

Communicable Disease Newsletter

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World Health Organization Regional Office for South-East Asia, New Delhi



Dr Margaret Chan is the new Director-General of WHO



Dr Margaret Chan assumed the office of the Director-General of WHO on 4 January 2007, after being appointed by a special session of the World Health Assembly on 9 November 2006.

She had earlier served as Assistant Director-General for Communicable Diseases and the Representative of the Director-General for Pandemic Influenza.

In her acceptance speech to the World Health Assembly, Dr Chan outlined her vision to focus on six key issues: health development, security, capacity, information and knowledge, partnership and performance.

Dr Chan has immense knowledge and international experience in the field of communicable diseases, health regulation, environmental health and chronic diseases among others. Prior to joining WHO in 2003 as Director, Department of Protection of Human Environment at Headquarters in Geneva, Dr Chan was the Director of the Department of Health of the Hong Kong Special Administrative Region of the People's Republic of China.

Dr Chan has first-hand experience in dealing with new and emerging infectious diseases. She provided outstanding leadership in combating the H5N1 outbreak in 1997 and the SARS outbreak in 2003.

Dengue outbreak in Bhutan

The local hospital in the border town of Phuntsholing in Bhutan observed an increased number of cases of fever, with rashes appearing after three to four days of illness, occurring at the end of June 2004. Malaise, headache, body aches, joint pain and vomiting were also reported by the patients along with high fever. This unusual increase of cases of fever with rashes in most patients prompted hospital authorities to inform the national authorities on 5 July. A retrospective analysis of the weekly cases of fever over the last four years indicated that the number of fever cases in 2004 was unusually higher than in previous years (Figure 1).

Epidemiology

Of the 495 such cases of fever, nearly 24% of the patients needed admission. The male-female ratio of affected persons was 2:1. All age groups were affected but about 80% were adult patients.

Nearly 26% of cases had evidence of shock and only 3% met the WHO criteria for Dengue Shock Syndrome. No dengue deaths were reported.

Entomological studies showed the presence of *Aedes aegypti* indoors as well as *Aedes albopictus* in outdoor settings. Single serum samples were sent for testing in India and Thailand. Of the 35 samples tested in Kolkata 3 (8.6%) were positive for IgM antibody, while 5 (14.3%) were positive for IgG antibody to dengue virus. Out of 52 samples processed at NICD, Delhi, 12 (23%) showed IgM antibody to dengue virus. Of the 8 different samples sent to AFRIMS, Bangkok, results were suggestive of acute primary dengue infection in 2 (25%) cases and acute secondary dengue infection in one case.

Outbreak control activities

For control measures, equal emphasis was given to vector control, case management and

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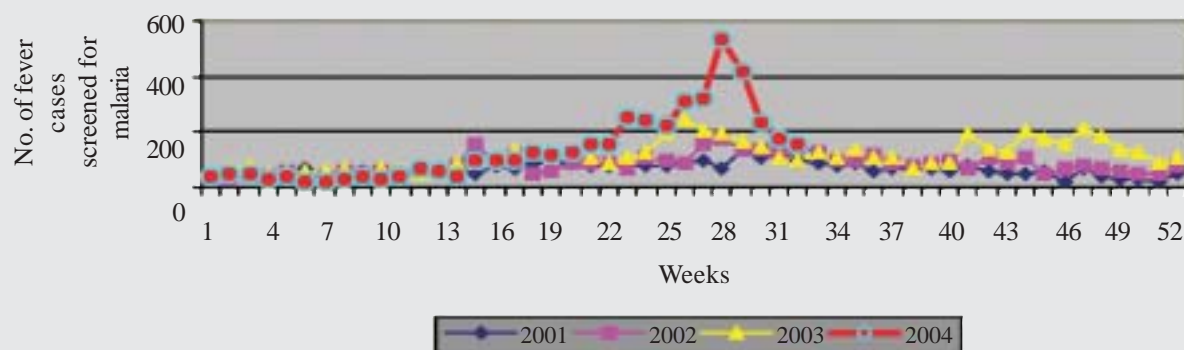
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Fig 1: Unusually high fever cases seen in Phuntsholing Hospital in June 2004 as compared to previous years



awareness creation among health workers, the public and administrators.

Thermal fogging with 1.25% Deltamethrin was carried out for three consecutive days from 10 to 12 July to ensure a knock-down effect on the vectors and this was repeated for another three days to eliminate residual vectors. IEC Materials for awareness campaigns were prepared focusing on personal protection and prevention methods. All the other districts were notified to step up vector surveillance wherever relevant and disease surveillance. For diagnosis and case management, the WHO protocol on management of Dengue/DHF was adapted. Doctors and health workers from nearby districts were also briefed on the diagnosis and management of dengue cases.

A total of 2517 cases compatible with dengue symptoms were seen in the out-patient department, an average of 100 to 150 patients per day, till 15 July. Thereafter, the cases declined dramatically.

A Multisectoral meeting was held to stress on source reduction chaired by the head of the local administration. The City Corporation initiated and supported mass cleaning campaigns involving all sectors including the business community. Health and city corporation teams carried out house to house entomological surveys. Simultaneously, whenever positive containers were found, anti larval measures were taken.

The following year (2005) only 11 cases compatible with dengue were reported from Phuntsholing. In 2006 from July to September, out of the 394 suspected dengue cases 88 (22%) tested positive and the serotyping performed by AFRIMS, Bangkok confirmed same was to be DENGUE-3.

Conclusions

To control an outbreak of dengue, it is important to reduce rapidly the density of the vectors with simultaneous control of breeding places and awareness campaigns. These strategies

with a multi-sectoral response and community participation have been the key for controlling the outbreak in Bhutan.

