World Health Organization
Regional Office for South-East Asia

Regional Technical Advisory Group (RTAG) for the Kala-azar Elimination Programme

Report of the Fifth Meeting
Paro, Bhutan, 17-19 September 2013

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Acronyms

ASHAs	accredited social health activists
DAT	direct agglutination test
DDT	dichlorodiphenyltrichloroethane
DNDi	drugs for neglected diseases initiative
EVM	environmental management
iOWH	one world health
IRS	indoor residual spraying
ISC	Indian subcontinent
ITNs	insecticide-treated nets
IVM	integrated vector management
KA	kala-azar
LAMB	liposomal amphotericin B
LAMP	loop-mediated isothermal amplification
LST	leishmanin skin testing
MoU	memorandum of understanding
MSF	Medicines sans Frontières
NTDs	neglected tropical diseases
PHC	primary health care
PKDL	post-kala-azar dermal leishmaniasis
QPCR	quantitative polymerase chain reaction
RDT	rapid diagnostic test

RTAG	Regional Technical Advisory Group
SEA	South-East Asia
SSG	sodium stibogluconate
TDR	Research and Training in Tropical Diseases
VL	visceral leishmaniasis
VL–HIV	visceral leishmaniasis–human immunodeficiency virus coinfection
WHO	World Health Organization

Executive summary

Kala-azar (KA) or visceral leishmaniasis (VL) is the second largest parasitic killer disease in the world after malaria and it is one of the most dangerous neglected tropical diseases (NTDs). The disease is prevalent in Bangladesh, India and Nepal in the WHO South-East Asia (SEA) Region. Recently, Bhutan started to report sporadic cases of KA. The disease affects the poorest communities in these countries and kills the patient if left untreated for a long time. Globally it is estimated that 200 000–400 000 new cases and 20 000–40 000 deaths occur every year. An estimated 147 million people in 119 districts in 4 countries, namely Bangladesh, Bhutan, India and Nepal, are at risk. India alone accounts for about 50% of the global burden. With little data on the burden of post-kala-azar dermal leishmaniasis (PKDL), surveillance needs to be established and/or strengthened for PKDL. The role of asymptomatic leishmania infection is not clear and further studies are needed. Diagnosis in past kala-azar cases, PKDL and asymptomatic infections, and test of cure are difficult as there are no tools currently available or the existing tools are not well standardized.

As recommended in the Fourth Meeting of the Regional Technical Advisory Group (RTAG), liposomal amphotericin B (LAMB) as single dose (10 mg/kg) (or multiple doses (15 mg/kg)) is the first choice regimen for the Indian subcontinent (ISC) in the attack phase. The combination regimens (LAMB/paromomycin, LAMB/miltefosine, and paromomycin/miltefosine) have been recommended as a second choice regimen, and to be used as a long-term strategy. Monotherapy with miltefosine was recommended to be