

Communicable Disease Newsletter

World Health Organization Regional Office for South-East Asia



Tsunami disaster: responding to communicable disease threats

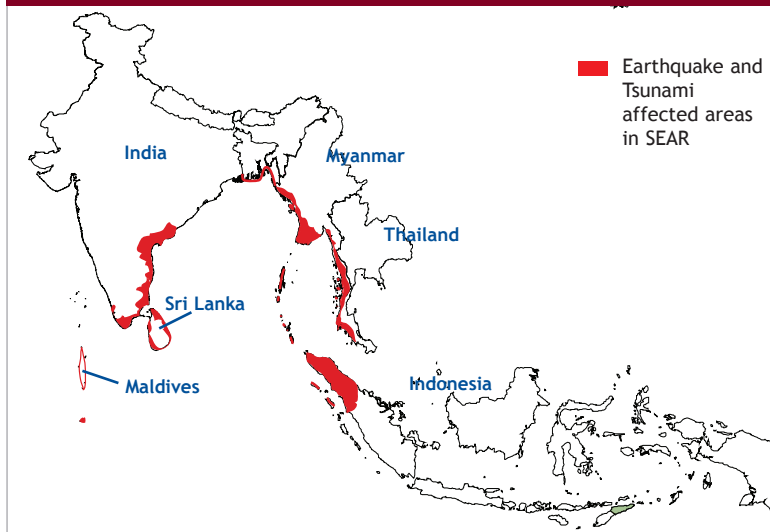
Triggered by a massive earthquake off the northwest tip of Indonesia, early on Sunday, 26 December 2004, an unprecedented Tsunami brought untold catastrophe to six countries of WHO South-East Asia Region, namely, India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand (Figure 1). Walls of water moving at high speed pounded coastal communities across the Region, leaving more than

more than half of the public health infrastructure was lost. In other areas, such as Sri Lanka, they remained largely intact.

WHO moved quickly to assist Member Countries from the start of the crisis, with initial support provided by WHO country offices, reinforced by the WHO Regional Office for South-East Asia (SEARO). Overall WHO response was coordinated by the Emergency and Humanitarian

Action/Humanitarian Crisis Unit. An operations room was set up to work round the clock with technical support provided by various programmes fully engaged under the banner of the Tsunami Technical Group (TTG). This comprised members from the Communicable Diseases Department (reinforced by Headquarters in Geneva and other regional offices) as well as other WHO SEARO departments including Immunization and Vaccine Development,

Noncommunicable Diseases and Mental Health, Emergency and Humanitarian Action, Health System Development, Family and Community Health and the Department for Sustainable Development and Environment. In addition, GOARN (the Global Outbreak Alert and Response Network) was mobilized by SEARO and headquarters to assist in outbreak detection, verification and management.



169 000 dead, 127 000 missing and two million displaced. The death toll was the highest in Indonesia (121 911), followed by Sri Lanka (30 974), India (10 872), Thailand (5395), Maldives (83), and Myanmar (61).

As with the loss of life across the Region, the consequences to public health varied from location to location. In the hard hit region of Aceh, Indonesia for example,

* The boundaries and names shown and the designations used on all the maps do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

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Issue 1

The TTG immediately anticipated implications for communicable diseases. During the first week, together with water contamination, injuries and resultant infections were perceived as the most urgent health threat. During the second week, estimated health risks included respiratory infections, measles and water-borne diseases such as diarrhoea and dysentery (including shigella and cholera) as a result of overcrowded conditions and poor sanitation. Vector-borne diseases were expected afterwards due to collection of stagnant water resulting in mosquito breeding.

More than 250 WHO staff and consultants have been deployed in the relief work at the three most affected countries, namely Indonesia, Sri Lanka and Maldives. More than 80 technical guidelines, outlining best practices to be followed, have been produced, transmitted to the field and posted on the web. Vaccines and life-saving drugs have been procured and stockpiled in the field. The WHO-deployed staff established quickly an emergency surveillance and early warning system with capacity to respond immediately to any case of communicable disease, be it measles or diarrhoea.

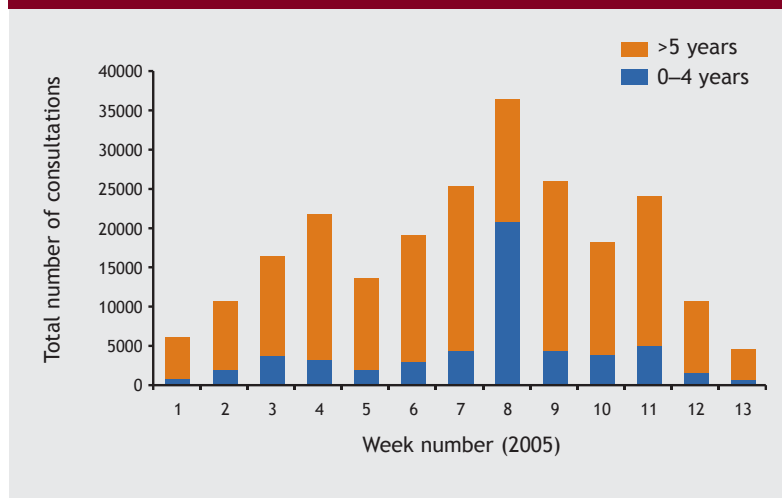
Three months after the disaster, amazingly the health situation remains under control, with no outbreaks identified, although many people came for health consultations (Figure 2). Many clusters of cases have been investigated and rumours verified. The rapid institution of the Early Warning and Response Network (EWARN) system, in addition to the establishment of mobile laboratories, deployment of staff and consultants

A Success Story in Aceh

An early warning system for targeted epidemic-prone diseases was established jointly by WHO's Epidemic Alert and Response team and the Provincial MoH by the first week of January 2005. WHO established excellent collaboration and coordination with all operational agencies providing health care to the affected populations. This resulted in weekly reporting on syndromes and immediate alerting of suspected cases for a rapid response to epidemic-prone diseases, including field case investigations and institution of appropriate interventions. The fact that so far no epidemics have occurred in the Tsunami-affected province of Aceh in Indonesia where there are approximately 400 000 internally displaced persons living in temporary housing, is a testament to this remarkable accomplishment.

—Contributed by Asheena Khalakdina,
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Figure 2: Health consultations, Aceh (week 1–13 of 2005)



Source: Aceh outbreak report, April 2005

for technical support in communicable diseases, psychosocial support, water and sanitation, and nutrition, made a tremendous difference to safeguarding public health across the Region. The remarkable job done by public health workers in averting any significant communicable disease outbreak is a testament to the strength of the public health community's emergency response systems.

Together with death and destruction, the Tsunami has taught us some lessons. First and foremost, to effectively respond to any disaster, preparedness is essential. It was clear that countries that had a better health infrastructure were able to respond better. The massive mobilization of resources and international support required an enormous amount of coordination, communication and logistical support in order to ensure that all actors on the ground worked in a coordinated manner. Now, the key challenge in many areas is the rehabilitation and re-establishment of the health system at all levels. WHO's strategy focuses on building public health capacity, establishing surveillance and laboratory back-up, strengthening logistic management and communication, and refining monitoring and evaluation systems.

Every disaster, however unfortunate, provides an opportunity to set the system right. Bringing massive disaster in its wake and killing thousands of people, the Tsunami now offers a chance, with international support, to strengthen the health system capacity and infrastructure in the affected countries, perhaps even better than what was available before the disaster struck.