Now that dengue has emerged for the first time in Bhutan there is no room for complacency. The challenges are to prevent the spread of dengue to other areas, effective control of the foci of dengue and strengthen disease and vector surveillance to prevent outbreaks, and to involve the communities and other sectors in this fight against dengue.

Karma Lhazeen
TDR Fellow, SEARO/New Delhi

CALL FOR APPLICATION FOR SEARO-TDR RESEARCH ON TROPICAL DISEASES (2007)

The South-East Asia Regional Office (SEARO) of the World Health Organization in collaboration with the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) requests submission of research proposals focused on the following diseases: dengue, kala azar, leprosy, lymphatic filariasis, malaria, schistosomiasis and tuberculosis.

How to apply: The original proposal must be sent through appropriate government channels to the concerned WHO Country Office, to be forwarded to SEARO. The deadline for submission of applications is 2 March 2007.

Proposal submission: The proposal must be submitted using the standard Proposal Form should be based on the Guideline for Writing a Research Proposal (Protocol). PROPOSAL FORM AND GUIDELINES are available on the WHO/SEARO website. (www.searo.who.int)

Young people and HIV/AIDS: the problem and response so far

Globally, an estimated 40 million people were living with HIV/AIDS by the end of 2006 and another 25 million had died of the disease. Nearly 7 million are living in the SEA Region, next only to Africa. Of these, young people account for half of all new HIV infections. Each day, six thousand young people become infected with HIV.

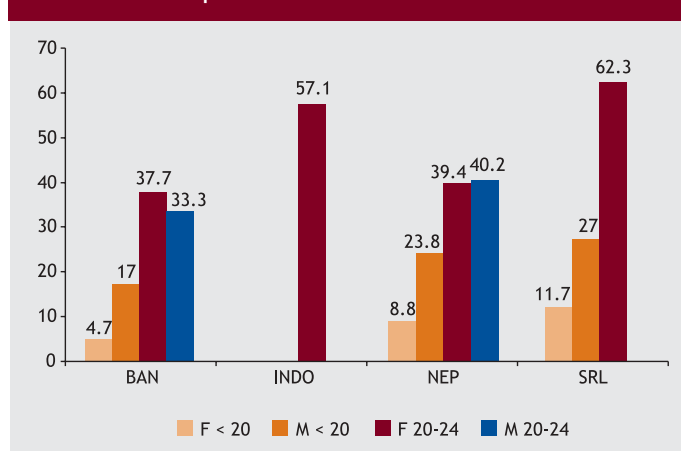
The vulnerability factors

In South-East Asia, as in other parts of the world, rates of HIV/AIDS are high among young people. According to WHO, nearly 2 million people living with HIV/AIDS in South-East Asia are between 15-24 years.

In many countries, the majority of young people are sexually active by the age of 20 and the age of sexual debut is lowering. A large number of injecting drug users (IDUs), sex workers (CSWs), and men having sex with men (MSM) are young people. Young people are at greatest vulnerability to HIV/AIDS, but are the least likely to have the knowledge, skills and access to services to protect themselves and their partners.

To meet the goals of the UN General Assembly Special Session on HIV/AIDS (UNGASS) and the MDGs, young people need access their services to reduce vulnerability to HIV/AIDS. WHO is working to strengthen and accelerate country-level health sector action in relation to young people and HIV/AIDS and thereby enable a range of actors to maximize their contribution to an expanded response for achieving the global goals. This will include a focus on “4 S”, Strategic information, Services and supplies, Supportive policy environment and Strengthening action in other sectors.

Fig 2: Knowledge of two or more methods of prevention of HIV/AIDS



Source: BAN-DHS 1999-2000, INO-DHS 2002-03, NEP-DHS 2001, SRL-DHS 2000

Addressing needs of young people: progress so far

To develop linkages between HIV/AIDS and adolescent sexual reproductive health programmes, WHO/SEARO organized a regional consultation on HIV/AIDS among young people, in Chiang Mai, Thailand, in October 2005. Programme managers from HIV/AIDS and adolescent health and development agreed on a common framework for implementing activities at country level and reviewed and provided feed back on the draft regional strategy on HIV and young people.

Technical assistance was provided to Bangladesh in developing national standards for youth friendly health services (YFHS) as a part of a programme on HIV/AIDS among YP funded by GFATM. Technical assistance was also provided to Sri Lanka in developing national standards for YFHS. In India, national standards, adaptation of packages for medical officers and health care workers and implementation guidelines have been finalized in collaboration with the Ministry of Health and Family Welfare, WHO and UNFPA. Implementation guidelines and training packages have been disseminated to all the states.

In order to understand the existing laws and policies affecting young people's access to health services and to strengthen the evidence base for policies and programmes consultation was held with partners like International Paediatrics Association, International Planned Parenthood Federation, International Association for Adolescent Health on issues relating to consent and confidentiality, in July 2006. The meeting identified strengths and weaknesses of the current policies and practices and identified priorities for action. WHO/SEARO in collaboration with WHO/HQ is developing guidance for service providers and mid level managers to assist them to respond more effectively to the specific needs of adolescents in relation to consent and confidentiality.

To review progress and to look at the evidence for effectiveness of interventions to prevent the spread of HIV among young people, WHO in collaboration with the UNAIDS Inter-agency Task team on Young People, UNFPA and UNICEF has developed a joint technical report series on preventing HIV/AIDS in young people after a systematic review of the evidence from developing countries. This identifies what should be done now to reduce HIV infection in young people, and achieve the global targets set by the world leaders.

