

Communicable Disease Newsletter

World Health Organization Regional Office for South-East Asia

Dr LEE Jong-wook (1945-2006)



On 22 May 2006, the world was shocked to hear about the tragic and sudden demise of Dr LEE Jong-wook, Director-

General of the World Health Organization. He was 61 years old. Dr LEE has been Director General since 21 July, 2003. Prior to that he had worked for more than 20 years for WHO, first battling leprosy in the South Pacific islands and then tackling vaccine preventable diseases including polio and tuberculosis.

Throughout his 23-year career at WHO, Dr LEE made a difference in every programme he managed - whether by leading the charge to eradicate polio from the Western Pacific or to launch a cutting-edge Global Drug Facility so people would have access to tuberculosis medicines.

Dr Lee's work in tuberculosis control and vaccines demonstrated his personal strategic focus on health interventions to reduce poverty.

Since the appointment as Director of the Stop TB Department in WHO in 2000 – and building on previous experience as head of the Global Programme on Vaccines and Immunization – Dr Lee rapidly built what is internationally recognized as one of the most successful and dynamic global public-private partnerships for health: the Global Partnership to Stop TB.

In accelerating movement towards the global TB control targets, he led efforts which will make a substantial contribution to reaching the Millennium Development Goals.

“In Dr LEE Jong-wook the world has lost a great man. He was a man of conviction and passion. He was a strong voice for the right of every man, woman and child to health prevention and care and advocated on behalf of the very poorest people,” said United Nations Secretary-General Kofi Annan.

Mr Tadahiro Lee, son of Dr LEE summed up the personality of his father. “My father was a man of action, whose adventurous spirit led him to experience more, see more, and do more. This spirit made him great at work, and great at life.”

Epidemiological features of avian influenza in humans

The threat of a potential pandemic caused by the H5N1 influenza virus continues. As the virus is now considered endemic in poultry in some parts of the world and is continuing to spread to birds in new areas, sporadic human cases will continue to occur. The widespread distribution of the H5N1 virus in poultry and the continued exposure of humans suggest the risk of the virus evolving into an agent with greater transmissibility in humans.

An analysis of currently available epidemiological, clinical and virological data is essential for a better understanding of the disease. This analysis may also help in

developing appropriate interventions to halt the occurrence of a pandemic or pre-empt it.

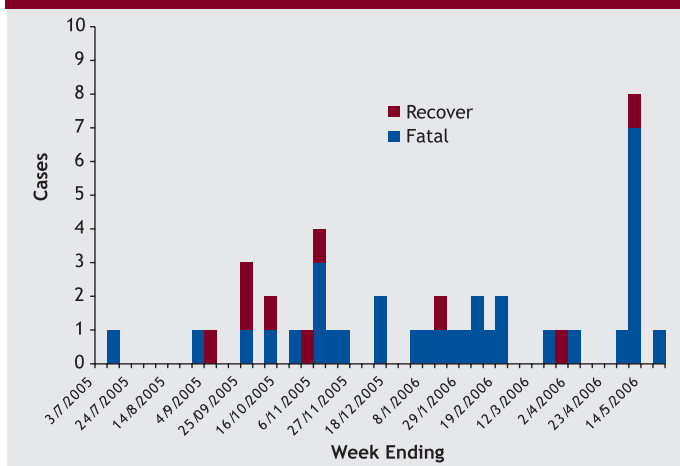
Avian influenza in humans

From 1 December 2003 to 31 July 2006, 10 countries have reported a total of 232 laboratory-confirmed human cases of H5N1 avian influenza to WHO. Of these 134 died. The number of new countries reporting human H5N1 cases has increased dramatically after October 2005, following the geographical extension of outbreaks among avian populations. Prior to mid-2005, only four countries had officially reported cases of H5N1 infection in humans. From October 2005 until the end of July 2006,

Inside

- **Delhi Declaration – the joint ministerial statement to combat avian influenza** 3
- **The revised malaria control strategy for the South-East Asia Region** 5
- **Partnerships contributing to TB control** 6
- **Update on Global Fund for AIDS, Tuberculosis and Malaria: Sixth call for proposals** 8
- **School deworming initiative in Myanmar** 9
- **WHO provides technical lead in the “Three Diseases Fund” in Myanmar** 10
- **News Bytes** 11
- **New SEARO Publications** 14
- **Mark Your Calendar** 15
- **Update on Avian Influenza** 16

Figure 1: Weekly distribution, H5N1 human cases, 2005-2006, Indonesia



Source: WHO Jakarta

six new countries reported cases of H5N1 infection in humans.

In the WHO South-East Asia Region (SEAR), Indonesia and Thailand have reported human cases. Thailand has reported 23 cases, of which 15 died. Only one human case has been detected in Thailand in 2006, Indonesia continues to report human cases. Till 31 July 2006, the number of cases and deaths due to avian influenza in Indonesia is 54 and 42 respectively.

Avian influenza in Indonesia

Human cases of avian influenza A (H5N1) have been reported in Indonesia since 2005. While these cases have occurred in eight provinces on two islands, infection in poultry has been reported from 27 of 33 provinces.

The age of the patients ranged between 18 months to 43 years with a mean of 20 years. 31 of the patients were males and 21 females giving a ratio of 1.4 : 1. While 44% of cases belonged to rural areas, 31% were detected in semiurban settings. 25% patients belonged to urban areas.

Direct exposure to H5N1-infected animals or animal by-products was seen in 38% of cases. Indirect exposure in an environment with poultry in vicinity or recent poultry deaths had occurred was observed in 37% cases. Possible human cases in a cluster where inefficient and non-sustained human to human transmission may have occurred in seven cases is currently under investigation to understand its epidemiology. In remaining six cases the evidence of exposure could not be established.

In 2005, 11 of the 17 avian influenza A (H5N1) cases died while in 2006, 31 of 37 cases died in the first seven months of the year. The case fatality rate (CFR) has therefore increased from 65% to 84%. The number of patients dying after H5N1 infection has increased almost three times in seven months as compared to 2005. The CFR in Indonesia is believed to be higher than most other countries. Statistically, however, the Indonesia CFR is not significantly different to that in Thailand or China. It is nevertheless significantly

higher than that in Viet Nam (RR 1.7, $p < 0.005$)

The weekly distribution of H5N1 human cases and deaths is shown in Figure 2. It shows a sudden increase in the number of human cases during the week commencing 14 May 2006 in which six out of seven affected persons died. All six cases were from a family in North Sumatra.

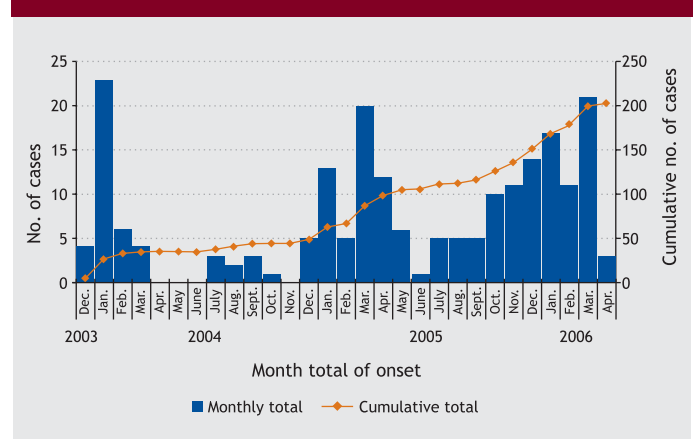
Human H5N1 clusters have been reported previously in Indonesia, as elsewhere in the world. Most clusters can be linked with exposure to H5N1 infected birds or contaminated material. However, limited human to human transmission in family clusters cannot be ruled out in some clusters.