“3 by 5” : An update

Over 900 000 of the 6 million people living with HIV/AIDS (PLWHAs) in the South-East Asia Region are in need of antiretroviral treatment (ART). India alone accounts for 80% of the total treatment gap. The “3 by 5” initiative, launched in September 2003 by WHO and its partners targets the provision of ART to 3 million PLWHAs by 2005 in the world. Progress during 2004 has been substantial in the SEA countries, doubling the numbers of people on ART in the public and private sectors from 37 500 to 85 000 (Figure 3). The initiative is accelerating the provision of a continuum of quality prevention, care and treatment services to PLWHAs and has already provided hope to millions in need of treatment.

Tremendous efforts have been made in HIV high burden countries through development of policies, mobilization and allocation of resources, development of tools and guidelines, capacity building, strengthening procurement and supply management, as well as monitoring and evaluation.

India. By the end of 2007, 100 000 patients are targeted to receive ART. As of December 2004, a total of 3284 PLWHAs have started treatment in the public sector. Progress in 2004 was mainly due to the announcement of a free ART programme, launched in April at eight tertiary hospitals in the six high-prevalence states of India plus Delhi, and has since expanded to 25 sites across the country. The programme will extend to 50 tertiary hospitals by the end of 2005 and prepare for building capacity at district level.

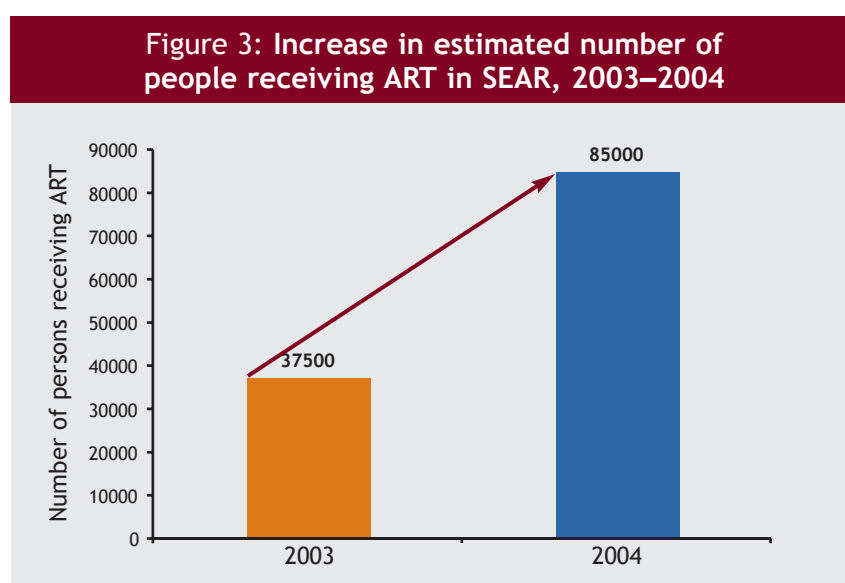
Indonesia. Setting the target to provide ART to 10 000 people, the country has started implementing the ART programme in 25 hospitals in nine high-prevalence provinces and the capital Jakarta. So far, 1555 people have started receiving ART in these centres with the majority in the capital.

Myanmar. The national AIDS programme is going to start ART for 400 patients in early 2005, in addition to the 500 patients already on ART in the non-government sector in Yangon. A second site will start providing treatment in Mandalay. Resources for scaling-up ART have been mobilized from the Fund for HIV/AIDS in Myanmar, the Global Fund to Fight AIDS, TB and Malaria and from the UK Department for International Development (DfID).

Thailand. The ART access-for-all target by 2005 seems well set following the exceptional progress made by the Royal Thai Government in delivering ART to more than 50% of those in need by 2004. High political commitment, harnessing the full potential of the strong public health system, and budget increase have been the key tools. The programme has rolled out to 914 hospitals covering 50 000 people on ART. PLWHA groups and nongovernmental organizations have been working together to support people with HIV/AIDS in accessing and adhering to treatment. The network currently monitors 10 000 people on ART.

Also, low HIV burden countries in the Region, such as Bangladesh, Maldives, Sri Lanka, and Timor-Leste, are preparing for ART services.

Achievements in scaling up ART are exceptional, and Thailand leads the way in Asia. All countries have located the ART programme within a comprehensive approach to the epidemic where treatment and care is linked with prevention as one package. Many challenges, however, remain, such as weak health systems, lack of human resources, HIV-associated stigma, and the high costs for drugs and reagents. But, these are progressively being addressed.



Source: “3 by 5” country reports, SEARO

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Eliminating kala-azar from SEAR

Bangladesh, India and Nepal, in collaboration with the World Health Organization are working together to eliminate visceral leishmaniasis or kala-azar from the South-East Asia Region (SEAR) by 2015. The elimination of kala-azar is aimed to be achieved with the target to reduce the annual incidence of the disease to less than one per 10 000 population at the district or sub-district level. This will contribute to mitigation of poverty and assist in developing equitable health systems in SEAR.

Globally, leishmaniasis is endemic in 88 countries. In SEAR, three countries, namely Bangladesh, India and Nepal, are affected where approximately 147 million people are at risk and at least 100 000 new cases are being encountered every year (Figure 4). The disease occurs predominantly in the poor and marginalized communities.

Kala-azar elimination in the endemic countries of SEAR is feasible and achievable for a number of reasons: the occurrence of the disease in the only reservoir human host; the only vector (*Phlebotomus argentipes*), historically eliminated as a collateral benefit of malaria control by indoor residual spray with DDT; the

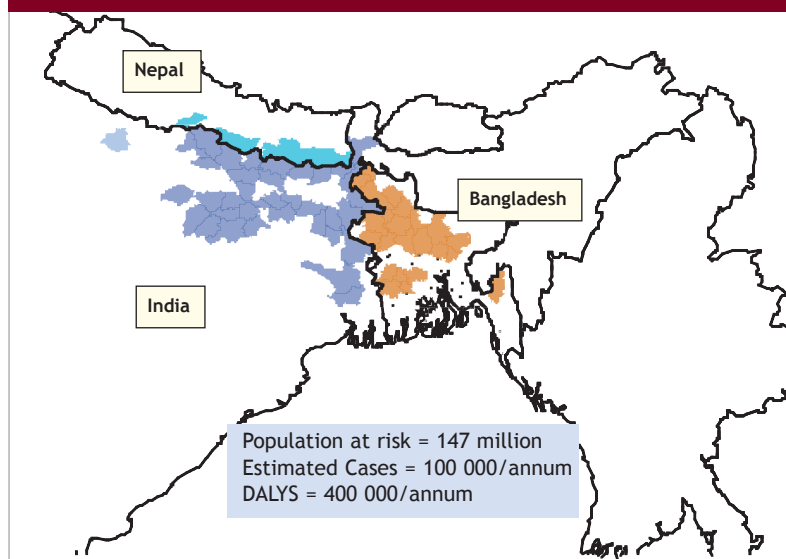
availability of safe and effective drugs, insecticides and rapid diagnostic tests (rk 39); and high political commitment of endemic countries. The strategies include ensuring access to early diagnosis and complete treatment, particularly for the most vulnerable groups, strengthening disease and vector surveillance, integrated vector management, social mobilization and building partnerships, as well as operational and clinical research.

At a meeting held in September 2004 in Maldives, the health ministers of Bangladesh, India and Nepal discussed a strategy for intercountry collaboration and a road map was agreed to. A Memorandum of Understanding between the three countries is being drawn up to affirm the commitment.

The three countries will begin the process of changing policy on first-line drug treatment (miltefosine) for kala-azar, and Nepal and Bangladesh will facilitate the process of registration of miltefosine in their countries (as miltefosine is currently registered only in India). The WHO Regional Office for South-East Asia will provide technical support to address the issues of spraying and of monitoring and supervising the operational aspects of vector control. A regional technical advisory group (RTAG) has been established to advise on technical and operational issues. WHO will also provide guidelines for clinical management of kala-azar.