Natasha Dawa & Neena Raina
AHD, SEARO/New Delhi

Chikungunya: a re-emerging disease in Asia

Epidemics of fever, rash and arthritis, resembling Chikungunya fever have been recorded as early as 1824 in India and elsewhere. Subsequently, outbreaks of Chikungunya fever have been detected in many parts of Africa and Asia.

Chikungunya virus belongs to the Alphavirus genus of the Togaviridae and is primarily transmitted by bites of mosquitoes of the genus *Aedes*, the same mosquito that transmits Dengue Hemorrhagic fever. Infection with chikungunya virus results in high fever with abrupt onset, myalgia and sudden intense pains in one or more joints. Accompanying signs and symptoms include headache, sometimes nausea and vomiting, coryza, conjunctivitis, photophobia and retro-orbital pains. Maculopapular rash develop on the 2nd to 5th days, sometimes accompanied by petechia. The clinical manifestations of Chikungunya fevers have to be distinguished from dengue fever, with which it often occurs. In the early stages when rash is absent, malaria has to be ruled out; and if rash is present, rubella infection has to be ruled out.

Factors triggering outbreak

Major epidemics appear and disappear cyclically, usually with an inter-epidemic period of 7-8 years and sometimes as long as 20 years. Interestingly, chikungunya and dengue fever virus tend to occur concomitantly but eventually, the dengue virus displaces the chikungunya virus. It is possible that minor chikungunya epidemics may go unnoticed especially in areas where dengue fever is prevalent. The epidemiology of Chikungunya fevers can be explained in terms of ecological factors that may be responsible for this cyclic phenomenon.

The principal factors are existence of different cycles for transmission; the density and competency of the mosquito vector; the anthropogenic activities creating artificial breeding sites for the mosquito; the evolution of the virus and the susceptibility of the population.

The role played by antibodies to Chikungunya viruses in determining the onset or offset of epidemics are not known



Swollen and painful joints associated with chikungunya fever

The principal vector for chikungunya fever is generally believed to be the Culex mosquito, *Aedes aegypti*. However, there is evidence to believe, especially in urban settings that *Aedes albopictus* can also serve as a competent vector. This contention is supported by studies demonstrating *Aedes albopictus* to be a more competent laboratory vector of chikungunya virus than *Aedes aegypti*. However, it has been observed that not all strains of *Aedes albopictus* are equally competent to transmit chikungunya virus: *Aedes albopictus* strains from different geographic parts of India vary in their susceptibility and transmissibility to chikungunya virus.

clearly. Sero-epidemiological surveys from India, Myanmar, Indonesia and Senegal have shown that between 35-60% of the population are infected with the chikungunya virus, prior to the onset of an outbreak, indicating a herd immunity of more than 60% for the prevention of outbreaks.

This phenomenon is also highlighted from the ongoing Chikungunya outbreaks in Reunion Island where the epidemic has not yet abated in spite of having infected about 33% of the population. The outbreaks in the Indian Ocean islands also show that the chikungunya viruses are evolving in its envelope proteins (E1). As the outbreak progresses, there is a shift in genotype of the E1 type showing a genetic mutation. The significance of these observations in causing epidemics remained to be established.

Controlling outbreaks

There is neither specific clinical treatment nor vaccines available against Chikungunya fevers. Therefore prevention is entirely dependent upon taking steps to avoid mosquito bites and elimination of mosquito breeding sites. Public health measures such as reduction of mosquito breeding sites (removal of all open containers with stagnant water in and round houses, or, if that is not possible, treatment with larvicides) have to be instituted for the prevention and control of chikungunya fever. The control measures are very similar to those used for dengue fevers.

Generally, during an inter-epidemic period, the number of infected adult mosquitoes is few so the emphasis should be on environmental control of mosquito larvae to limit the density of the mosquito population. However, during an epidemic period, there is an increase in the number of infected-adult mosquitoes so one should control both the larvae and the adult mosquito population in addition to limiting exposure to mosquito bites by personal protective measures.

XDR TB and its implications for the SEA Region

XDR TB, or extensive drug-resistant TB, is a new entity and is currently defined as resistance to the 2 most potent anti-TB drugs, isoniazid and rifampicin, (MDR-TB) plus resistance to fluoroquinolones and one of the second-line injectable drugs, (amikacin, kanamycin, or capreomycin). These strains leave patients with few treatment options that meet international standards.

Epidemiology

The burden of anti-TB drug resistance in the Region is not well documented as few countries have capacity to undertake mycobacterial cultures and drug susceptibility testing. India, Nepal, Myanmar and Thailand have undertaken and published results on population-based drug-resistance surveys (DRS) in the past 5 years. There is therefore, an urgent need in the Region to accelerate the development of the laboratory capacity to establish regular nation-wide drug resistance surveillance (DRS) in countries in the Region. From available survey data, WHO had estimated in 2006, that the prevalence of multi-drug resistant tuberculosis was less than 4% among previously untreated cases in the SEA Region. Among previously treated cases, the prevalence of MDR-TB was estimated to be 14.9%.

XDR-TB in the SEA Region and its implications

Very little data is available from countries in the South-East Asia Region on XDR-TB, since this requires drug susceptibility testing for second-line drugs. At the Tuberculosis Research Center, Chennai, between May 2000 and March 2005, 66 patients from the Chennai area with MDR-TB had isolates tested for second-line drug resistance and XDR-TB was found in only 1 isolate (1.5%). While this represents a minimum estimate due to the limitations in testing, these findings suggest that XDR-TB is rare at this time.

The emergence of XDR TB could seriously jeopardize the success of TB control programs in the Region. Second-line drugs are widely available throughout the South East Asia Region, and largely prescribed outside of national programmes, except at a few pilot sites. In the absence of standardized treatment protocols and unsupervised use, the risk of developing resistance to these drugs is high. It is currently unknown as to how many patients are being treated using these drugs.

