MAKING A DIFFERENCE
WHO IN SOUTH-EAST ASIA REGION
The World Health Organization strives to be more responsive to the fast changing public health arena in the South-East Asia Region. When I took charge as Regional Director in February 2014, it was at a critical time in the evolution of WHO. The paradigm shifts were evident in the agendas of the World Health Assembly and Regional Committee meetings. Noncommunicable diseases, universal health coverage, intellectual property rights, the Millennium Development Goals, virus sharing, essential and affordable medical products and the impact of socioeconomic and environmental determinants on health were already increasingly getting more prominence.
In view of the changing health scenario, WHO in the Region is now focusing on four strategic areas - addressing the persisting and emerging epidemiological and demographic challenges; advancing universal health coverage and robust health systems; strengthening emergency risk management for sustainable development; and articulating a strong regional voice in the global health agenda.

All countries in the Region are making concerted national efforts to improve the health of their people. As a result, we are seeing substantial progress in some areas. Impressive efforts are being made in the fight against malaria. The lessons from polio eradication programme are now being applied to reach the vulnerable children with other lifesaving vaccines. Some countries have rolled out unique interventions to engage and reach communities with immunization and other health programmes. The Region has halted and reversed the HIV and AIDS epidemic.

This document captures advances and gains made in some of the strategic areas and flagship programmes. It also details the progress in some other areas following concerted national efforts to improve the health of people. None of these could have been possible without political commitments and strong leadership by the national government, consistent support by partners and donors, tireless efforts of the health workers and the support of the communities. Together we are ‘Making a Difference’, and will continue to do so to improve health and positively impact the lives of people.
Sprad by the bite of infected female sandflies, Visceral Leishmaniasis, also known as Kala-azar, is a neglected tropical disease. Over 147 million people in the World Health Organization’s (WHO) South-East Asia Region are at risk of contracting this life-threatening disease, mainly in Bangladesh, India and Nepal, with recent, sporadic cases being reported from Bhutan and Thailand. Of the total 109 districts in these three countries where Kala-azar is endemic, 52 are in India, 45 in Bangladesh, and 12 in Nepal.

Characterised by high fever, loss of weight, anaemia and swelling of the liver and spleen, Kala-azar is debilitating, and without treatment, it is fatal in almost all cases. Defeating the disease involves early detection of all Kala-azar and post-Kala-azar dermal Leishmaniasis cases, improved treatment for post-Kala-azar dermal Leishmaniasis cases, and compliance with treatment along with effective vector control.

Governments and health experts across the South-Eastern region are hopeful that the killer disease will soon be eliminated as a public health problem. Elimination of the disease, defined as annual incidence of less than 1 per 10,000 population at the district or sub-district level, will not only be a public health success story, it will also help in the mitigation of poverty in the affected areas.

“Several endemic areas in the Region are reporting zero or very few cases of Kala-azar and both reported cases and death from Kala-azar are at the lowest in the Region. There is strong political commitment from top health leadership in all endemic countries in the Region, not only to accelerate work within the countries but also on inter-country collaboration and working together. There is strong support from donors and partners and a highly effective drug is been provided freely to endemic countries. Historically we are in a favourable moment where we can indeed eliminate this disease if the momentum is maintained,” says Dr Ahmed Jamshed Mohamed, Medical Officer, Vector-Borne Diseases, WHO Regional Office for South-East Asia.

What is changing on the ground? In India, Bihar accounts for 60% of all Kala-azar cases. But today, health experts travelling through Bihar exude optimism as Bihar is not alone in waging a battle against Kala-azar.

Dr Saurabh Jain, Technical officer for vector borne and neglected tropical diseases, in the World Health Organization India office, offers some key insights. While travelling across Bihar, he has noticed a visible intensification of activities aimed at elimination of the diseases. This is due to the concerted efforts by state and national governments, international partners and other key stakeholders.

“These are exciting times for India’s Kala-azar Programme. There are clear-cut activities defined under the (2014) National Roadmap for Kala-azar Elimination launched by the Health Ministry. Now, there are inexpensive and user-friendly rapid diagnostic tests. A newer, safer and effective treatment regimen is available. And the role and responsibilities of major partners and stakeholders are clearly defined, he says.”

**New treatment regimen**

One of the most exciting developments has been the new treatment regimen using Liposomal Amphotericin B (LAmB). Elimination efforts have gained momentum with the donation of Liposomal Amphotericin B facilitated by the WHO. In 2011, the WHO signed an agreement with Gilead Sciences for the donation of 445 000 vials of Ambigome (amphotericin B liposome for injection) for the treatment of kala-azar.

The donation, which aims to treat more than 50 000 people infected by the disease...
The importance of collaboration

Since 50% of the cases in the three main affected countries occur in areas close to international borders, these measures will strengthen inter-country collaboration to control and eliminate Kala-azar and will accelerate results.

In 2014, WHO led the efforts to bring together Health Ministers from five SEAR countries affected by Kala-azar. The Ministers from Bangladesh, Bhutan, India, Nepal and Thailand signed a Memorandum of Understanding to collaborate in the elimination of kala-azar. Areas for collaboration include mutually agreed mechanisms of resource mobilization; exchange of information; intersectoral collaboration; research; capacity building and technical support.