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Figure 4: Kala-azar distribution in SEAR*, 2004



SEARO inputs to this historic effort

The WHO Regional Office for South-East Asia is providing technical support to address the issues of monitoring and supervising the operational aspects of vector control, and has established a regional technical advisory group (RTAG) on technical and operational issues. The Memorandum of Understanding between Bangladesh, India, Nepal and WHO on the elimination of kala-azar from SEAR has been planned to be signed during the World Health Assembly in May 2005.

The Regional Strategic Framework for Elimination of Kala-azar from the South-East Asia Region (2005–2015) has been approved during the first RTAG meeting on Kala-azar Elimination in December 2004. Moreover, a roadmap to guide the endemic countries in developing national strategies and plans for elimination of kala-azar has been developed and presented at the consultation with the Bill and Melinda Gates Foundation and Indian Council of Medical Research, New Delhi in January 2004. A technical consultative meeting with the partners and the programme managers of the endemic countries for elimination of this disease will be organized soon.

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After guineaworm eradication: Yaws?

The eradication of yaws is an achievable goal. The availability of a safe and cost-effective intervention—a single injection of long acting Benzathine Penicillin—that can completely cure the disease, makes it unacceptable that it still persists or spreads. In addition, in the South-East Asia (SEA) Region, yaws is restricted to a few endemic pockets in three countries—India, Indonesia and Timor-Leste—among the indigenous and tribal people living in remote areas. The WHO Regional Director has declared eradication of yaws a regional priority and an achievable goal by 2010. A reasonably low investment can ensure eradication of yaws and thus another public health triumph for the SEA Region, after smallpox and guineaworm eradication.

Yaws is a contagious, non-venereal infection that predominantly affects children, particularly from the marginalized groups, living in remote tribal areas, where there is a general lack of clean potable water and sanitation facilities. In the modern world, the continued presence of a disease like yaws should be considered as a sign of “backwardness”. The treatment is however simple, safe, affordable, effective and available at all health facilities. The challenge is to reach remote areas, establish contact with the people and identify and treat those who have the disease and their close family contacts.

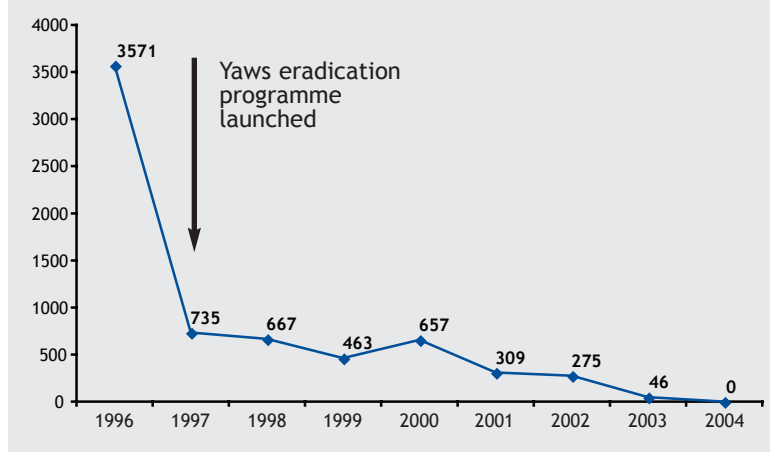
Present situation

In **India**, yaws was reported from 49 districts of 10 states. In 1997 a yaws eradication programme was launched. Since then, the annual new cases reported have steadily declined from a peak of 3571 in 1996 to 46 in 2003 and nil cases in 2004 (Figure 5). India hopes to eliminate yaws (no early infectious case) by 2005 and eradicate it by 2008.

Indonesia has the highest disease burden, with about 3000–4000 cases reported annually since the last four years. Yaws was reported from eleven provinces, with four provinces alone accounting for 97% of the cases in 2003. The disease continues to linger on since the 1970s, when it was brought to very low levels as a result of the eradication campaign and thereafter it was made a part of the general health service. With a final push, Indonesia could also achieve major strides like India.

In **Timor-Leste**, about 1000 cases are estimated annually even though actual data is not available. Yaws is endemic in six of the 13 districts. The country is in the

Figure 5: Yaws cases, India 1996–2004



Source: National Institute of Communicable Diseases, New Delhi, India

early stage of planning and launching of a control programme.

Yaws eradication: making it a reality

The key objectives are:

- to interrupt the transmission of yaws by detecting and treating all cases and their contacts
- to prevent the disability and its socio-economic consequences.

SEARO inputs

To support this eradication programme, WHO-SEARO organized an inter-country workshop in Jakarta, Indonesia from 14–16 December 2004, with participants from the three affected countries. The workshop concluded that eradication should be based on country needs, since they are at different stages of implementation.

WHO will, in addition, assist countries in the timely procurement of quality injection Benzathine Penicillin; in strengthening surveillance systems, capacity building and monitoring and evaluation of the eradication programme; mobilization of the required resources for yaws eradication; and promotion of yaws eradication as an achievable goal through advocacy activities. The initiative could also serve as an entry point for primary health care among the marginalized and socially vulnerable populations of the Region.

Yaws eradication could become a reality provided partnership and support are mobilized from interested donors. This is a historic occasion to do something for the poor and marginalized sections of our society and a step towards building a good image of public health.

Marching towards leprosy elimination

With improved attention to the quality of diagnosis and minimization of 'operational factors', WHO is hopeful that the South-East Asia Region can achieve the targeted elimination goal, i.e. prevalence below one case per 10 000 population, by December 2005. Already, around 12 million people have been cured in the Region, of which 11 million are in India, since initiation of the multidrug therapy (MDT) in 1985.

Political commitment continues to be sustained in all countries which are implementing focused activities to further reduce the disease burden. The eight countries where national-level elimination has been achieved have maintained national prevalence levels below one case per 10 000 population and further reduced the burden of leprosy. The remaining three countries, India, Nepal and Timor-Leste, are on track and have intensified their efforts to achieve the regional goal by December 2005.

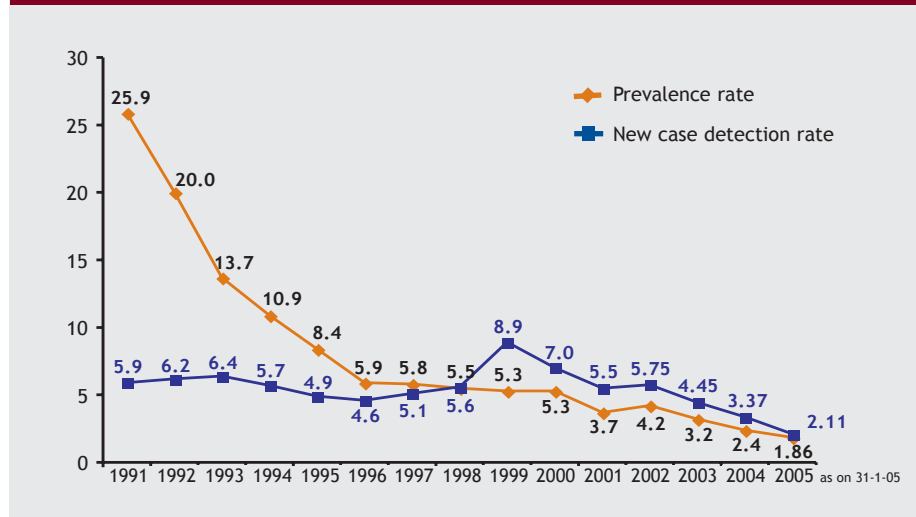
The regional leprosy prevalence declined from 1.9/10 000 population in March 2004 to 1.56/10 000 population as of December 2004 and is expected to dip below 1.4/10 000 population by early 2005, when the fiscal year figures for India will be available. The new case detection rate declined from 33.3/10 000 to 25.6/10 000 during 2003–2004.