Preventive Measures

Preventing the emergence of drug resistance requires a sustained quality DOTS implementation. There is need for strengthening the national capacity for quality-assured laboratory diagnosis of MDR and XDR-TB and supporting

Fig 3: Second Line Drug Classes for Treatment of MDR TB

Aminoglycosides	Amikacin, Kanamycin
Polypeptides	Capreomycin
Fluoroquinolones	Ciprofloxacin, Ofloxacin
Thioamides	Ethionamide, Protionamide
Cycloserine	
PAS	

XDR is defined as an MDR isolate resistant to 2 of the 6 major classes of second-line drugs.

the establishment of appropriate management of MDR-TB through expansion of DOTS-Plus treatment programmes using internationally recommended case management protocols. Intensified support and help to mobilize resources for MDR-TB management and gather the evidence needed to inform ongoing response and action, including providing relevant information to all stakeholders, including the media, are important priorities.

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SEARO Training Course on Leadership and Strategic Management for TB Control

The goal of this training is to provide programme managers with the necessary understanding and skills to develop and strengthen the management of TB programmes in countries. The skills learnt through these modules could, however, well be applied in the context of other disease control programmes.

The training course includes the following modules that may be used independently or as a complete package

- Managerial Styles
- Building Partnerships
- Personal Effectiveness
- Role Efficacy
- Communication Skills
- Team Building
- Leadership and Leadership Styles

Each module comprises an introduction which states the objectives of the module, information that will assist the participant in achieving the objectives of the module, exercises with instructions to enable participants to analyze their present capabilities and strengthen these, or acquire new skills.

WHO in the countries: Timor-Leste

Integrated control of communicable diseases initiative in Timor-Leste



*Dr Alex Andjaparidze
WR Representative in
Timor-Leste*

Tuberculosis, malaria, dengue, diarrhoeal diseases, Japanese encephalitis, intestinal parasitic diseases, filariasis and leprosy are major health problems in Timor-Leste. HIV/AIDS prevalence, while small in comparison with the above and confined primarily to high-risk populations, continues to be a worry. Malnutrition, particularly under-nutrition resulting from food insecurity, continues to be a priority concern. 42.6% of children below five years of age have been found to be underweight and 46.7% of were found to be “too short” or stunted.

Genesis and implementation of the Integrated Programme

While developing operational guidelines and manuals, training materials, tools for monitoring and evaluation to implement the strategies for lymphatic filariasis (LF) and Intestinal Parasitic Infections (IPI), suggestions to integrate additional interventions, particularly that of detection of suspected TB, leprosy and other skin infections with mass drug administration (MDA) were made. Emanating from this the training materials and operational guidelines produced included instructions on not only how to conduct MDA but also to detect suspected cases of TB, leprosy and other skin infections.

National strategy for Lymphatic Filariasis and Intestinal Parasitic Infections control in Timor-Leste includes once-yearly combined administration of diethylcarbamazine (DEC) and albendazole to all except children under 2 years of age, pregnant women, and very sick individuals; a single albendazole dose to be given to children aged 2-16 years after 6 months of the once yearly administration of DEC and albendazole; and a single Pyrantel dose every 6 months to children aged between 6 months to 2 years of age.

Step-by-step approach to planning and implementation of the initiative

At first the selected district was stratified using geographical information system (GIS), identified number of population, number of trainers required for conducting training of volunteers, number of volunteers, logistical support and

National strategy for lymphatic filariasis (LF) and Intestinal Parasitic Infections (IPI) control in Timor-Leste

- Once-yearly combined administration of diethylcarbamazine (DEC) and albendazole to all except children under 2 years of age, pregnant women, and very sick individuals.
- A single albendazole dose to be given to children aged 2-16 years after 6 months of the once yearly administration of DEC and albendazole.
- A single pyrantel dose every 6 months to children aged between 6 months to 2 years of age.

possible involvement of church, teachers and representatives of national and international NGOs operating in the district.

In the second stage, Ministry of Health and WHO visited the district and carried out orientation of administration and district health staff, the Church, teachers, representatives of the community and national and inter-national NGOs operating in the district on the integrated programme and steps to be undertaken to successfully implement the activities. The Suco (village) Chiefs were requested to select volunteers who were able to read and write, communicate well and well known and respected in the community. The required number of volunteers for the village was determined on the basis that each volunteer will visit maximum 40 households during the operations.

The next stage included visit of trainers from the Institute of Health Science and Ministry of Health to conduct two-day Training of the Trainers, using the training manuals and modules on conducting MDA, detection of suspected TB, leprosy and skin infections. After the training, the trained facilitators conducted two-day training of volunteers.

The trained volunteers conduct a series of household visits. In the first visit they register every household member and provide information on the control programme. During their second visit they provide Pyrantel to eligible children. On the third visit, they provide albendazole and diethylcarbamazine (DEC) to every child over 2 years in the household. On the fourth visit, they assess drug reactions, if any, and search for suspected



Volunteer administering drugs

cases of TB, leprosy and skin infections. Additionally, every six months children aged between 6 months and 16 years receive another dose of either pyrantal or albendazole as appropriate for their age. The list of households that received the drugs, as well as the list of persons having symptoms of TB, leprosy and skin infections are then provided to the Community Health Centers (CHC) for follow-up. This schedule is to be repeated every 12 months for five years.