Avian influenza in other countries

Globally ten countries have reported human H5N1 cases. Five of these countries detected human cases between October 2005 and July 2006.

The median age of confirmed cases was 20 years while the age of cases ranged from three months to 75 years ($n = 202$). Half of the cases occurred among people aged < 20 years; 90% occurred among those aged < 40 years. Among cases aged < 10 years, 21 children were aged below 5 years and 32 children between five and nine years. The overall sex ratio of males ($n = 97$) to females ($n = 106$) was 0.9.

Figure 2: Seasonal distribution of human cases



Source: Weekly Epidemiological Records, 2006:81, 249-260

The overall case-fatality rate was 56%. The highest case fatality rate reported was 73%; this occurred among those aged 10–19 years ($n = 49$). The lowest case-fatality rate (18%) was in patients > 50 years of age.

Although cases have occurred all year round, the epidemiological curve of H5N1 cases peaked during the cooler periods (Figure 2) in the northern hemisphere for each of the years studied. If this pattern continues, an upsurge in cases could be anticipated starting in late 2006 or early 2007. Further studies are needed to assess the relationship between climatic conditions, poultry outbreaks due to H5N1 infection and associated human cases.

(The article has been based upon published and unpublished information made available by various WHO offices)

Delhi Declaration – the joint ministerial statement to combat avian influenza

The outbreak of avian influenza A H5N1 in poultry and wildbird populations reported in Asia, Europe and Africa over the past two years and the consequent human cases have resulted in a public health and economic impact not only in the affected countries but also worldwide. To combat this threat to global health security, countries must continue their preparedness and planning efforts. To assist in this goal and agree on a strategy for action which will consolidate in country and inter country collaboration, the World Health Organization and Government of India in collaboration with the Food and Agriculture Organization jointly hosted a Regional Conference of Ministers of Health, Agriculture/Livestock with their respective advisers from countries in the South-East Asia Region together with Afghanistan and the People's Republic of China in New Delhi on July 28 2006.

The objectives of the conference were:

- (1) To review the situation on avian influenza and the risk of a pandemic;
- (2) To identify mechanisms for integrated and multi-sectoral response at the national level;
- (3) To develop intercountry collaboration for effective action against the pandemic threat; and
- (4) To develop a common strategy for combating avian influenza

During the inauguration session welcome addresses were given by Dr Samlee Plianbangchang, Regional Director WHO Regional Office for South-East Asia, Dr He Changchui, Assistant Director General and Regional

Representative for Asia and the Pacific, FAO, and Dr Teruhide Fujita, Regional Representative for Asia and the Pacific, OIE. Opening remarks were also given by Mr Sharad Pawar, Union Minister of Agriculture and Consumer Affairs, Food & Public Distribution, Government of India, and Dr Anbumani Ramadoss, Union Minister of Health & Family Welfare, Government of India. Mr Somnath Chatterjee, Speaker Lok Sabha of India graced the concluding session in which Delhi Declaration was released.

The outcome of the conference was a joint ministerial statement in the form of "Delhi Declaration" which articulates the commitment of the Ministers to:

- Develop and/or further strengthen animal and human disease surveillance and response systems for early detection and prompt containment of avian influenza and other emerging zoonotic diseases;
- Mobilize required resources to develop, strengthen and sustain disease surveillance and response systems, including those employed in the prevention and control of avian influenza;
- Improve bio-safety, infection control and bio-security measures and implement necessary interventions to prevent the spread of animal diseases such as avian influenza to humans;
- Further strengthen regional and international collaboration on all aspects of avian influenza, including investigation of cases and outbreaks and efforts at further research in defining the epidemiological and virological characteristics of the disease.



- Improve risk communication in raising public awareness and empowering communities to take positive action on prevention and control of avian influenza, taking into account relevant socio-behavioral, cultural and economic factors;
- Promote collaboration between all institutions and sectors involved in response to the disease outbreak at local, national, regional and international levels;
- Collaborate and coordinate with all relevant agencies and sectors in promoting safe animal husbandry practices, trade in animal and animal products and food safety with the aim of minimizing human health risks from avian influenza;
- Facilitate prompt and open exchange of information on avian influenza between and among countries and with concerned international agencies to ensure transparency in reporting and facilitate consultation on health-related measures of international concern, especially during disease outbreaks;
- Further strengthen and harmonize activities related to all important aspects of avian influenza, both in animals and humans, including surveillance, investigation of suspected cases, collection of specimens, laboratory support and characterization of the virus; determining the epidemiological aspects of the disease, and defining appropriate public health responses and other interventions such as appropriate compensation mechanisms;
- Develop a mechanism for inter-country and interregional collaboration in outbreak investigation and containment, information dissemination, and strengthening each other's capacity in responding to avian influenza and other emerging infectious diseases;
- Take necessary steps to update and implement effective national influenza pandemic preparedness plans involving all the sectors and stakeholders in the planning and implementation process;
- Voluntarily adopt the relevant articles of the International Health Regulations and suitable national regulatory framework as a measure of preparedness for influenza pandemic;
- Collaborate in efforts to develop and produce drugs, vaccines and diagnostic tests for avian and pandemic influenza and promote other appropriate research activities;
- In view of the aforementioned, we the Ministers recognizing the importance of regional initiatives, hereby recommend our governments and the existing regional fora in Asia, such as, ASEAN and SAARC along with the World Health Organization (WHO), the Food and Agriculture Organization (FAO) and the World Organization for Animal Health (OIE) in



collaboration with other relevant international organizations to:

- Develop a common framework within which countries could build specific strategies for prevention and control of avian Influenza and to be prepared for pandemic influenza threat.
- Define uniform standards and monitor their implementation for reducing the risk of HPAI infection to humans by appropriate control measures of its outbreaks in poultry and other animals.
- Share available knowledge and expertise and also take leadership in the respective regions in surveillance and outbreak investigation, laboratory support, risk communication and research, and
- Further intensify efforts to make sufficient resources available to address this public health threat.