Country updates

The reduction in prevalence and new case detections has been most significant in **India**. This is mainly due to minimization of 'operational factors' like wrong diagnosis, re-registration of cases, wrong grouping, delayed treatment completion, over-treatment and delayed release from treatment. The evidence that "operational factors" were influencing prevalence and new case detections in India was established through a WHO-supported Leprosy Elimination Monitoring (LEM) and Case Validation Study conducted in 2003 and 2004. Results showed 25–30% "over-detection". The National Leprosy Eradication Programme (NLEP) in India initiated prompt corrective action to minimize these factors and this explains the dramatic reduction in prevalence and new case detections during the past two years (Figure 6).

In **Nepal**, the achievement of the goal seems quite difficult because of the political situation. **Timor-Leste** was able to launch an effective leprosy programme only in 2003 after a 4-year dislocation of services. Hence, it is likely to have a large backlog of cases to be detected.

Figure 6: Leprosy prevalence and new case detection rates per 10 000, India, 1991–2005



Source: WHO SEARO, New Delhi, India

SEARO inputs

Leprosy elimination is a priority for WHO SEARO. The programme, managed by a Regional Adviser, receives inputs on technical and programme aspects from a 10-member expert Regional Technical Advisory Group (RTAG). At the first RTAG meeting held on 11 October 2004, the members expressed satisfaction on the progress of leprosy elimination in the Region and WHO's technical support to Member Countries. However, they also identified problems, constraints and challenges that need urgent action in order to achieve the elimination target. To accelerate the process further, the Director-General of WHO took the decision to relocate the global leprosy unit from Headquarters to SEARO, effective 1st March 2005.

Targeting the December 2005 goal, WHO SEARO will continue to provide technical support to Member Countries; to assist them in mobilizing the required resources and in strengthening partnerships; and to supply free MDT blisters. Novartis Foundation for Sustainable Development has formally communicated to WHO SEARO that free supply of drugs will continue until 2010. The drugs will be provided to all endemic countries through WHO SEARO. The Nippon and Sasakawa Foundations are providing continued financial support for achieving leprosy elimination in the Region.

An incredible expansion of DOTS in India

Tuberculosis (TB) is the leading cause of death in India due to infectious diseases, responsible for almost 400 000 deaths each year. India also has the highest TB burden in the world accounting for one-fifth of the new global cases every year. To tackle this huge burden the Government of India launched the Revised National Tuberculosis Control Programme (RNTCP) in 1993. It was based on the WHO-recommended Directly Observed Treatment, Short course (DOTS) strategy. Following successful pilot testing in a small population, the scaling up of RNTCP began in 1998 after receiving a World Bank loan.

The RNTCP is today the world's largest and fastest expanding TB control programme initiating around 100 000 patients on treatment each month. To date over four million patients have been initiated on treatment (1.2 million in 2004 alone), as a result of which 700 000 lives have been saved.

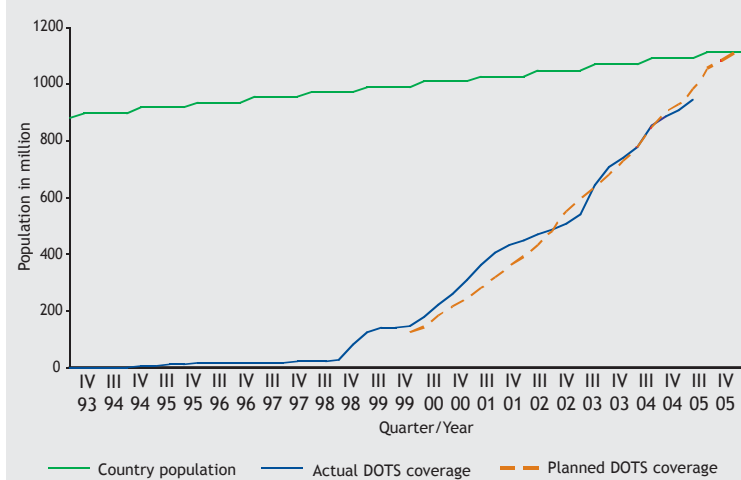
The RNTCP is presently covering one billion of the population and the Government of India is committed to cover the entire country by the end of 2005. The RNTCP has already involved over 900 NGOs, 5000 private medical practitioners, 200 medical colleges and several health facilities under other Ministries as they also treat a large number of TB patients, directly delivering DOTS services.

The success of the treatment was consistently over 80%, and in the last few quarters, exceeded the global target of 85%. The case detection rate has shown an increasing trend and achieved the 70% global target in 2004. With these results the RNTCP is in a good position to achieve the global targets set for 2005 (70% case detection and 85% treatment success), after which the focus will be on achieving the reduction of mortality and morbidity as envisaged in the Millennium Development Goals (Figure 7).

Many factors have been responsible for the success of DOTS under the RNTCP, including strong central level commitment; capacity building and appraisal of each district prior to the start of service delivery; distribution of unique patient-wise drug boxes ensuring that no patient breaks treatment due to nonavailability of drugs; dedicated supervisory staff at sub-district level; and a large network of locally recruited and trained WHO consultants providing technical assistance at the state and district levels.

Challenges ahead include maintaining and consolidating the quality of the existing RNTCP services with nationwide expansion of DOTS and addressing the problems of TB/HIV and multi-drug resistant forms of TB.

Figure 7: DOTS Expansion in India, 1993–2005



Source: Central TB Division, Ministry of Health, Government of India

If these trends are maintained, over the next few years RNTCP is bound to make a measurable impact on the national and global incidence, prevalence and mortality of TB.

The RNTCP is supported by DANIDA, DfId, GDF, GFATM, USAID and the World Bank. WHO provides technical assistance to RNTCP, financially supported by CIDA, DfID and USAID.

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Stop TB

Use DOTS

Revising International Health Regulations: The process

WHO has more than five decades of experience in the global control of communicable diseases based on its Constitutional mandate. The International Health Regulations (IHR), the prior International Sanitary Regulations (ISR), and an array of World Health Assembly (WHA) resolutions support WHO surveillance, response and other activities. Particularly relevant to the IHR, the WHO Constitution states that the Organization's functions include:

- “to act as the directing and co-ordinating authority on international health work” (Article 2a);
- “to furnish appropriate technical assistance and, or emergencies, necessary aid on the request or acceptance of Governments” (Article 2d); and”
- “to propose conventions, agreements and regulations, and make recommendations with respect to international health matters...” (Article 2k).

The current IHR, last modified in 1981, requires Member States to notify only on cholera, plague and yellow fever. With increasing international travel and trade, and the emergence and re-emergence of infectious diseases, they have become outdated and are inadequate to address the new challenges. Recognizing this need, in 1995, the WHA requested their revision.

The WHO Regional Office for South-East Asia (SEARO) and Member States have actively participated at various steps of the revision process, including:

- First Regional Consultation on the revised IHR, 13–14 April 2004: the regional meeting of National IHR Focal Points critically reviewed key issues in the revised draft IHR for further discussions at national level, and prepared an action plan for national consultation meetings.
- National-level Consultations on the revised IHR, April–June 2004: national-level consultations with participation of various sectors from ministries of health, livestock, agriculture, tourism, civil aviation,

justice, foreign relations, etc. were conducted in Member States of the Region.