The model was piloted in the most difficult district of Oe-cusse in February 2005 and since then suitable modifications were made based on the lessons learnt. Since the commencement of this programme in February 2005, more than 650,000 people (approximately 65% of Timor-Leste's population) in eight districts have been treated and data

suggests that treatment coverage of 92-100% have been achieved. If financial resources are available the remaining 5 districts will also implement the integrated programme.

The programme commenced with the financial support of the Sasakawa Health Memorial Foundation and Australian Government. Later on resources were also provided by USAID. So far the Institute of Health Sciences, Ministry of Health and WHO have jointly trained over 250 facilitators and 3,250 health volunteers. The WHO Collaborating Centre for Control of Lymphatic Filariasis, James Cook University in Australia and Aichi Medical University in Japan are providing assistance to the Ministry of Health to undertake necessary monitoring and evaluation. Sentinel sites for microfilaria surveys have been established.

Conclusions

The initiative so far has detected more than 800 and 95 suspected cases of TB and leprosy respectively and were referred to the health facilities for further investigation and diagnosis. In addition, many cases of skin infections were also referred, including suspected cases of yaws. Out of the 95 suspected cases of leprosy, 53 were confirmed.

The success of the programme is associated with the free supply of albendazole through the Global LF Elimination Programme and active collaboration with the Country Office by WHO/HQ, WHO/SEARO, Ministry of Health and other collaborating institutions. It is hoped that the representatives of the donor countries will be able to identify resources for continuation of this important programme in Timor-Leste.

WHO establishes a Regional CSR sub-unit in Bangkok

On 27 October 2006, H.E. Dr Mongkol Na Songkhla, Minister of Public Health, Thailand and Dr Samlee Plianbangchang, Regional Director, WHO SEAR signed an agreement formalizing the establishment of the first Communicable Diseases Surveillance & Response sub-unit based in Bangkok. The main role of the sub unit will be to provide technical assistance in the field of disease surveillance and outbreak response to Member countries by bringing WHO operations closer to the countries, as an example of decentralization. SEARO is currently engaged in a similar agreement with the Ministry of Health and Family Welfare, India for another sub-unit to be based in Delhi.



News Bytes

World AIDS Day, 1 December 2006 “STOP AIDS, Keep the Promise”: Some features

To commemorate World AIDS Day 2006, the HIV/AIDS Unit, SEARO organized a series of activities.



◀ A press seminar on the theme, “Stop AIDS. Keep the Promise” with a focus on scaling up services for populations in need was held in the Regional Office. Media representatives from the Region visited selected HIV/AIDS programmes in Thailand and India involving vulnerable populations such as sex workers, injecting drug users, men having sex with men and young people. A photo exhibition was also displayed.

JAMGHAT, an NGO working for street children and youth in Delhi, performed a skit and organized a series of street plays in the city targeting young people and street youth to raise awareness on HIV/AIDS.



◀ In **India**, the National AIDS Control Organization (NACO) held a major event on 30 November 2006 at Indira Gandhi Indoor Stadium, in which more than 15 000 youth participated. A ‘Paediatric Initiative’ was launched at Kalawati Saran Children Hospital in Delhi. It was inaugurated by the UPA Chairperson Mrs. Sonia Gandhi. Former US President Mr. Bill Clinton, a guest of honour for the event, announced a successful deal with pharmaceutical companies to supply cheap antiretroviral drugs to HIV-positive children in India.

In **Bhutan**, World AIDS Day was commemorated at the football ground in Samtse on December 1. The UNFPA Goodwill Ambassador, Her Majesty the Queen Ashi Sangay Choden Wangchuk, who attended the programme, highlighted the need for partnerships in stemming the spread of HIV and prevent discrimination against those affected by HIV/AIDS.



In **DPR Korea**, more than a hundred HIV/AIDS UN Theme Group members and international diplomats gathered at the WR Office to observe the World AIDS Day.

A campaign for officials to wear the red ribbon from 1-7 December 2006 to show solidarity with people living with HIV/AIDS was launched in **Maldives**. At an official programme to mark Republic Day, H.E. the President of Maldives and all participants sported HIV/AIDS ribbons.

In **Indonesia**, at a major event that took place at Bunderan HI – Thamrin, people living with HIV, joined members of government and non governmental organizations, civil society, media and any others working on HIV/AIDS participated in a candle light ‘Long March’.

World AIDS Day was observed in all the other member countries also. The key messages delivered this year were to advocate for continued action to increase access to HIV interventions among vulnerable populations and to accelerate the commitment for scaling up HIV/AIDS interventions from all relevant development partners, decision making bodies, government leaders, programme managers, the media and others involved in the campaign against HIV/AIDS.

Dhaka: The SEA Regional Committee passes a resolution on eradication/elimination of tropical diseases

The 59th Regional Committee recognized that leprosy, kala-azar, lymphatic filariasis and yaws are significant health problems in the Region that affect the most vulnerable and marginalized populations but are amenable to eradication/elimination in view of the availability of safe, simple and cost-effective interventions. It passed a resolution urging Member States to continue to accord high priority to these diseases, include them in their national development plans, allocate appropriate budgetary support and scale-up safe and cost-effective interventions while making them accessible to all affected populations, particularly the vulnerable groups. WHO is to increase technical support to countries to intensify efforts towards eradication/elimination of these diseases and mobilize funding from external sources to support national efforts, the Regional Committee resolved.

Dhaka: Health Ministers endorse the Revised Malaria Control Strategy

The 24th meeting of Ministers of Health of countries of the South-East Asia Region endorsed the revised SEA Region Malaria Control Strategy in Dhaka, Bangladesh in August 2006. The key elements of the revised strategy include evidence-based programme management, balance between prevention and treatment interventions, emphasis on



ecological, environmental and behavioural determinants that play a key role in disease transmission, research and the building of a strong monitoring and evaluation system.

