Part III.IV Leishmaniasis: The Future

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The Past

Old World cutaneous leishmaniasis was well known over 2000 years ago long before it was realised that it was caused by *Leishmania*. Because of its long healing time of several months and the resulting ugly scars, it was, and still is, an important public health problem. It was Carini in 1911 who discovered the mucosal lesions of South American leishmaniasis. Kala-azar was described for the first time by Leishman in 1903, and though less impressive than the cutaneous forms it represents, by its high mortality, the most important health problem amongst the diseases caused by *Leishmania*.

The Present

Leishmaniasis is endemic in over a hundred countries. Its prevalence at world scale is unknown because of the absence of reliable data-collection from most of the endemic areas, and the lack of such data due to inadequate diagnostic facilities. In many of the endemic areas, leishmaniasis was reduced considerably as a result of the malaria vector control programmes after the Second World War. With the cessation of many of these programmes, leishmaniasis has re-emerged. There are few nationwide programmes for the control of leishmaniasis and local programmes within countries are not well known. The reasons why leishmaniasis control has not received as much attention as one would expect are firstly, because the health importance of leishmaniasis control has often been underestimated; secondly, the precontrol epidemiological investigations requiring field scientists and expertise for their interpretation forms, for many a health service, an unsurmountable obstacle; and thirdly, health budgets in the developing world are restricted, and the financial means to design a control programme correctly are often not available.

The Near Future

To stimulate the development of control programmes it is obligatory to simplify the preparatory studies as well as the control techniques and to reach the best possible compromise between a technically ideal solution and one suited to the operational restrictions. The first and simplest step is to ensure that leishmaniasis can be detected. By providing diagnostic facilities and drugs together with the necessary training and a simple reporting system, the relative importance of leishmaniasis in

the various areas can be assessed and monitored. At the same time, human suffering will be alleviated and the transmission rate may fall. Once the prevalence and the geographical boundaries of transmission are more or less known, the areas where preventive measures are indicated can be identified and in some regions, the decision can be taken to opt for a control strategy based on the experience obtained in well-studied similar ecological situations in similar regions. Where more detailed epidemiological studies will be needed, an international corps of public health oriented leishmaniasis experts could be made permanently available for training, *ad hoc* participation in preliminary studies and for evaluation. International support for establishing national control programmes should include: (1) *ad hoc* technical support; (2) organisation of training and distribution of manuals for control (3) establishing international liaison for supplies; and (4) assistance in identifying suitable donors.

The Long Term Future

Research into further simplification of diagnosis and evaluation of the newly-developed serodiagnostic test will lead to better detection of patients. New drugs could make chemotherapy, and particularly the treatment of mucocutaneous leishmaniasis, more effective and safe. Leishmanization could be standardized and eventually replaced by a vaccine. Advantage could also be taken of ecological modifications to be planned as part of rural development schemes.

REFERENCES

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Finally, we would like to dedicate the proceedings of the Centenary Event to Colonel H E Shortt on the occasion of his reaching his 100th year.