- Second Regional Consultation on the revised IHR, 29 June–1 July 2004: based on the outcomes of the national consultations, there was an overall consensus that the implementation of the proposed IHR would contribute to health security, and that issues and concerns raised should be considered in the global revision process of the IHR document.
- First Inter-governmental Working Group (IGWG), 1–12 November 2004: SEARO and Member States participated at this meeting which discussed the revised draft and recommended to conduct further national and regional discussions upon request of some countries.
- Third Regional Consultation on the revised IHR, 27–29 January 2005: based on inputs from the first



The 2nd Intergovernmental Working Group (IGWG) Meeting, Geneva

IGWG meeting in November 2004 to conduct further national and regional discussions, consensus on all major issues and articles was reached and further discussion at the Second IGWG Meeting recommended.

- Second IGWG Meeting, 21–26 February 2005: all amendments proposed by SEAR Member States were agreed upon with little or no modifications. One of the biggest

concerns of WHO SEARO was identified as the need for technical and financial support by most Member States in the Region to build the necessary core capacity for the implementation of the revised IHR, at the national, intermediate, ports of entry/exit and community levels. Since the second IGWG meeting was unable to complete the work assigned, it was decided the meeting be suspended and convened in May 2005, just prior to the WHA to reach a consensus and be able to submit the revised IHR document for consideration by the 58th WHA.

MDGs and communicable diseases

In the Millennium Development Goals (MDGs), 6 out of 8 goals, 9 out of 18 targets, and 18 of the 48 indicators are on health and health-related subjects, highlighting the centrality of health to development and to the alleviation of poverty. In particular, Goal 6 is specifically related to communicable diseases and includes targets aimed to halt by 2015 and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases.

How is our Region doing regarding progress on Goal 6 of the MDGs? Infectious and parasitic diseases are still a leading cause of morbidity in SEAR, accounting for 21% of the total burden (Figure 8).

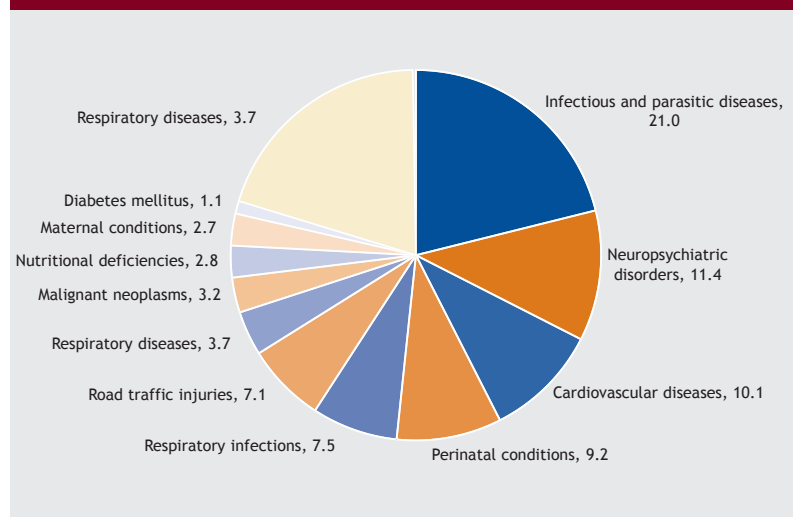
With nearly 6 million people with HIV/AIDS, South-East Asian countries have the second highest burden in the world. Nearly 99% of all cases in SEAR are in India, Indonesia, Myanmar and Thailand. Commercial sex and injecting drug use are the two main factors driving the epidemic in the Region, but it has spread to cover lower risk populations in several countries. All SEAR countries have started to implement national plans with full involvement of government agencies, the private sector and non-governmental organizations (NGOs). WHO's "3 by 5" strategy has also been initiated; the challenge is how to make antiretroviral treatment (ART) accessible at affordable prices and expand HIV prevention programmes.

Malaria continues to threaten the life of an estimated 1.2 billion people or 85% of the total population of the Region. It affects all age groups, especially the poor, pregnant mothers, infants and young children. The challenge is the constantly changing scenario of malaria which requires the adoption of a stratified approach and intensification of surveillance for control.

The Region carries 35% of the global burden of tuberculosis, with 3 million new cases and nearly 750 000 deaths occurring every year. Rising trends in HIV infection in some countries together with the emergence of multi-drug resistant strains pose additional threats. The key constraints are the lack of continuity of tuberculosis treatment (particularly in countries with decentralized health care), inadequate human resources to sustain DOTS, and low community awareness leading to poor utilization of available services.

Based on current trends, some countries are unlikely to achieve the MDG targets by 2015. This is

Figure 8: Causes of morbidity in SEAR (as percentage of total DALYs)



Source: World Health Report, WHO Geneva, 2003

despite the fact that there are increasingly effective and affordable interventions, as well as international assistance for specific diseases. There is general consensus that a primary bottleneck to achieving the MDGs is lack of health systems effectiveness. Thailand is one of the very first countries to have achieved MDG relating to HIV/AIDS.

In some SEAR countries, health systems are too fragile and fragmented to deliver the volume and quality of services to those in need. It is sometimes described as the "double crisis" of devastating disease and failing health systems. The drive to produce results for the MDGs has led many stakeholders to focus on disease priority, with an implicit assumption that the system would be strengthened as a consequence. Experience to date, however, suggests that if health systems are lacking in capabilities, they may not be able to respond adequately to such challenges.

Improved coverage with effective interventions supporting families and communities in preventing disease will result in significant progress in achieving the MDG. This requires not only an increased allocation of funds to identified priorities, but also the strengthening of service planning and delivery. In many countries this means strengthening Primary Health Care (PHC) and the health system as a whole. As stated in the World Health Report 2004, the "3 by 5" initiative cannot be implemented in isolation from a regeneration of the health system.

WHO in the countries – India



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Progress in polio eradication

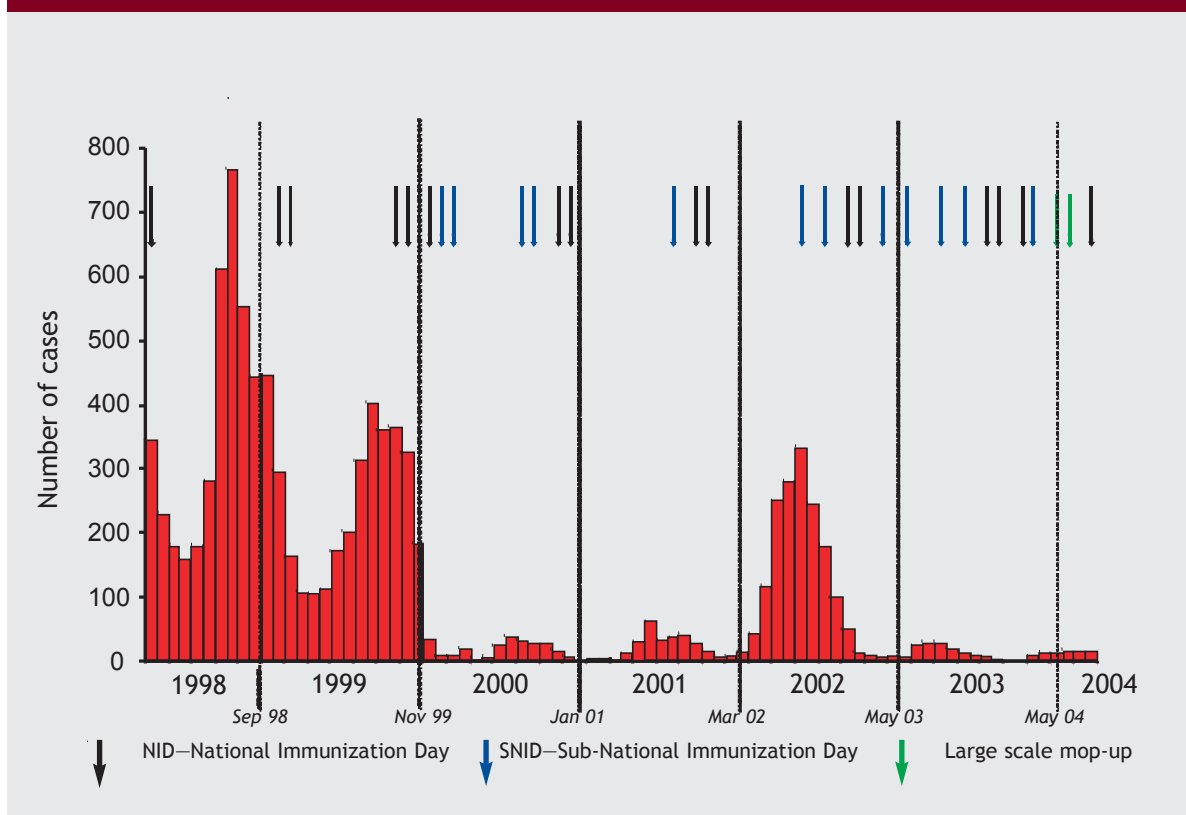
Recent progress in polio eradication offers India a historic opportunity to interrupt wild polio transmission. Globally, polio eradication will improve children’s health and alleviate poverty by removing the burden especially on poor people, with global cost savings of about US\$ 1.5 billion a year.