Bangladesh is also gearing up to eliminate Kala-azar. During the past 5 years, more than 15 000 cases have been diagnosed and treated in a country where detection had until recently been a challenge. During the past 5 years, more than 15 000 cases have been diagnosed and treated in a country where detection had until recently been a challenge.
“We used every available means to engage the public to help us get down to detecting the maximum number of cases in endemic upazilas (sub-districts). We combined active case searches, treatment and vector control strategies, and our strategy is working,” says Professor BeNazir Ahmed, a senior official in Bangladesh’s Ministry of Health and Family Welfare.

Kala-azar affects extremely poor communities in remote, rural locations often neglected by weak health care systems. This prevents proper surveillance, leaving cases undetected with delayed treatment. A cycle of poverty is created where people who cannot afford treatment are not well enough to go to work.

WHO technical guidelines for Kala-azar in the Region include diagnosis and treatment of Kala-azar, indoor residual spraying and insecticide treated nets. Training packages for doctors, nurses, health workers, supervisors and spraying teams include surveillance guidelines regarding disease and vector surveillance, consistent reporting systems and formats and supervisory systems, quarterly monitoring and checklists.

All these measures are critical to success, not just against kala-azar, but other diseases as well.
Making a Difference: WHO in South-East Asia Region

Today, APAL is not only a source of immense support for people affected by leprosy, its presence is increasingly being felt in policy circles within the country and beyond.

Narsappa’s life story reflects the success and challenges posed by leprosy in the WHO South-East Asia Region.

Leprosy is a chronic infectious disease caused by Mycobacterium leprae. It usually affects the skin and peripheral nerves but also has a wide range of other clinical manifestations. Among communicable diseases, leprosy is a major cause of physical disabilities. Timely detection and treatment of cases, before nerve damage sets in, is the most effective way of preventing disabilities due to leprosy. The year 2000 marked the elimination of leprosy as a public health problem at the global level -- a significant milestone in history. Elimination means the prevalence of less than one case per 10 000 population, globally. The elimination target has also been achieved by most of the endemic countries at the national levels by the end of 2005.

However, as Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia, says, “Though the prevalence has come down to less than one case per 10 000 population globally, new cases are being reported from more than 100 countries. As per the leprosy statistics published in 2014 by WHO, 215 656 new leprosy cases were detected worldwide. The WHO South-East Asia Region alone contributed 155 385 cases, 72% of the global leprosy case count.”

Globally, 13 289 such new cases with visible deformities or grade 2 disabilities were detected in 2013.

Vagavathali Narsappa, 47, is a hero not only to people affected by leprosy in his home city of Hyderabad, in central India, famous for microchips and minarets, but also to tens of thousands of people across the country.

Narsappa has been living with leprosy since he was eight. His fingers were affected and had to be amputated.

“I only have my two thumbs and little fingers.” The disability meant that he could not work. There was a time when he begged on the streets. But the rejection, humiliation and discrimination did not crush his spirit or his love for life.

Currently, the president of India’s Association of People Affected by Leprosy (APAL), Narsappa fondly talks about his wife, Nirmillah. He met and fell in love with her at the leprosy hospital where both were being treated. “We have been together almost 25 years,” says the man who learnt to turn adversity into advantage.
Laws exist in many countries of the WHO South-East Asia Region that discriminate against leprosy-affected persons and their families.

One of the biggest challenges in the battle against leprosy is the fact that one in every ten new leprosy patients is a child. This fact needs greater attention, as it can cause childhood disabilities not unlike polio.

Over the last two decades, much has changed for the better. Narsappa talks about lessening stigma and more awareness about leprosy. Then, there was a breakthrough in treatment that dramatically reduced the global leprosy caseload from 11 million to under a quarter million today.

In the early 1980s, WHO introduced the multidrug therapy (MDT), which revolutionized treatment of leprosy. MDT offers multiple benefits. The infected person ceases to be infective with a single dose; it is a complete treatment for leprosy, and it reduces the risk of disabilities and consequent stigma. In the long run, MDT reduces treatment costs on the health system.

However, at the societal level much remains to be done. Laws exist in many countries of the WHO South-East Asia Region that discriminate against leprosy-affected persons and their families. These laws impact chances of employment, marriage and other areas.

The WHO is working with governments and leprosy partners to reduce these barriers. Hearteningly, groups such as the Association of People Affected by Leprosy in India are robustly adding their voice to the fight for the rights of those with leprosy to push for an end to this stigma.

Early detection as a path to eliminating leprosy

“With the arrival of MDT, we have not seen any more new colonies of people affected by leprosy in the country. That is great news. Now, as a person affected by leprosy, my mission is to work towards zero disability. For that to happen, we need to sustain the momentum by removing misconceptions about leprosy among the public, have early detection and voluntary reporting. School curricula should make children aware that early detection can prevent disability. People affected by leprosy should be made partners in policy making," says Mr Narsappa who is thrilled that in the colony of people affected by leprosy where he lives, no children have leprosy.

