladesh, India and Nepal), but recipients will also include the eastern Africa subregion, where AmBisome is used as second-line treatment to treat severe or complicated cases (under discussion to include Kenya as part of the donation).

Case management manuals

Manuals for surveillance of CL and VL were developed in 2016, e.g. for the WHO European Region, and support was provided to national programmes, such as the recently finalized national guidelines for VL in Kenya. The WHO South-East Asia Regional Office published a document on the process of validating the elimination of kala-azar as a public health problem in South-East Asia¹ also in 2016.

Managerial considerations

Finally, in his presentation, Dr Ruiz-Postigo led discussions about managerial considerations, such as increasing human resources at country, regional and headquarters' levels, in order to expand delivery of activities in response to the increased demands of national programmes and partners. Funding increases and accountability to donors were stressed in line with the messages: *“risk of continuation of financial support if results are not tangible”* and *“WHO has commitment with donors and beneficiaries of the programme and we need to ensure we deliver high-quality activities on time”*. Mechanisms to support countries were proposed, including monthly teleconferences to discuss programme challenges and achievements. Teleconferences are taking place with Sudan and Ethiopia; Kenya, Somalia and Uganda will be added soon. They improve communication through informal channels, such as telephone or WhatsApp instead of email, clarify and accelerate resolution of issues and avoid misunderstandings.

Dr Ruiz-Postigo made a proposal to encourage the organization of the next regional meetings by the WHO regional offices.

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