Improvements made in India in 2004 have resulted in the most sensitive and accurate surveillance activity for polio in the country’s history. Indian children are better vaccinated against the disease than ever before. An increase in the number of immunization activities in 2003–2004, combined with major improvements in programme quality, have resulted in a reduction of the number of cases as well as geographic distribution of the wild polio virus (Figure 9). The number of affected districts was reduced from 159 in 2002 to 44 in

2004. The disease is now localized to three geographical areas: Western Uttar Pradesh, Bihar and Mumbai (Thane).

However, the task is not over and the final push towards polio eradication requires intensive surveillance and targeted supplemental immunization activities to interrupt transmission. The struggle against polio, in seeking to reach all communities, is supported by a partnership led by the Government of India. It includes various stakeholders from the public sector, civil society, professional bodies, WHO and UNICEF, and others, among which most notably are Rotary International, DfID, USAID and CDC.

Figure 9: Polio incidence by month, India, 1998–2004



Situation Reports

HIV/AIDS Epidemiology

HIV/AIDS burden and transmission routes, 2004

Country	Adult HIV prevalence (%)	Number of people living with HIV/AIDS	Mode of HIV transmission	
			Heterosexual	Injecting drug use
Bangladesh	<0.2	7 500	+	+
Bhutan	<0.1	<100	+	-
DPR Korea	-	-	-	-
India	0.9	5 100 000	+++	++
Indonesia	0.1	110,000	+	++
Maldives	<0.1	<100	+	-
Myanmar	1.2	330 000	+++	++
Nepal	0.5	61 000	+	++
Sri Lanka	0.1	3 500	+	-
Thailand	1.5	570 000	+++	++
Timor Leste	<0.1	<100	n/a	n/a

Route of HIV transmission
 (-) Unknown or minimal HIV transmission;
 (+) limited HIV transmission;
 (++) moderate HIV transmission; and
 (+++) major HIV transmission

DOTS Expansion

Success of DOTS, 30 September 2004

Country	DOTS coverage 2003	DOTS case-detection 2003		Treatment results, 2002 cohort	
		New smear positive	Rate	New smear cured	positive success
Bangladesh	99%	53 618	33%	81%	84%
Bhutan	100%	360	32%	76%	86%
DPR Korea	80%	16 445	91%	85%	88%
India	85%	372 088	47%	86%	87%
Indonesia	98%	92 566	33%	72%	87%
Maldives	100%	68	106%	95%	95%
Myanmar	95%	27 448	73%	71%	81%
Nepal	94%	14 348	60%	84%	86%
Sri Lanka	74%	3 652	70%	79%	81%
Thailand	100%	28 459	72%	69%	74%
Timor Leste	78%	1 027	53%	71%	81%
SEAR total	84%	610 079	45%	81%	87%

Malaria Situation

Malaria profile, 2003

Country	Reported malaria cases	Reported malaria deaths	Annual parasite incidence
Bangladesh	56 879	574	0.4
Bhutan	3 806	15	5.4
DPR Korea	16 538	0	1.9
India	1 863 303	1006	1.8
Indonesia	175 558	211	0.8
Maldives			
Myanmar	177 496	2476	3.3
Nepal	9 394	3	0.4
Sri Lanka	10 510	2	0.6
Thailand	37 355	325	0.6
Timor Leste	31 819	8	38.6
SEAR total	2 382 661	4620	1.8

News Bytes

Dengue outbreak in Timor-Leste

In an outbreak of dengue in Timor-Leste from January to April 2005 a total of 730 cases occurred, with 34 (4.6%) deaths. Eight districts have been affected: Dili, (442 cases, 27 deaths), Baucau (166 cases, 4 deaths), Bobonaro (Maliana) (84 cases, 2 deaths), Manatuto (11 cases, 1 death), Liquica (6 cases), Ermera (2 cases), Viqueque (16 cases), and Manufahi (3 cases) (Figure 10). Most of the cases were among 1–14 year-olds (68%).

WHO provided technical support in collaboration with the WHO Collaborating Centre for Case Management of Dengue Fever (DF)/Dengue Haemorrhagic Fever (DHF)/Dengue Shock Syndrome (DSS) (Queen Sirikit's National Institute of Child Health, Bangkok, Thailand). Initially, the case fatality rate was high and declined remarkably due to the training on case management provided to health care workers by WHO: 11.6% on 31 January 2005, 9.3% on 15 February 2005, 7.4% on 22 February 2005 to 5.5% on 14 March, 2005. However, the fatality rate of 2.06% among cases admitted during 16 February to 14 March 2005 was still unacceptably high.

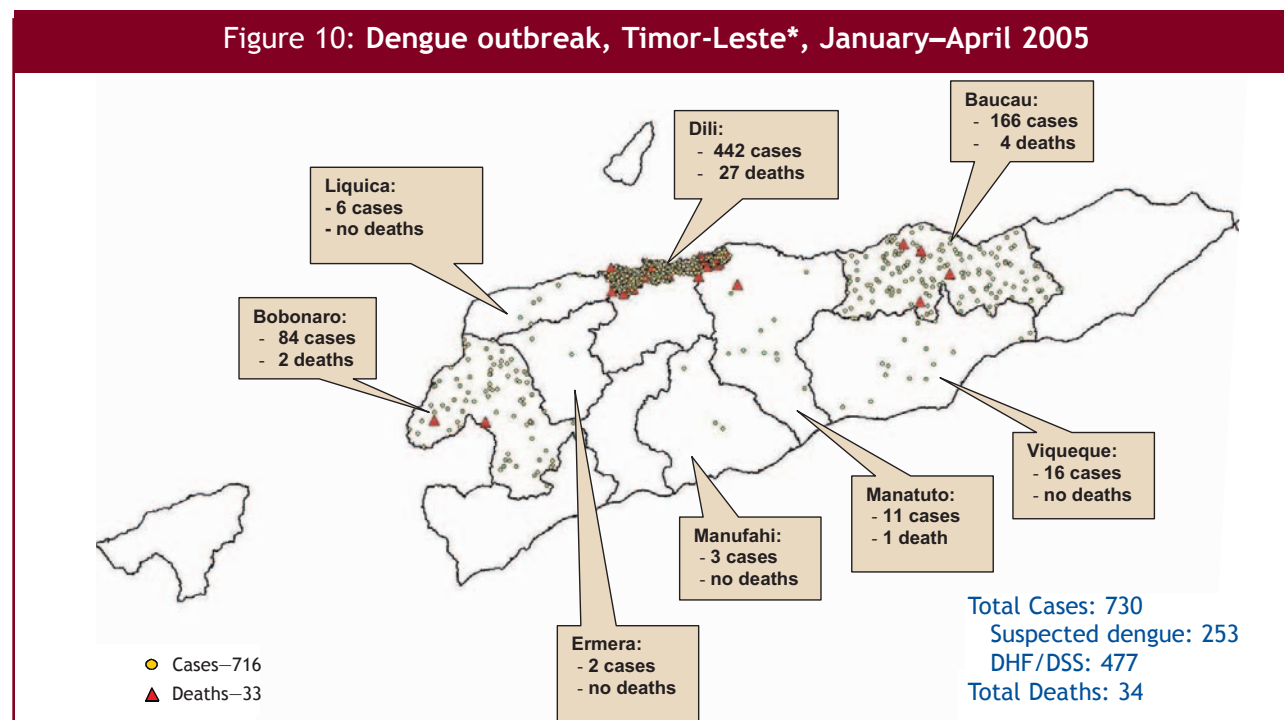
A virologist and an entomologist from the National Institute of Infectious Diseases, Japan, partners in the WHO Global Outbreak Alert and Response Network, assisted the Ministry of Health (MoH). Preliminary laboratory results have identified Dengue 3 as the main circulating strain in this outbreak.