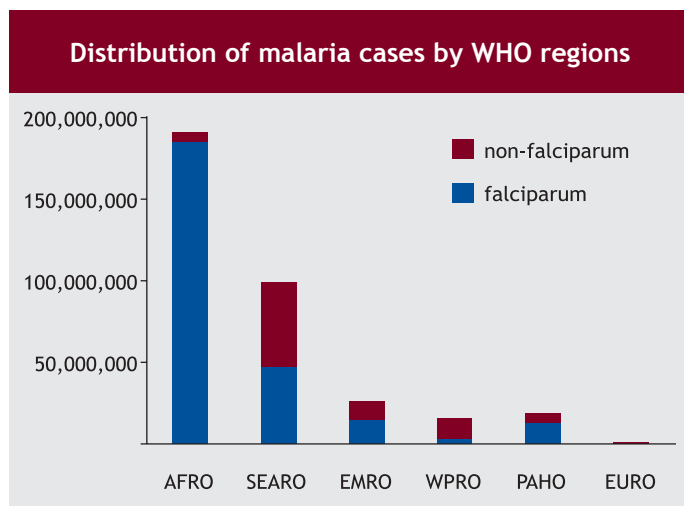
In addition to adoption of Delhi Declaration, the Ministers and senior officials from countries of WHO's South-East Asia Region, Afghanistan and China also recommended

- (1) That existing regional Asian forums like ASEAN and SAARC together with WHO, FAO and OIE should develop a common framework within which countries could build specific strategies for prevention and control of AI and to be prepared for pandemic influenza threat.
- (2) To define uniform standards and monitor their implementation for reducing the risk of H5N1 infection to humans by appropriate control measures.
- (3) To share available knowledge and expertise.
- (4) To take leadership in the respective regions in surveillance and outbreak investigation, laboratory support, risk communication and research

The Delhi Declaration shall serve as a blueprint for future action to combat avian influenza in the Region and make all out efforts to prevent the pandemic.

The revised malaria control strategy for the South-East Asia Region

The burden of malaria in Asia is second only to sub-Saharan Africa (figure below). The disease is endemic in virtually all the countries of the WHO South-East Asia (SEA) Region.



Source: WHO Provisional Estimates 2004

While reported deaths due to malaria have dropped (45.1% reduction in 2004 over 1994) and there is a slow declining trend in reported cases (3.37 million in 1994 to 2.53 million in 2004), the proportion of *Plasmodium falciparum* cases has increased steadily (from 19.6% in 1970 to 47.9% in 2004). The problem of multi-drug resistant *P. falciparum* is expanding geographically. At the same time the importance of *P. vivax* has been ignored as the disease is non-fatal. Focal outbreaks of malaria were reported in almost all countries and this reflects the unstable nature of malaria transmission outside Africa as well as the inadequacies in the control programme.

Revised malaria control strategy

WHO/SEARO in recognition of the urgency for such a revision, held a brainstorming workshop to revise the strategy for malaria control in SEA Region countries in SEARO in 2005. The workshop, attended by international experts, recommended key elements for development of the malaria control strategy. The revised strategy was further discussed during the Malaria Programme Managers' Meeting in Manesar, Haryana, 2006. The stated goal is to achieve reduction of malaria morbidity and mortality by 50% of the level of the 2000 levels by 2010 and to meet the malaria-related Millennium Development Goals (MDGs) by 2015.

The guiding principles behind the revised strategy include scaling up of preventive interventions based on ecological, behavioural and environmental determinants prevailing in an area, using a multisectoral approach so that a balanced provision of both prevention and treatment services is ensured.

The key strategic elements of revised strategy are:

- (1) Reforms aimed at programme planning and management (including monitoring & evaluation).
- (2) Augmenting vector and disease surveillance and operational research.
- (3) Scaling up coverage and use of prevention and treatment services (targeted at "hard-to-reach" populations).
- (4) Early detection and rapid response to outbreaks to save lives and avert economic loss.

Implementation of strategy

To implement the strategy and interventions, emphasis needs to be on programme planning and management comprising of advocacy, planning and information exchange, mobilization of additional resources, acceleration of human resource development, strengthening of health infrastructure and development of a monitoring and evaluation framework to track progress of implementation.

Expected outcomes by 2010

- All countries adopted and implemented revised malaria control strategy as part of healthy public policies.
- 80% coverage of households with insecticide treated nets or indoor residual spray, focusing especially on the population at risk.
- 80% of fever patients treated in malaria endemic areas.
- 50% reduction in case fatality rate (institutional malaria death due to *P. falciparum*).

Implementation of revised strategy shall require building strong partnerships between various stakeholders, notably the Ministry of Health, Ministry of Agriculture, private sector, civil society and communities. A Regional Technical Advisory Group constituted in 2004 shall provide technical guidance.

It is through strong political commitment and concerted efforts in implementation of the revised malaria control strategy that Member States are expected to reach the goals by 2010 and achieve related MDGs by 2015. This would require increased visibility and awareness of malaria through strong and high-level political commitment and a significant increase in financial support for malaria control.

The revised malaria control strategy will be discussed during the Health Ministers' Meeting Dhaka in August 2006.

Partnerships contributing to TB control

Success Stories from South-East Asia Region

Substantial progress has been made by the Member States of the South-East Asia Region to achieve the World Health Assembly targets set in 2000 for case detection and treatment success under DOTS. Tuberculosis (TB) case detection rates have increased steadily to over 60% in the Region as a whole. Treatment success rates of over 85% among new smear-positive cases are consistently being achieved. Between 1997 and 2004, almost 15 million patients were put on treatment, six million of these under DOTS programmes in the Region, thereby averting nearly 500 000 deaths. For the first time in decades, a demonstrable impact on TB morbidity and mortality is being seen.

Much of this progress is attributed to wider coverage with DOTS; intensified efforts to improve the quality of services, and growing partnerships with other providers particularly nongovernmental organizations (NGOs), the private health sector, medical schools and large public enterprises (Table 1).

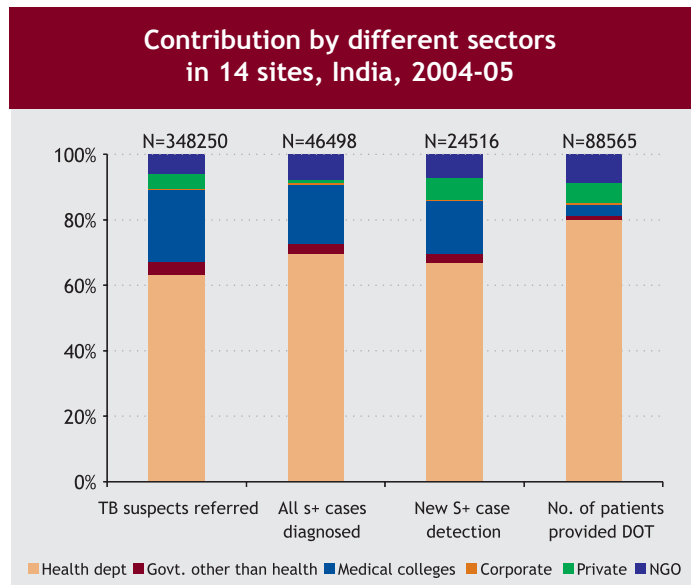
Public-private, public-public and private-private mix (PPM) collaborative activities for TB are being scaled up at 14 sites in India.

Table 1: PPM activities in SEAR Member States

	Public-private partnership	NGO involvement	Community TB care interventions
Bangladesh	x	x	x
Bhutan	-	-	x
India	x	x	x
Indonesia	x	x	x
Maldives	x	x	x
Myanmar	x	x	x
Nepal	x	x	x
Sri Lanka	x	x	x
Thailand	x	x	-
Timor-Leste	-	x	x

Partnerships for TB Control

Reports from India, Indonesia and Myanmar indicated that, where initiated, public and private partnerships for TB control have resulted in increments of up to 25% in case notification with good treatment outcomes. Medical



Source: RNTCP

colleges in several Member States have begun to teach and practise DOTS, and are establishing DOTS centres in their clinical units. DOTS services are increasingly being provided at workplaces.