Geneva: Global Malaria Programme recommends the use of indoor residual spraying with DDT

WHO now recommends the use of indoor spraying not only in epidemic areas but also in areas with constant and high malaria transmission, including throughout Africa. Of the dozen insecticides approved as safe for indoor spraying, the most effective is DDT. Well-managed indoor spraying programmes using DDT pose no harm to wildlife or humans. In the SEA Region, DDT is still used for malaria and kala-azar control in India and for malaria epidemics in Myanmar. Its use however has become limited as several primary mosquito vectors have developed substantial resistance.

Bangkok: Dr Dilip Mahalanabis, a pioneer of Oral Rehydration Therapy awarded the 2006 Prince Mahidol Award

Dr Dilip Mahalanabis, Director of the Society for Applied Studies, a non governmental research organization in Kolkata, India, Prof. Stanley G. Schultz from Houston Medical School, University of Texas, Dr David R. Nalin, former Director of Vaccine Scientific Affairs at Merck & Co's Vaccine Division in Pennsylvania, and Dr Richard C. Cash, from the Harvard School of Public Health in Boston, were awarded the prestigious 2006 Prince Mahidol Award for research that led to an inexpensive but effective treatment of severe diarrhoea.

The four, selected from among 59 nominees in 29 countries, dedicated their careers during the 1960s and the 1970s to the discovery, introduction and widespread use of Oral Rehydration Solution (ORS) or Oral Rehydration Therapy (ORT). Five million children under the age of five died from severe diarrhoea annually in the years before this simple, inexpensive and effective treatment was introduced.

Bangkok: SEARO organizes a workshop to introduce table-top exercises for pandemic preparedness

Member countries of the WHO South-East Asia Region were introduced to the SEARO step-by-step guidelines on table-top exercises for pandemic preparedness at a workshop held from 30 November to 1 December 2006. A guide for conducting table-top exercises for use in countries which was developed by CSR with inputs from technical experts was discussed at the workshop and the final version approved. Countries will conduct exercises based on the Guide and test the preparedness plans to see that they would be able to stand up to a real pandemic. All countries in the Region have National Influenza Pandemic Preparedness Plans that set out strategies and actions for prevention and control of avian influenza.

Bangkok: SEARO Member countries discuss regional preparedness and response for emerging diseases

WHO SEARO organized a meeting on preparedness and response to emerging diseases in Bangkok, from 27-29 November 2006. The meeting focused on helping countries to assess their capacity for preparing and responding to emerging diseases using the Asia-Pacific Strategy on Emerging Diseases (APSED) workplan and in the context of the IHR (2005). The outcome was an action plan outlining the next steps for member countries and SEARO in achieving the objectives of the emerging disease strategy as well as for implementing IHR 2005 to detect and respond to public health threats.

Jakarta: Call to stop TB in Asia launched, aiming to half TB deaths by 2010

A meeting of partners to control TB in the South-East Asia Region was held from 27-30 November 2006 in Jakarta, Indonesia. The meeting coincided with the 11th meeting of the Stop TB Partnership Coordinating Board. Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, said in his message "The key issue before us is whether we have the means to implement the new Stop TB Strategy successfully over the next 10 years. One of the main concerns is to reach the unreached; the poor, underserved and the marginalized. We have to ensure that our plans to alter the course of TB, TB/HIV and drug-resistant TB in the South-East Asia Region are effectively implemented in the years ahead".

Members of the Stop TB Coordinating Board and participants at the meeting of partners for TB control in the South-East Asia Region endorsed 'the call to stop TB in Asia'. The Call to Stop TB in Asia urges all decision-makers, national and local governments, technical and financial partners to fully support the implementation of the new Stop TB Strategy in Asia, recognizing that success in Asia would be critical for TB control globally on the road to achieving the Millennium Development Goals.

New Delhi: Sasakawa Memorial Health Foundation Advisory Board meets in Delhi.

The annual meeting of the Sasakawa Memorial Health Foundation (SMHF) Advisory Board with WHO was held in SEARO from 9-10 October 2006. The Advisory Board is chaired by Professor Kenzo Kiikuni and has six other members. The staff of Global Leprosy

Programme and Regional Focal Points for Leprosy from AFRO, AMRO, SEARO and WPRO attended the meeting along with the Director CDS, SEARO. The SMHF Advisory Board considered the Annual reports of GLP and the Regions for 2006 and the budget requests for 2007 and approved a total grant of US\$ 3400000 for 2007. This includes a grant of US\$ 1250000 for leprosy activities in the SEA Region .

New Delhi: India announces elimination of yaws

The Health Minister of India has formally declared that India has achieved total elimination of yaws. At a programme at Vigyan Bhavan, New Delhi on 19 September 2006, he informed that no new cases of yaws have been reported in the country since the beginning of 2004 and the same has been validated through independent appraisals.

Dr Samlee Plianbangchang, who was a special guest on the occasion, congratulated the Government of India and the concerned health officials and staff from the endemic states and districts on the achievement of the important milestone. He said that “the effective programme in India will serve as a model for Indonesia and Timor-Leste, the two other endemic countries of the region, and also encourage other countries in the world, still reporting yaws, to take the path shown by India and the South East Asia Region”.

India is now aiming at Eradication of yaws by 2008, defined as zero-incidence and no evidence of transmission, to be determined through sero-survey in children under the age of five in previously endemic areas.