Entomological surveys suggested *Aedes aegypti* as a major vector in Dilli. Plastic bottles, drums, used tyres and flower pots in cemeteries contributed to mosquito breeding.

The Ministry of Health has been carrying out community mobilization activities to reduce the breeding sites of the *Aedes* mosquito. Community and religious leaders were also involved in the development of the plan for community mobilization and WHO has helped MoH technically and operationally. In addition, space spraying of insecticide has also been applied in high-risk areas in Dilli.

The combined effort is a demonstration of WHO (country, regional and headquarter) leadership in providing support to a country with limited resources and capacity. WHO was able to strengthen capacity of MoH in responding to the epidemic. Surveillance data generated by the MoH was used to obtain political commitment and government support as well as to attract donor and international community support to control the outbreak.

—Based on reports provided by Dr Yuwono Sidhart, WHO Office, Dili



Source: WHO Office, Timor-Leste, April 2005

* The boundaries and names shown and the designations used on all the maps do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Indian Patent Act revised: Possible implications for AIDS treatment scale-up worldwide

On 23 March 2005, the Indian Parliament passed the 3rd Amendment to the Patents Act. This Amendment was necessary to make India compliant with the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The amendment introduces product patents for pharmaceuticals. Before 2005, India did not grant such protection; therefore generic versions of medicines that were patented elsewhere in the world could be produced in India. The Amendment to the Patent Act will change this.

Moreover, under TRIPS transitional provisions, India had to set up a 'mailbox' system to receive applications for medicines patented elsewhere between 1995–2004. These applications, which may include some antiretroviral medicines as well as other relatively new medicines, now will have to be assessed, and patents may be granted.

From a public health perspective, the most immediate concern relates to whether the production of generic versions of medicines with "mailbox-patents" would have to stop. Fortunately, the 3rd Amendment provides that the production of generic medicines which are already on the market in India can continue, subject to the payment of royalties to the patent holder. This is an important positive feature of the amendment, since it will help to ensure that there is no backsliding in access to affordable medicines in the short term. At the same time, the production and marketing of additional generic versions of medicines with patent applications in the mailbox may well be delayed.

Update on avian influenza

From 28 January 2004 up to 20 April 2005, a total of 88 confirmed human cases of avian influenza with 51 deaths (fatality rate=58%) have been officially reported from Cambodia (3), Thailand (17), and Viet Nam (68). Among these, 41 confirmed cases (of which 16 were fatal) in Viet Nam, and 3 in Cambodia (all fatal) were reported from 31 December 2004 to 20 April 2005. No new confirmed human case of avian influenza was reported in Thailand since end of October 2004.

Surveillance to detect early, investigate and contain avian influenza continues in all the three above-mentioned countries. Further details on the situation of avian influenza are available at http://www.who.int/csr/disease/avian_influenza/en/

By February 2005, the WHO Influenza Surveillance Network had characterized H5N1 influenza viruses isolated from humans and animals from several countries affected by the 2004/2005 H5N1 outbreak in Asia. Based on that, WHO collaborating centres and reference laboratories have developed several recombinant H5N1 prototype vaccine strains, which have already been made available to a number of institutions and companies and

Cumulative Number of Confirmed Human Cases of Avian Influenza A/ (H5N1) reported from January 2004 to 20 April 2005

Country/Territory	Total Cases	Deaths
Cambodia	3	3
Thailand	17	12
Viet Nam	68	36
Total	88	51

Source: SEARO and WPRO daily outbreak updates

several different vaccines have been produced for clinical testing.

In late March 2005, an outbreak among poultry was reported from three chicken farms in DPR Korea (H7 sub-type). A total of 220 000 chickens were culled and buried to contain the outbreak. WHO and FAO are providing technical support to the national authorities.

Development of the Department of Communicable Diseases Communication Strategy

The high burden of communicable diseases is a major concern to WHO. In some countries of the WHO South-East Asia Region, communicable diseases are estimated to be responsible for majority of childhood and adult deaths. While leprosy, lymphatic filariasis and kala-azar are targeted for elimination, HIV, tuberculosis and malaria still occur in epidemic proportions, taking a heavy toll of life.

New threats are emerging: the recent outbreaks of SARS and avian influenza and the consequences for health of the Tsunami disaster have seriously put at risk the population and have attracted the interest of policy makers, donors, media and the public. This has highlighted the need to keep the community informed on associated risks and how people should protect themselves.

In this context, a Department of Communicable Diseases (CDS) communication strategy is critical to draw attention of policy makers to key topics and their subsequent commitment to reduce the disease burden, and to provide tools for an effective response to outbreaks thus contributing to their control. The Department is also developing a fundraising communication strategy to sustain financing of communication activities. Cristiana Salvi, Communication Officer, CDS, WHO SEARO, has been developing the communication strategy with input from various technical units.

Global Fund to Fight AIDS, Tuberculosis and Malaria calls for its 5th Round of proposals

More than US 1 billion dollars is expected to be available in the 5th Round of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) financing, as compared to US 960 million dollars in Round 4. The deadline for receiving proposals is 10 June 2005. The call for applications was announced on 18 March 2005.

For the 5th Round, GFATM has applied some changes in the application process, particularly in the revision of the list of components, which will no longer include HIV/TB. Changes have also affected the eligibility criteria. This includes the concept of "CCM requirements," which refers to certain conditions that Country Coordinating Mechanisms (CCM) must necessarily fulfil in order to qualify for GFATM support.

GFATM was set up in January 2002 as a financial instrument to attract, manage and disburse additional resources for AIDS, tuberculosis and malaria, through a new public-private partnership. These diseases account for nearly 6 million deaths per year worldwide. By making a sustainable contribution to mitigate their impact, GFATM is contributing to poverty reduction as part of the Millennium Development Goals.

WHO SEARO stands ready to assist Member Countries in preparing proposals for the 5th Round.

Bi-regional Workshop on Strategic Framework for Emerging Diseases

A bi-regional WPRO/SEARO workshop to review the draft joint strategic framework for emerging diseases was conducted in New Delhi, India from 7–9 March 2005. In his closing remarks, Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, underscored the need for mapping of resources within the two regions for implementation of the strategy. He also noted that bi-regional activities should continue and be enhanced while the strategy is being developed. At the opening of the three-day workshop, the Director, Programme management, Dr Bjorn Melgaard, underlined the threats posed by emerging diseases in both SEAR and WPR Member Countries and highlighted the significance of the bi-regional strategic framework for combating emerging diseases.