Figure above illustrates the relative contribution of each sector in referring suspects, identification of new and retreatment smear-positive cases and provision of DOT or directly-observed treatment.

There are many examples of successful and sustainable partnerships in the Region with private healthcare providers, medical schools, NGOs and businesses and industries.

Partnerships with private health care providers

In many high TB burden countries, over 60% of TB suspects and patients continue to seek care from private or NGO health care providers. Most of these providers, if not actively engaged by national TB programmes, use unstandardized diagnostic and treatment protocols leading to incorrect diagnosis and poor treatment outcomes, at risk of patients developing drug-resistant forms of tuberculosis. Furthermore, in the absence of any legislation to notify TB cases, most patients are not reported. Engaging with health care providers outside the government health system, and especially with private healthcare providers, is therefore critical to the progress with DOTS in the Region.

The public-private mix for DOTS (PPM DOTS) initiative began in the early 1990s with supporting and documenting pilot projects in countries in this Region. Several of these initiatives demonstrated the feasibility of

engaging private providers under programme conditions. These pilot projects have since been incorporated into routine programme implementation by national TB control programmes. They documented highly successful outcomes while simultaneously achieving significant increases in TB case notification ranging between 20-30%, as shown in Table 2.

Table 2: Increase in case notification through public-private partnerships

Site	Additional cases contributed by PPM projects *
Hyderabad, India	23%
Lalitpur, Nepal	21%
Delhi, India	29%
N. Sumatra, Yogyakarta and Palembang, Indonesia	24%
Taunggyi, Myanmar	10%

* Baseline: historical record in same area or neighbouring area with similar set up without PPM project

Source: NTP records

Partnerships with NGOs

Unlike national TB programmes (NTPs), NGOs have a comparative advantage in their flexibility, responsiveness and sense of urgency to effect change over shorter periods of time. Several NGOs are involved in successfully delivering TB services at the community level in this Region.

An outstanding example of a successful Government-NGO collaboration is in Bangladesh, where NGOs (among them BRAC and the Damien Foundation) collaborate with the NTP through a memorandum of understanding to provide DOTS services to a large section of the country's population.

At the core of the BRAC TB control programme is the utilization of community-based voluntary health workers, called *Shasthyo Shevikas*. These are women identified by their community, between 25-35 years of age. Most of them have no formal education but are trained by BRAC on essential health activities including TB control. Their responsibilities in relation to TB control include: to disseminate information about TB to the community; to identify TB suspects and refer them for diagnostic investigations; to ensure DOT; to dispense medication during the intensive and continuation phase; and to follow up on TB patients during and after treatment.

Treatment outcomes in the areas covered by BRAC are very impressive. The cure rate has been over 85% since 1995 and as high as 92% in some areas. Case detection rates are above the nation's average in these areas.

Partnerships with the business sector and industries

TB affects people of all ages, but the hardest hit are those between 20 and 45 years of age- men and women during

the most economically productive years of their lives. These workers spend most of their waking hours at their places of work. The need therefore to introduce access to TB control services may be stronger in this setting than in any other.

The business sector has a large stake in controlling TB. The illness imposes great costs on employers on account of disruption of work, reduced productivity, high treatment costs, and, in addition, significant indirect costs linked to replacement and retraining of workers.

Examples of successful interventions for TB in the workplace were documented from countries around the Region. A regional consultation on introducing DOTS into the workplace was held in 2004. Several examples of employers helping employees through referring them for diagnosis and helping them to be treated in order to prevent the spread of TB both at the workplace and by extension, in communities in which they live, are to be found in the Region. TB control in the Myanmar Railways is a documented successful example of interventions for TB in the workplace.

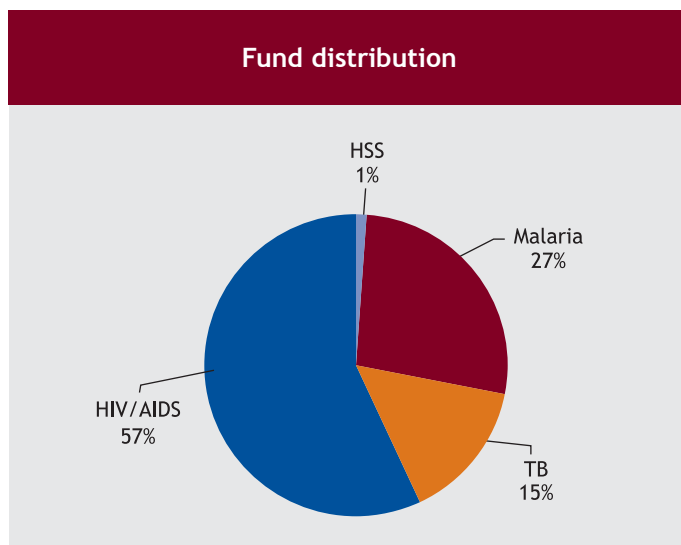
Partnership between the Myanmar Railways and NTP

The Myanmar Railways employs over 30,000 workers and provides free health-care services to workers and their families through the Myanmar Railways Medical Services (MRMS). Pulmonary tuberculosis was recognized as the commonest reason for hospitalization of railway workers. Accordingly, the MRMS in partnership with the NTCP established TB control services to extend DOTS to all railway posts in the country. Training of Medical officers, laboratory personnel and basic health staff has been completed. All workers are being counselled. Those suffering from TB are diagnosed and treated. DOTS services are now being extended to the families/communities of the workers with medical officers supervising treatment. Between 150 to 200 TB cases, half of whom are smear-positive cases, are being registered under DOTS by the MRMS every year with excellent treatment outcomes. The number of TB cases hospitalized and deaths due to TB have been reduced five-fold.

Building partnerships is essential to deal with the many different but interconnected forces involved in delivering health services, including services for TB, under the stewardship of NTP. These efforts can integrate the strengths of individual partners into national and local programmes and enhance overall capacity to deliver essential TB control services.

Update on Global Fund for AIDS, Tuberculosis and Malaria: Sixth call for proposals

The Global Fund (GF) is an international financing mechanism intended to support a country's response to AIDS, TB and malaria through multi-sectoral partnerships. GF has so far accepted proposals for funding through calls for applications. In the previous five rounds of funding, it has approved 359 proposals involving potential funding of over US\$ 3.8 billion over two years. The percentage distribution by disease components is shown in figure below. The call for the sixth round of proposals has been recently announced.



HSS: Health Systems Strengthening

The deadline for submission of proposals is 3 August 2006. GF strongly recommends that proposals be prepared by a broad representation of public and private sector stakeholders and submitted through the country coordination mechanisms (CCMs).

WHO initiatives

WHO/SEARO has been supporting Member States of the Region in accessing the GF funds by providing technical support. Efforts have been made in collaboration with the GF for countries to increase the possibility for successful proposals in this sixth round which will enable nations to improve availability of health services, strengthen national capacity, promote behaviour change, conduct operational research, and gain better access to treatment.

A workshop on Global Fund was organized from 5-7 June 2006 at the WHO Regional Office for South-East Asia in New Delhi, India. The workshop provided Member States with several key points which would be of use in

development of the sixth round proposals. The participants were also introduced to a guideline for writing a procurement and supply management plan and a tool for self assessment of the existing monitoring and evaluation (M&E) system. The guidelines have been prepared by the GF to enable countries to assess the strengths and weaknesses of their M&E systems.