Paris: India TB Programme Director bags the first Kochon Prize

The first Stop TB Partnership Kochon Prize was awarded to Dr L.S. Chauhan, National TB Control Programme Manager from India. He has overseen the rapid expansion of the DOTS TB control programme in India since 2002, a remarkable accomplishment in a country that bears the world's highest TB burden. Dr Chauhan has championed for the cause of TB control in India, and has played a stellar role in guiding and inspiring thousands of frontline TB care-providers, both in the public and private sectors. Through this prize, the Stop TB Partnership and the Kochon Foundation wishes to recognize and encourage those at the forefront of the campaign to accelerate the battle against TB.

Guatemala: SEA Region scores high in the Global Fund 6th Round

The Global Fund for AIDS, TB and Malaria Board during its 14th meeting in Guatemala in November 2006 approved 85 of the 196 Round 6 proposals costing over US\$ 846 million over the first two years and US\$2,519 million over five years. Proposals from the South-East Asia Region had a success rate of 55% as compared to the global rate of 43%. The substantial jump in successful grants, from a low of 16% only in Round 5, will help programmes in the countries of our Region to scale up their fight against HIV, TB and Malaria.

On a similar context, the WHO Stop TB Department in Geneva in collaboration with the Global Fund Secretariat is convening a meeting of successful TB proposals from 16-19 January 2006 to discuss the procedures involved in accessing the grant and subsequent implementation.

Bangkok: Thailand issues compulsory license for AIDS drug Efavirenz

On 29 November 2006, the Ministry of Public Health in Thailand announced the issuance of a compulsory license for public non-commercial use of efavirenz. This will enable import and/or local production of generic versions of efavirenz for use in the public health sector which, in turn, will reduce costs. This will then enable the Ministry to provide more people with access to this important antiretroviral medicine.

Moreover, by enabling procurement from multiple suppliers, this action may also increase the reliability of the supply. A compulsory licence for public non-commercial use (sometimes referred to as ‘government use’) is an important TRIPS-compliant mechanism to safeguard access to medicines. The same mechanism had earlier been used by Malaysia and Indonesia.

Bangkok: WHO/SEARO calls for urgent scaling up of HIV prevention, care and treatment

A regional meeting on scaling up HIV prevention, care and treatment took place in Bangkok from 31 October to 3 November 2006. Seventy participants from 10 Member countries of the South-East Asia Region attended along with representatives from donor and partner agencies. The meeting was co-hosted by WHO-SEARO with the Thai Bureau of AIDS, TB and STI. The objectives of the meeting were to review the HIV/AIDS situation, identify scale up strategies, review indicators and targets and identify areas for partnership.

The meeting addressed HIV and STI epidemiology, issues of human rights, targeting populations at the highest risk, the regional STI strategy, coverage of antiretroviral therapy, technical support, setting targets and measuring progress. Representatives from ADB, ASEAN, AusAID, DFID, FHI, and USAID made presentations that dealt with priorities for supporting a regional scale up.

Key recommendations and suggested action points for countries were advocacy for increased coverage, particularly for highest risk populations; emphasis on essential intervention packages that can be scaled up quickly, and promotion of a comprehensive continuum of care for people living with HIV. It was emphasized that expansion of HIV counselling and testing must continue to ensure principles of confidentiality, counselling and informed consent.

New SEARO publications on communicable diseases

Tuberculosis control in the South-East Asia Region: Annual report, 2006

The annual report provides an overview of the activities conducted over the last year by WHO SEARO to support national TB control programmes in Member countries of the Region. It also describes the regional TB burden and highlights the achievements in the light of the targets set by the World Health Assembly as well as the progress towards reaching the Millennium Development Goals. The implications of HIV on TB and drug resistance are also discussed. A country profile for each country is provided.



Management of HIV infection and antiretroviral therapy in infants and children

Successful scaling-up of antiretroviral therapy (ART) requires rational use of antiretroviral drugs. These guidelines include diagnosis of HIV infection in infants and children, followed by patient evaluation, prevention and management of opportunistic infections, when and how to start antiretroviral therapy, when to switch and how to ensure treatment adherence.

HIV/AIDS STI and risk behaviour surveillance training modules

The WHO South-East Asia Regional Office in collaboration with the Centres for Disease Control and Prevention, Atlanta, USA has developed a series of training modules to improve surveillance for HIV, AIDS and STIs in Asia. The modules introduce trainees to the theory and practice of public health surveillance, the practice of public health surveillance for AIDS, HIV and STIs, a practical overview of data collection, analysis and reporting and dissemination of public health surveillance data. The course is meant primarily for district-level surveillance officers.



Regional Strategy on Eradication of Yaws (2006-2010)

Yaws remains a focalized problem affecting parts of only three countries in the SEA Region. Cost-effective tools are available to detect and cure the disease. The persistent foci of yaws in this 21st century can be considered unacceptable in view of the availability of a simple, safe and cost-effective intervention. Its eradication, therefore, has been declared a regional priority and an achievable goal. The Regional Strategy incorporates the goal, objectives and the key elements of the strategy to eradicate yaws in the South-East Asia Region.

Avian Influenza in SEA Region: A bibliography

This bibliography reviews recent published articles on various aspects of avian influenza and its control including the areas of epidemiology, clinical presentation, antivirals and vaccines, non-pharmaceutical interventions and risk communication. This is a resource mainly for policy-makers, programme managers and those working in influenza control in developing countries.



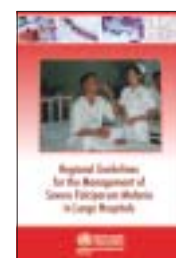
Avian Influenza in South-East Asia Region: Priority Areas for Research

A review of the information in the document *Avian Influenza in SEA Region: A bibliography*, makes it clear that there are many unanswered questions in managing avian influenza. This document identifies priority areas for future research on a number of key issues relating to prevention and control of avian influenza such as epidemiology, laboratory, clinical, social behavioural, and related to economic and policy concerns.