The meeting was attended by Directors of CDS, coordinators, and experts on disease surveillance from the two WHO Regional Offices. The participants reviewed the draft bi-regional strategy, agreed on milestones to finalize the document, and discussed joint mechanisms for enhancing advocacy and resource mobilization for the implementation of this strategy.

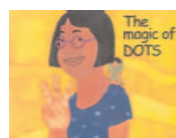
New SEARO Publications



1. **AIDS in Asia. The Challenge Ahead**, Editor Jai P. Narain. Sage Publications. 2004 , ISBN 0761932259, 395 pages, Rs 295. This important and comprehensive volume focuses on the epidemiological and programmatic aspects of the HIV/AIDS epidemic in Asia. The contributors discuss the dynamics and determinants of HIV and cover a wide range of pertinent topics related to its prevention, care and treatment. In addition the volume provides country-specific HIV reports. The contributors highlight success stories as also the lessons learned from the Asian response to the challenge. They argue that facilitating access to care, including antiretroviral treatment, is now a matter of crucial importance as is scaling up innovative practices that have proved effective in Asia.



2. **Combating Emerging Infectious Diseases in the South-East Asia Region**, 2005, SEA-CD-139, 36 pages, gratis. Prepared in consultation with leading experts in public health from the Region, the document highlights the impact of emerging diseases, including dengue fever, SARS, avian influenza, and drug-resistant pathogens. The document articulates broad strategies and key activities for effective surveillance, outbreak alert and response.

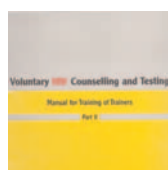


3. **The magic of DOTS**, 2005, SEA-TB-A2, 63 pages, gratis. The story in this book deals with a tuberculosis (TB) patient. One day, Chehek is absent from school. Her class friends missing her are trying to find out why. They find her at home taking care of her mother who is suffering from TB and going to die. The children are desperate, until Mishti fairy appears to one of them, telling the good news that TB is curable. The children don't hesitate to explore more, they go to the dispensary and learn more about TB and its treatment. They go immediately back to Chehek and convince her mother to go to the dispensary.

4. **Protecting Humans from Avian Influenza**, 2004, 10 pages, gratis. This small booklet is adapted from WHO guidelines on "Prevention and Control of Influenza due to Avian Influenza virus-A H5N1", for the South-East Asia Region. It provides information on control of avian influenza in humans giving practical details for protection of people involved in culling of potentially infected animals.

5. **Regional Strategic Plan for Elimination of Lymphatic Filariasis**, 2004, SEA-FIL-29, 37 pages, gratis. Lymphatic filariasis (LF) is one of six infectious diseases targeted by WHO for elimination, i.e. a reduction in micro-filaria rate to <1%, by the year 2020. This is an achievable goal since a cost-effective intervention in the form of Mass Drug Administration of two drugs (DEC+albendazole) is available. To assist the nine LF endemic countries of SEAR in their efforts towards achieving the LF elimination goal, a Regional Strategic Plan has been developed which covers the 2004–2007 period.

6. **Leprosy Elimination Monitoring in India**, 2004, Joint Government of India, National Institute of Health & Family Welfare and WHO publication, 2004, 63 pages. Leprosy Elimination Monitoring (LEM) was developed by WHO as a monitoring tool to assess the progress of leprosy elimination and quality of leprosy services through various indicators. In India a third component was added in 2003—the validation of leprosy diagnosis. LEM in India is jointly conducted by the Government of India, National Institute of Health & Family Welfare and WHO, in collaboration with the International Federation of Anti-leprosy Associations (ILEP). This publication explains the results of the study.



8. **Voluntary HIV Counselling and Testing, Manual for Training of Trainers: Part I and II**, 2004, ISBN9290222336. This two-part publication is a supporting document for two training workshops. The first training workshop is on basic HIV counselling (for a duration of 2 weeks) and the second training workshop is on training technology (for a duration of 1 week).



9. **Expanding Access to HIV/AIDS Treatment, A Strategic Framework for Action at Country Level**, 2004, SEA-AIDS-145, 26 pages, gratis. For the vast majority of people living with HIV/AIDS in resource poor countries, antiretroviral treatment (ART) has remained largely inaccessible. A well designed strategy and plan for scale up of ART is of critical importance. This document outlines a strategic framework within which the ART programme can be implemented in the South-East Asia Region. It underscores the important need to strengthen the capacities of health systems to identify individuals who need therapy, facilitate their entry into the ART programme, provide an uninterrupted supply of antiretroviral drugs and diagnostics and ensure treatment adherence.



10. **Expanding Access to HIV/AIDS Treatment, Operational Research to Scale-up Antiretroviral Treatment in the South-East Asia Region**, 2004, SEA-AIDS-148, 29 pages, gratis. In South-East Asia, a nearly 10-fold scale-up is required to close the HIV/AIDS treatment gap, however, evidence base on how to scale-up is unavailable. As ART programmes are accelerated, several questions are likely to emerge—Is the programme working? How can we make it more efficient? What can we do to increase access? Is the health sector burdened or strengthened by treatment activities? Prioritizing research questions is an important first step towards generating relevant strategic information for guiding ART scale-up.

Communicable Disease Newsletter

<http://w3.who.sea.org/cds/>



Mark Your Calendar

Upcoming Conferences and Meetings

1-5 July 2005

7th International Congress on AIDS in Asia and the Pacific (ICAAP)

Location: Kobe, Japan

The 7th ICAAP under the theme "Bridging Science and Community" encourages a greater involvement of people living with HIV/AIDS and other affected communities, to present the most recent achievements in science and community work and will encompass efforts and activities related to prevention, care and treatment at all levels. For more information visit www.icaap7.jp

7-11 August 2005

The 6th Global Conference on Health Promotion—Policy and Partnerships for Action: Addressing the Determinants of Health

Location: Bangkok, Thailand

A lot has changed in the world during the past 20 years, including globalization, the internet, greater move towards private sector involvement in public health, and emphasis on a sound evidence-based approach and cost-effectiveness. The 6th Global Conference has been convened to meet these challenges and to better exploit the opportunities presented for health promotion in the 21st Century. For more information visit www.who.int/noncommunicable_diseases/6gchp/en

21-25 August 2005

XVII IEA World Congress of Epidemiology

Location: Bangkok, Thailand

This congress is designed to promote discussion and exchange of ideas, experiences, technical advances to tackle health challenges posed by dynamic national, regional and global contexts. Users of epidemiology, health actors and policy makers will benefit from the Congress. For more information visit <http://wce2005.org>

25-29 September 2005

23rd IUATLD Eastern Region Conference

Location: Lahore, Pakistan

The goal of this conference is to bridge the gap between developed and underdeveloped countries in tuberculosis control, specifically in the Eastern Region, as well as to formulate a strategic and coordinated mechanism to combat TB in the countries that form the South Asian Association of Regional Cooperation (SAARC). For more information visit <http://www.patba.com/conference.html>

18-22 October 2005

36th IUATLD World Conference on Lung Health

Location: Paris, France

The theme of the 36th annual conference is "scaling up and sustaining effective tuberculosis, HIV and asthma prevention and control." A main focus of the conference is using the tools that effectively tackle TB, HIV/AIDS, asthma, and other lung diseases, such as pneumonia in children, efficiently and correctly. For more information visit www.worldlunghealth.org/Conf2005/index.php

CDS Upcoming Events

- **April 2005**
Launching of the Bi-regional (SEAR/WPR) Report on TB control in Asia and the Pacific.
- **3-4 May 2005**
First Meeting of the South East Asia Regional Programme Review Group (RPRG) for Lymphatic Filariasis SEARO-New Delhi.
- **2-13 May 2005**
Bhutan National TB Programme Review, Thimphu, Bhutan.

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