Key elements of sixth round proposals

The minimum requirements that CCMs must meet to be eligible for sixth round are:

- A minimum of 40% of the membership of a CCM must comprise the non-government sector.
- Positions of the Chair and/or Vice-Chair should not be from the same entity to avoid conflict of interest.
- Coordinating mechanism, information and grant processes, should be transparent and documented.

Only eligible proposals will be forwarded by the GF to the Technical Review Panel (TRP). The TRP will evaluate the proposals for their soundness of approach, feasibility and potential for sustainability. The proposals may aim to prevent the spread of disease, treat people who are ill, and/or provide care and support for affected people and/or communities by scaling up existing effective interventions or piloting new and innovative responses.

Proposed activities may include efforts to improve the availability of health services, strengthen health systems and human resource capacity, promote behaviour change, provide critical health products (such as antiretroviral therapy, drugs for tuberculosis, and anti-malarial drugs), or conduct operational research.

Resources from the GF can also be used to support programme implementation, financial reporting, procurement and supply management, and monitoring and evaluation.

Inclusion of funds for technical support to principal recipient is often neglected but is critical for the successful implementation of the grant. It would also ensure efficient use of resources for scaling up interventions for prevention and treatment. This will greatly facilitate achievement of national programme goals and objectives.

School deworming initiative in Myanmar

Progress and Issues

Intestinal worms infect about a third of the world's population and of them 300 million people suffer from severe illness due to these infestations. More than 50% of those affected are school children aged between 5 and 14 years. Soil transmitted worm infestations mainly round worms, whipworms and hookworms are common in South-East Asia (SEA) Region. Deworming is a safe, simple and cost-effective public health intervention that can be integrated into other health interventions.

A regional strategic plan aiming to control these infestations and contributing towards achieving the global target of 'regular deworming of at least 75% of all school-aged children at risk by 2010' is being implemented. Myanmar has demonstrated rapid achievements towards implementing the deworming strategy within a short period.

School deworming programme

Myanmar commenced its school de-worming programme in 2002, with technical assistance from WHO and financial assistance from the German Pharma Health Fund (GPHF). Myanmar is divided into four ecological areas – Hilly, Plains, Delta and Coastal. A baseline survey was conducted in the Delta area which showed a high prevalence (92%) of soil-transmitted helminthiasis (STH) among children.

The survey was followed by a training session of 200 school teachers in the area on health education and treatment for STH. Following the training, 25000 children in 200 primary schools were dewormed in 2002.

Scale up of deworming activities

Deworming activities were scaled up in 2003. The assessment of baseline level of STH infestations in the remaining ecological zones in the country was also completed. Baseline surveys indicated that school-aged children had STH prevalence rates of over 70% in three out of the four ecological zones in the country.

Myanmar planned to cover all the children in these three endemic zones using the existing school infrastructure. A total of 765 teachers were trained for drug distribution and providing health education to children. A total of 90600 schoolchildren in 765 schools were treated in 2003.

The children covered in 2002 in the Delta zone also received two rounds of treatment during 2003. School deworming activities which were piloted in 2002-2003 were expanded in 2004 country-wide to cover 1.5 million children in 7500 schools. In addition, 7500 teachers were also trained.

There were two rounds of deworming in 2005. In the first round, deworming was further expanded to cover 3 million primary schoolchildren from 13 states/ divisions. This round was implemented during the "School Health Week" which is a package featuring several health interventions. In the second round in December 2005, 4.8



Children being administered deworming drugs.

million school-age children and 2.1 million preschool-age children from all 17 states and divisions were dewormed.

New IEC materials were developed and two million pamphlets, 0.2 million posters and 0.2 million guidebooks were distributed to schools all over the country. Advocacy meetings on deworming programmes integrated with school health were also held in all states and divisions.

In Myanmar, STH control programmes gained momentum with the active involvement of other health projects such as school health, nutrition, maternal and child health and lymphatic filariasis elimination. There is the need to explore the possibility of integrating STH control with other programmes such as malaria, Vitamin A distribution and ante-natal care. It was also a model of collaboration between the Ministry of Health, Ministry of Education, WHO and UNICEF.

Albendazole is widely used in the lymphatic filariasis (LF) elimination programme along with diethyl carbamazine in the annual Mass Drug Administration (MDA) campaigns. This campaign provided collateral deworming benefits to 17 million people in 26 districts. In the districts co-endemic for both LF and STH, school deworming rounds are synchronized with MDA rounds to maximize the cost benefits.

During next three years, Myanmar has set the target of two rounds of treatment for all preschool children aged between two and five years and all school-age children between five and nine years together with one round of treatment for all women who are more than three months pregnant.

Efforts are also being made to address the major issues and challenges pertaining to sustainability, coverage and impact assessment.

Dr Aung Tun
Project Manager and Deputy Director (School Health),
Ministry of Health, Myanmar

Dr Myo Paing
WR's Office Myanmar

Dr E A Padmasiri
STP/VBC SEARO

WHO in the countries: Myanmar

WHO provides technical lead in the “Three Diseases Fund” in Myanmar



Dr Adik Wibowo
WHO Representative
in Myanmar

HIV/AIDS, tuberculosis and malaria are three key public health diseases in Myanmar. Combating these diseases require substantial resources. The Global Fund for AIDS, TB and Malaria (GF) had earlier provided US\$ 11.94 million to Myanmar for HIV/AIDS, TB and malaria. After the withdrawal of GF from Myanmar, WHO along with other agencies initiated efforts to generate alternate funding to fill the gap.

Consultations were held with the Ministry of Health, UN agencies and other stakeholders in Myanmar and planning process for an institutional arrangement for a new “**Three Diseases Fund (3DF)**” has been initiated. The 3DF is likely to provide financial support through direct and competitive grants to the implementing partners under a programme based on the National Strategic Plan.

The 3DF is being established by a group of six donors (AUSAID, DFID, the European Commission, Netherlands, Norway and Sweden). The 3DF shall be managed by the Fund Manager, UNOPS, who will report to a Fund Board. The Fund Board will have responsibility for the policies and operations. The 3DF will work with a range of partners, particularly the UN and international NGOs, and through decentralized cooperation with township medical officers.

A formulation mission deputed by the donor consortium visited Myanmar from 7-28 February 2006 and provided additional consultancy to the donor consortium to ensure effective and timely completion of all required documentation for formal project submission to their respective governments.

WHO as a technical lead partner was fully involved with this mission in assessing the current status of the three diseases, finalizing the strategic framework and developing a draft monitoring and implementation strategy for HIV/AIDS, tuberculosis and malaria. WHO shall continue to provide technical support to the 3DF in strengthening the in-built monitoring and evaluation mechanism.

Following the Government approval of the 3 DF establishments, the donors returned to Myanmar to present the final proposal on the fund’s mechanism to the Minister of Health and other related ministries in June 2006.

A new Coordination Mechanism (CM) has been constituted to utilize the support from 3DF. This committee

shall be chaired by the Minister of Health with members – shall be from other relevant ministries, civil societies, UN agencies, international NGOs, local NGOs, other group service providers, bilateral donors and demand side groups. Three technical and strategic groups (TSGs), one for each disease, shall be constituted soon. The TSG will be responsible for co-coordinating and reviewing the National Strategy; preparing the three-year rolling operational plan and budget, and coordinating implementing partners.