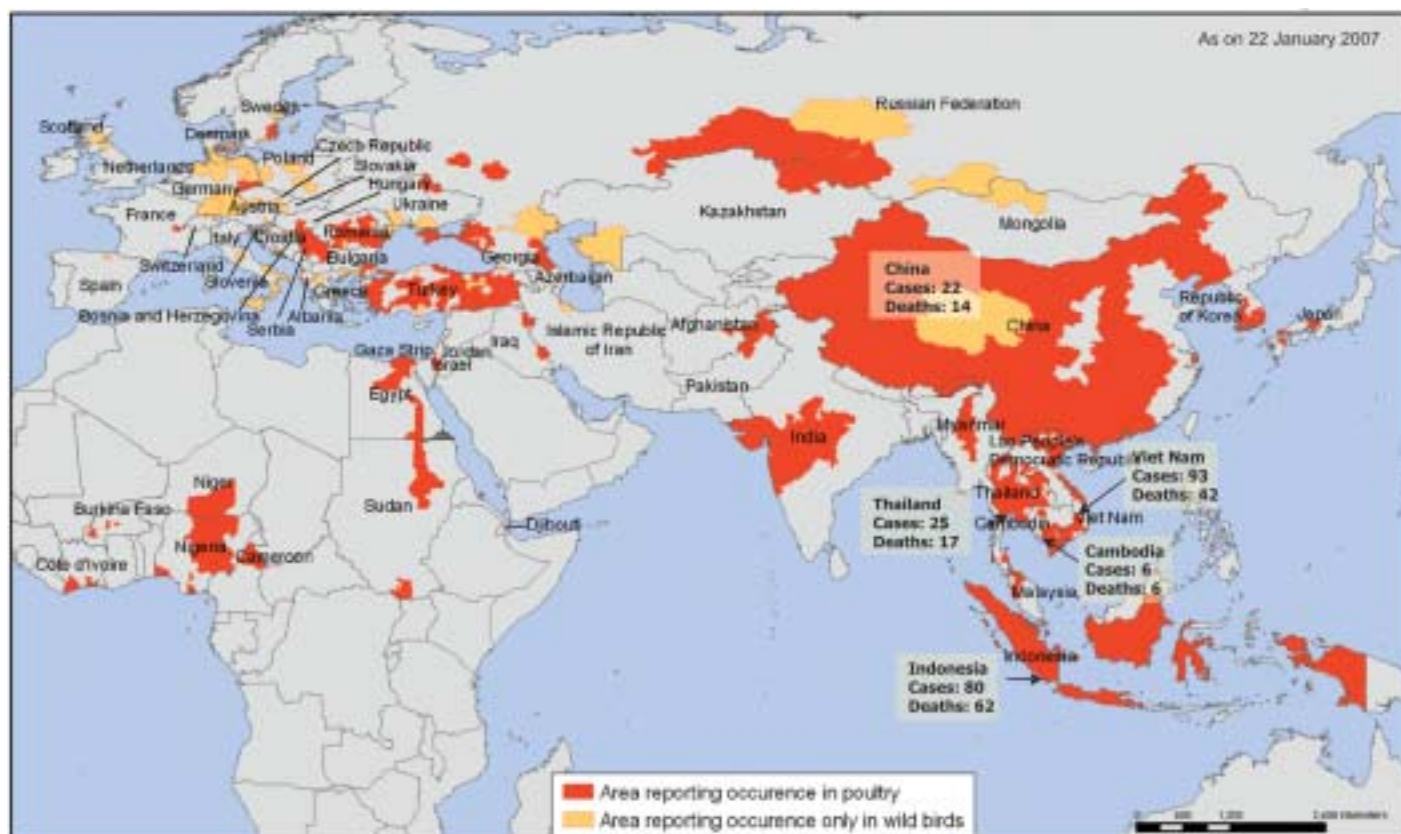
Regional guidelines for the management of severe falciparum malaria in small and large hospitals, SEARO, Oct 2006

These are in fact two parallel guidelines, one for small hospitals and another for large hospitals. In view of the heavy burden of malaria and prevalence of drug resistant falciparum malaria in the South-East Asia Region, the guidelines were developed for use by medical personnel who treat severe malaria patients, referred from lower-level health facilities. The guidelines were developed by WHO-SEARO and the WHO Collaborating Centre for the Clinical Management of Malaria, Faculty of Tropical Medicine, Mahidol University, Thailand.



Surveillance Report: Update on Avian Influenza

Since 2003 the number of countries worldwide with H5N1 outbreaks has increased markedly, along with a steadily rising number of human deaths. The current outbreak originated in South-East Asia and since spread to the Middle East, Europe, Africa and other parts of Asia. In 2006 alone, more than 30 countries have reported outbreaks in poultry (see map). By January 2007 more than 160 people had died globally. Furthermore, the fatality rate among those infected is increasing, currently standing at 60% against 53% in during the start of 2006.



Countries in the SEA Region can be categorized as those which have had both poultry and human cases (Thailand and Indonesia); those with cases reported only in poultry (India, Myanmar and DPR Korea) and those without any case of avian influenza (Sri Lanka, Bangladesh, Maldives, Bhutan, Timor-Leste and Nepal). Since the beginning of 2004, Thailand and Indonesia have reported 25 and 74 cases respectively, of which 17 and 57 have been fatal. Indonesia, where the disease may be endemic within the domestic poultry population, has in 2006 witnessed an average of one human death every week. Reports of possible human-to-human transmission of the virus among a family cluster in North Sumatra in May this year has again highlighted the uncertainty as to when and where a possible mutation might take place.

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