The exercise to estimate the financial requirements for the next three years’ operational plan has been initiated. A health economist has commenced work to formulate the overall budgets for the three years. The resource gaps shall be submitted to the 3DF by the end of August 2006.

Given the constraints from donors in providing direct support to national programmes at the central level, the WHO Country Office is proposing to broaden its scope of work and play more active roles in supporting implementing partners in Myanmar. In the project document WHO is expected to play the following roles:

- To act as secretariat of the TSGs for malaria and TB and to share responsibility with UNAIDS for the HIV/AIDS component.
- To be an implementing partner for the three diseases.
- To channel funds for implementation at the central and state/divisional level.



The Formulation Mission team during their field visit observing programme implementation at township and community level.

WHO working together with the Ministry of Health and other implementing partners, will help ensure a well coordinated, technically sound, operationally feasible and effective national response against the three diseases.

News Bytes

New Delhi: India achieves 100% DOTS coverage

On World TB Day 2006 the Union Health and Family Welfare Minister of India announced full geographical coverage of the country under the Revised National TB Control Programme (RNTCP). This is indeed a tremendous achievement; one in which national authorities, national and provincial programme managers and thousands of health workers and community workers/ volunteers from the state level to the remotest village across the country worked together to achieve the landmark. WHO, through its Regional and Country Offices, continuously provided technical support to this national endeavour.

On World TB Day, the Government of India and WHO committed themselves to respond effectively to the challenges of continuously improving TB services everywhere, to address the issues of MDR-TB and TB/HIV, to implement the external quality assessment scheme in all microscopy centres and to other important facets of TB.

Jakarta: Indonesia holds experts' consultation on avian influenza

The continuing avian influenza outbreak, involving both humans and animals in Indonesia, was the focus of a three-day international consultation in Jakarta. The meeting was organized at the request of Indonesia's National Committee for Avian Influenza Control and Pandemic Influenza Preparedness, with the following objectives:

- Review the status of the H5N1 virus in humans and animals;
- Provide recommendations to control the virus in both animals and humans;
- Review lessons learned for rapid response and containment; and,
- Provide an authoritative risk assessment of avian influenza in Indonesia in both humans and animals.

This consultation brought together experts from Indonesia's Ministries of Health and Agriculture, with those from the World Health Organization, the Food and Agriculture Organization, and UNICEF and Airlangga University Surabaya, Udayana University Bali, Persahabatan Hospital, U.S. Centres for Disease Control and Prevention, France's Epicentre, Hong Kong University, NAMRU-2 Laboratory and Japan's National Institute for Infectious Diseases.

The H5N1 virus is considered firmly entrenched in poultry throughout much of Indonesia. This widespread presence of the virus has resulted in a significant number of human cases. This year alone Indonesia has already reported 37 cases which resulted in 31 deaths. Unless the poultry outbreaks are controlled effectively, sporadic human cases are likely and human-to-human transmission is possible.

Geneva: WHO South-East Asia Region on track to reach tuberculosis control targets

Three of the six regions of WHO are expected to achieve their targets for tuberculosis (TB) control, a WHO report published on World TB Day 2006 said. The Region of the Americas, the South-East Asia and Western Pacific Regions should reach the targets set by the World Health Assembly to detect 70% of TB cases and successfully treat 85% of these by the end of 2005, as has been stated in the Global Tuberculosis Control 2006 report.

New Delhi: Masters of Public Health in Field Epidemiology course commences in India

The National Institute of Communicable Diseases (NICD), New Delhi has commenced a Masters of Public Health in Field Epidemiology (M.Ph) course from the 2006-2007 session with an intake of 20 students. There is also the provision for admission of five international students. WHO shall be promoting this course along with disseminating information to other Member States and facilitating selection of the international candidates. The tuition fees for the two year course is USD 7000. The NICD course seems to be the most cost-efficient M.Ph training course available currently.

Yangoon: Myanmar National AIDS Programme reviewed, 27 March - 07 April 2006

The National AIDS Programme Myanmar, with support from WHO and the participation of UNAIDS and UNICEF, conducted an external review of the national health response to HIV/AIDS from 27 March to 7 April 2006 as part of the process of development of the National Strategic Plan 2006-2010. The general objectives of the review were to assess the

progress of the national HIV/AIDS programme, especially in areas related to health sector responses, and recommend revision of interventions and strategies. A group of public health experts were invited as members of the review team. The teams were deployed to seven zones and visited eight states and divisions and 23 townships.

A general finding of the review was that significant progress had been achieved in the national response to HIV/AIDS. The magnitude of the epidemic has been recognized and the efforts needed to respond to it have been reflected in formal policy and planning documents. Importantly, there is a stated commitment in existing strategic documents to focus prevention, care and support efforts to the most vulnerable populations. The National AIDS Programme has played a critical role in the implementation of HIV/AIDS activities through the formal health system, and coordinated the inputs of national and international organizations engaged in this field. The review team prepared a detailed report and recommendations.

Bangkok: Her Royal Highness Princess Maha Chakri Sirindhorn launched World Blood Donor Day 2006

The global launch of World Blood Donor Day 2006 was inaugurated by Her Royal Highness Princess Maha Chakri Sirindhorn of Thailand in Bangkok on 14 June 2006. World Blood Donor Day recognizes the “gift of life” made by voluntary blood donors to save lives and is also aimed at raising awareness globally about the importance of and need for regular and voluntary blood donation.

In her inaugural address HRH Princess Sirindhorn lauded the contributions of millions of people who donate blood to save human lives. She appealed for regular voluntary donation of blood by healthy people, especially the youth.

Currently, 61% of the total blood units collected in the South-East Asia Region are donated by voluntary blood donors. The celebration of World Blood Donor Day is aimed to enhance awareness about the need, importance and safety of voluntary blood donation.



Geneva: Global Malaria Programme (GMP) launched with a new Director and new direction

The Malaria Department at WHO/HQ has been restructured. The erstwhile Roll Back Malaria Department has been renamed to give way to the newly created Global Malaria Programme (GMP). Dr Arata Kochi has assumed office as its Director. Under his leadership, WHO has initiated efforts which shall lead to development of a new, results-based direction and strategies. The GMP has shifted its focus from an Africa-centric approach to a global fight against this dreaded disease.

GMP shall advocate the ban on monotherapy with artemisinin. The use of artemisinin-based combination therapy (ACT) shall be promoted to replace the failing drugs such as chloroquine, to combat drug resistance. WHO plans to dissuade countries from using monotherapy artemisinin that may lead to resistance to malaria parasite faster in comparison to ACT. As a first step in this direction, Dr Kochi held a meeting in SEARO in April 2006 with leading Indian manufacturers of malarial drugs to impress upon them the need to switch to the combination therapy.

Bangkok: National Leprosy Programme Managers' meet, 15-17 May 2006

The General objective of the meeting was to review the progress of leprosy elimination in the region and discuss sustainability of leprosy services and critical activities. The specific objectives were (a) to follow-up on the progress of implementation of leprosy elimination in the countries (b) to review the national plans of action for the 2006-07 biennium, and, (c) to identify mechanisms for sustaining leprosy activities and further reducing the burden through quality services;

This meeting assumed significance since it was the first to be held since the South East Asia Region along with India, which traditionally accounted for the highest burden of leprosy globally and regionally, had achieved the goal of elimination of leprosy as a public health problem. Only Nepal and Timor-Leste were yet to achieve the elimination goal by the end of 2005.

The third meeting of the Regional Technical Advisory Group (RTAG) was held back-to-back with the National Programme Managers' Meeting. RTAG reviewed the progress of leprosy elimination in the region and congratulated India on achieving the leprosy elimination goal. It also requested WHO to document the progress and success of leprosy elimination in the region.

Jakarta: National Lymphatic Filariasis Programme Managers' meet, 5-7 July 2006

The Programme Managers or their representatives from eight of the nine Lymphatic Filariasis (LF) endemic countries participated. There were representatives from four partners (1) Glaxo-Smith-Kline, donors of the free supply of albendazole, (2) JICA-Bangladesh, (3) Sasakawa Memorial Health Foundation, and (4) GTZ-Indonesia.

WHO Representative for Indonesia read the inaugural address of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, which highlighted the progress and achievements as well as the issues and challenges.

The objectives of the meeting were to review the progress and plans for the future, specifically with regard to the scale-up of Mass Drug Administration and other activities, and to discuss the revision of the Regional Strategic Plan for 2006-2010.

Of the 1.3 billion people globally at risk of LF, about 840 million reside in South-East Asia. In 2005, 83.5 million were provided Mass Drug Administration (MDA) with DEC+albendazole but that is only 10% of the population at risk. Thus there is the need to scale up MDA and other activities to ensure that the goal of elimination of LF as a public health problem by 2020 is attained.

The meeting identified lack of adequate resources as the most critical problem and requested WHO for advocacy and assistance in resource mobilization. The integration of LF with other programmes was also endorsed.

Chiang Mai, Thailand: Partners call for an Asia-Pacific Dengue Partnership

A two-day meeting of partners on dengue prevention and control in Asia and the Pacific was held in Chiang Mai, Thailand on 23-24 March 2006. The objectives of the meeting were designed to review the evolving dengue situation and strengthen partnership in the Asia-Pacific to discuss priority strategies and interventions and to promote and discuss partnership roles.

A total of seventy five participants attended this meeting. These included National Programme Officers and



representatives of several partner agencies namely Asia Pacific Economic Cooperation (APEC), USAID, UNICEF, South-East Asia Education Organization on Tropical Medicine (SEAMEO Tropmed), the private sector, foundations, academia, WHO Collaborating Centres, WHO country and regional offices, WHO/HQ and TDR.

It was agreed that an 'Asia-Pacific Dengue Partnership' be established that will include a core group and technical working groups, in order to increase public and political commitment to achieve financial and programmatic targets for prevention and control of dengue in the Asia-Pacific.

Aberdeen: Global Forum on Leprosy Control, and WHO Technical Advisory Group meet: 18-21 April 2006

The Global Forum on Leprosy met on 18 to 20 April 2006 to discuss, revise and finalize the draft "Operational Guidelines" for implementation of the Global Strategy for further reducing the leprosy burden and sustaining leprosy control activities. There were 37 participants which included National Programme Managers from selected countries, Members of WHO Technical Advisory Group on Leprosy (TAG), Members of international Federation of Anti-leprosy Associations (ILEP), and WHO staff from Global Leprosy Programme and regional offices.

On 21 April 2006, the TAG, in accordance with its mandate, reviewed the current global leprosy situation and made recommendations to WHO. Several technical presentations were made in this meeting. These included "Rifampicin-resistant leprosy-A challenge not to be ignored" by Professor Baohong Ji, of France, "Treatment of pauci-bacillary leprosy with single-dose rifampicin - ofloxacin-minocycline" by Dr M.D.Gupte of India and "Status report on WHO-sponsored study on "Uniform multi-drug treatment (MDT) regimen for all types of leprosy" also by Dr M.D.Gupte.

TAG discussed on issues related to verifying elimination at the national level and made the recommendation that verification or validation of leprosy elimination is not relevant since reliable tools are not available at present.

New SEARO/CDS Publications

Training Toolkit - HIV Care and Antiretroviral Treatment Recording and Reporting System, 2006, SEA/AIDS/161.



Accurate recording and reporting is very important for care and antiretroviral treatment monitoring and programme evaluation. This HIV Care and Antiretroviral Treatment Recording and Reporting System training toolkit provides guidelines on how various forms used in treatment programmes at the national/provincial/district/state levels are to be completed. This toolkit has been prepared with the purpose that countries will adapt the sample forms as well as training methods to suit their needs. An electronic version of this manual is available for adaptation.

Scaling-up Towards Universal Access to HIV Prevention, Treatment and Care: Report of the WHO-UNAIDS Joint Regional Technical, Briefing on Universal Access, 2006, SEA/AIDS/160.

Universal access is an important initiative to scale up coverage and quality of HIV/AIDS interventions, particularly for the poor and marginalized populations. The meeting discussed the conceptual framework and process for achieving universal access as well as opportunities, obstacles, and suggestions from Member States. It was concluded that the universal access should be a country-driven process with nations setting their own realistic but challenging enough targets.



Universal Access to HIV/AIDS Prevention, Care and Treatment in the Health Sector: Report of the 18th National AIDS Programme Managers' Meeting Kathmandu, Nepal, 5-7 December 2005, SEA/AIDS/163.



In response to the need to rapidly scale up HIV prevention, care and treatment in the health sector, the World Health Organization (WHO) organized a meeting of National AIDS Programme Managers in Kathmandu, Nepal on 5-7 December 2005. One day was made common with National Tuberculosis Programme Managers to review and discuss TB/HIV collaborative activities. The meeting reinforced the call for urgent action to implement collaborative TB/HIV activities including development of national strategies, technical and operational guidelines and TB/HIV surveillance.

The Regional Strategic Plan for TB Control 2006-2015 incorporates the additional interventions defined under the new Stop TB strategy and included in the Global Plan to Stop TB. Focusing on priorities for TB control in the South-East Asia Region, it highlights the four key strategic approaches towards achieving the TB-related Millennium Development Goals: (1) Sustaining and enhancing DOTS to reach all TB patients, improve case detection and treatment success; (2) Establishing interventions to address HIV-associated TB and multidrug-resistant TB; (3) Forging partnerships to ensure equitable access to an essential standard of care to all TB patients; and (4) Contributing to health systems strengthening.



The Generic Guidelines for the Estimation of the Annual Risk of Tuberculosis Infection is a tool to assist countries in designing and conducting tuberculin surveys. Successful implementation of the all interventions as envisaged in the new Stop TB strategy is expected to reduce the transmission of TB infection. The publication gives a complete overview of all steps required for setting up a representative survey, starting from planning to publishing of the final survey report.



HIV Surveillance among Tuberculosis Patients - Report of an Informal Consultation.

The rapid growth of the HIV epidemic in many countries has resulted in an equally dramatic rise in TB. The importance of surveillance of HIV among TB patients is increasingly being recognized. In many countries the HIV prevalence in TB patients is a sensitive indicator of the spread of HIV into the general population. Information on HIV level in TB patients is essential to respond to the increasing commitment to provide comprehensive HIV/AIDS care and support, to HIV-positive TB patients.

Meeting of Partners on Tropical Diseases Targeted for Elimination/Eradiation: Report of the Meeting, Bangalore, India, 17-18 November 2005.

The meeting discussed four tropical diseases targeted for elimination/eradication, namely, leprosy, lymphatic filariasis, leishmaniasis(kala azar) and yaws and also soil transmitted helminthiasis(intestinal parasites) which is targeted for intensified control. There were 39 participants from 22 agencies. The publication includes a summary of the technical overview on each of the targeted diseases, statements by partner agencies, two special presentations, one on the "Role of Industry in Health" and the other on "Human Rights and Health". The meeting culminated in the adoption of the "Bangalore Declaration" which calls upon Member States and development partners to accord high priority and adequate resources to these diseases.



Mark Your Calendar

Upcoming Conferences and Meetings

August 2006

XVI International AIDS Conference

13-18 August 2006

Venue: Toronto, Canada

Theme: Time to Deliver

AIDS 2006 will be one of the most important scientific gatherings in the fight against AIDS, as well as a unique opportunity for science, government, community and leadership from around the world to advance collective response to the epidemic.

September 2006

Training Course in HIV prevention, treatment and care for Injecting Drug Users, Supported by FHI, USAID, WHO/SEARO, WHO/WPRO, Malaysian Ministry of Health and Bamrasnaraduras Institute: 28 August to 6 September 2006

Venue: Bangkok, Thailand

The objective of the course is to train clinicians in the HIV prevention, treatment and care for IDUs to enhance country-level capacity in the provision of HIV care and treatment services for them.

Consensus Development Conference on the Prevention of Disability in Leprosy,

13-16 September 2006

Venue: Cebu City, the Philippines

Theme: Prevention of disability in leprosy

The conference is being jointly organized by the International Federation of Anti-Leprosy Associations (ILEP) and WHO. The National Leprosy Programme Managers of all countries are invited.

October 2006

Sasakawa Memorial Health Foundation(SMHF)/The Nippon Foundation(TNF) Consultative Meeting on Funding to WHO for Leprosy Elimination Activities in 2007

9-10 October 2006.

Venue: WHO/SEARO, New Delhi

This annual meeting determines the provisional grants for leprosy elimination activities to be provided by the Nippon Foundation to the Global and Regional leprosy activities of WHO.

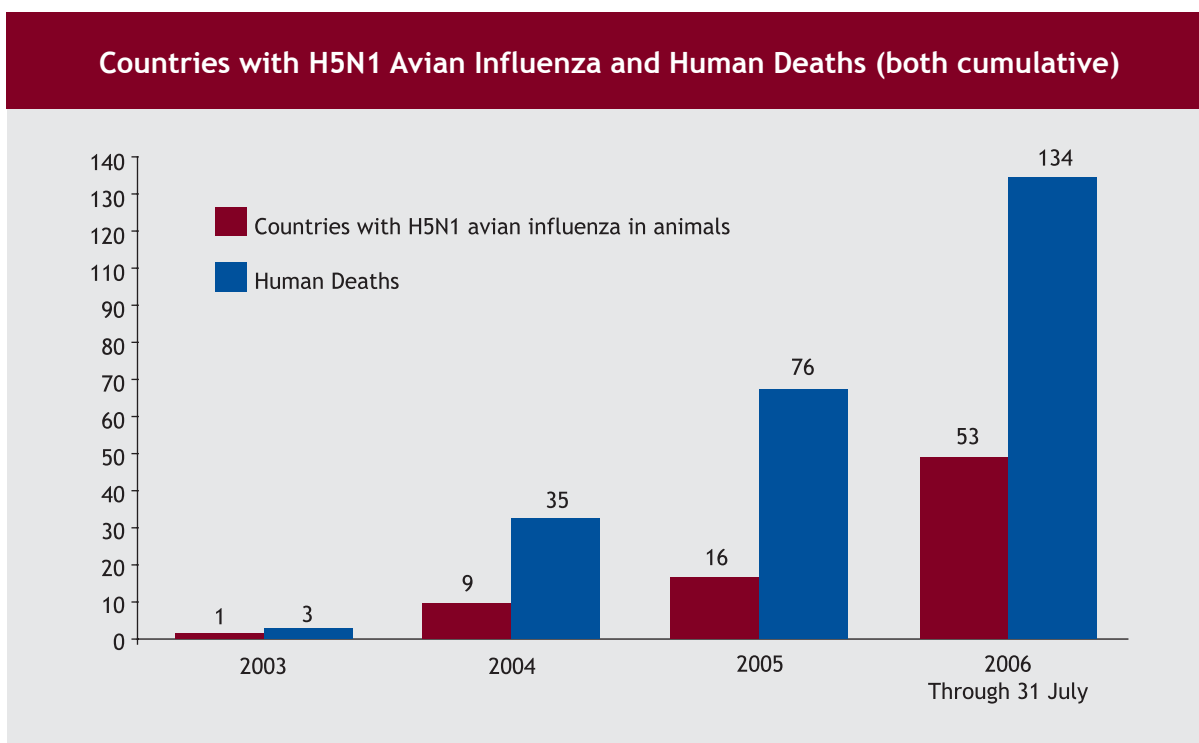
Update on Avian Influenza

The H5N1 virus has been spreading relentlessly. Till date 53 countries have reported detection of this virus to OIE. While several countries have been successful in containing the infection in poultry, in few others the virus seems to have attained endemicity.

Since 1 December 2003 10 countries have reported a total of 232 laboratory-confirmed human cases of H5N1 avian influenza to WHO. Of these 134 died. The number of human infections and deaths reported to WHO has accelerated in the past six months. There were 41 deaths in all of 2005, but 58 in only the first seven months of 2006, more than twice the pace of last year.

The number of new countries reporting human H5N1 cases has increased dramatically after October 2005, following the geographical extension of outbreaks among avian populations. Prior to mid-2005, only four countries had officially reported cases of H5N1 infection in humans. From October 2005 until the end of July 2006, six new countries reported cases of H5N1 infection in humans.

The progression of the infection to a pandemic shall entail tremendous economic loss apart from huge mortality. The World Bank estimates a severe avian flu pandemic among humans could cost the global economy about 3.1% of world gross domestic product – around US\$1.25 trillion of a world GDP of \$40 trillion.



Editor: Dr Jai P Narain

Editorial Support: Dr Rajesh Bhatia, Jitendra Tuli

Design, pre-press support and layout: Text Processing and Designing, World Health Organization

Printing: KRITI

For complimentary copies, write to

Communicable Disease Newsletter, Department of Communicable Diseases
 World Health Organization, Regional Office for South-East Asia, World Health House, IP Estate, New Delhi 110002, India
 Tel : +91-11-23370804 Fax :+91-11-23378412, email: narainnj@searo.who.int
 Communicable Disease newsletter is a half-yearly communication of the Department of Communicable Diseases, WHO/SEARO.

The designations employed and the presentation of the material in this publication do not imply the expression of an opinion whatsoever on the part of the Secretariat 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.

The material used in this half-yearly communication may not always reflect WHO policy.

Reproduction of material from Communicable Disease Newsletter, in part or in whole, is encouraged, as long as credits and acknowledgements are given.