“We are focusing on disclosure of cases to individuals, families and communities. A coming out to doctors and medical staff can only happen when we address the stigma of leprosy. We need to make the public and practitioners partners in leprosy detection, treatment and cure to eradicate leprosy," says Dr Vijaykumar Pannikar who has worked as a WHO expert for 35 years fighting leprosy and who led the successful trail of multi-drug therapy (MDT).

Now retired, Dr Pannikar continues his work with WHO and partner organizations in what he expects to be the final push. He feels that the global community has overcome the hurdles of developing treatments and ending leprosy is now within our reach.

Since 1995, WHO has provided MDT free of cost in all Member States. Now that the number of leprosy cases has been drastically reduced, WHO is flagging the need for renewed efforts and a focus on “zero” children with deformities and detecting all new leprosy cases before disability.

The last mile in leprosy eradication will need enabling environments where people with leprosy feel enabled to identify themselves and seek treatment.

Leprosy elimination: a WHO flagship

In July 2013, 17 countries came together at the International Leprosy Summit to commit to a global target of less than one case per million by the year 2020 through the Bangkok Declaration.

The declaration recommends measures such as including leprosy-affected persons in the leprosy control initiatives. “The WHO has played a catalytic role in strengthening the capacity of people affected by leprosy. Today, they are more involved in national and subnational leprosy programmes and are better equipped to voice their demands for more funds and human resources,” says Dr Sumana Barua, WHO’s Team leader for the Global Leprosy Programme.

Reflecting the importance of partnering with people affected by leprosy and their families is a WHO set of Guidelines for Strengthening Participation of Persons Affected by Leprosy in Leprosy Service, published by the WHO Regional Office for South-East Asia.
Leprosy declared a Flagship programme for WHO SEARO targeting zero disability among new child cases by 2020.

“WHO SEARO has declared leprosy as a Flagship Programme that intends to result in zero disability among new child cases by 2020. There will be a greater focus on the social issue that has prevented leprosy elimination – the stigma that prevents early detection and proper treatment.

The WHO is working with The Nippon Foundation, Novartis Foundation for Sustainable Development (NFSD), International Federation of anti-leprosy associations (ILEP) and the networks of persons treated for leprosy to create the roadmap for the last mile in leprosy elimination.

As WHO fine tunes its upcoming 2016–2020 Global Strategy for Leprosy, the views of Narsappa and his colleagues are being sought in consultation with that of other key stakeholders. The new WHO strategy will aim to detect all cases before disability sets in and will focus on zero disability cases among children by the end of the decade.
A few months ago, when 45-year-old Rita Soares, who lives far from a health post, developed a fever, she felt drained and wondered how she would get treated. In fact, help arrived in the shape of a community health worker who came to her and tested her for malaria.

“When it turned out that I had malaria, he gave me the medicine I needed and I was soon feeling better. I am really grateful as I didn’t need to go to a city hospital for either tests or for treatment.”

Much has changed in the malaria programme in Timor-Leste. Malaria is a life-threatening disease caused by parasites that are transmitted to people through the bites of infected Anopheles infected mosquitoes. An estimated 3.3 billion people are at risk of malaria, of whom 1.2 billion are at high risk. There were an estimated 198 million cases of malaria worldwide in 2013, and an estimated 584 000 deaths.

Malaria is an acute febrile illness. Early symptoms are fever, headache, chills and vomiting – may be mild and difficult to recognize as malaria but if not treated within 24 hours, P. falciparum malaria can progress to severe illness often leading to death. Children with severe malaria can develop severe anaemia, respiratory distress, or cerebral malaria. In adults, multi-organ involvement is also frequent. The best available treatment, particularly for P. falciparum malaria, is artemisinin-based combination therapy (ACT). The concerns are of emerging parasite resistance to antimalarial medicines and mosquito resistance to insecticides.

In tropical Timor-Leste, it is early morning. A team of 4 uniformed men can be seen trawling a crocodile-infested wetland area just outside the capital city of Dili. The men are equipped with soup ladles, pipettes and plastic bowls. Their eyes riveted to the ground, they are taking water samples for collection and storage in little plastic containers. These Ministry of Health staff are working for the National Malaria Control Programme in Timor-Leste. One of their tasks: to survey the density of mosquito larvae in the water and identify the different species in order to better understand the main vectors, how they behave and how to develop efficient measures to deal with them and thus protect people from malaria.

“In 2006, when I started to work with WHO on malaria control as a consultant, we had no equipment for entomological surveys in Timor-Leste and only 2 full-time staff in the Ministry,” reports Dr Manel Yapabandara, WHO Technical Advisor on Malaria. “So I brought microscopes from my home country Sri Lanka and bought some soup ladles in the local supermarket so we could carry out the survey. I also sewed my own mosquito traps using netting material I bought in the market.”

**Examining mosquitoes to prevent malaria**

Entomological surveys are the backbone of malaria prevention measures. Depending on the type of the mosquito, where it breeds, when and where it rests, how it bites and how susceptible it is to insecticides, local authorities can assess the best malaria prevention approaches.

Dr Manel’s surveys have enabled the National Malaria Control Programme to limit yearly indoor residual spraying with insecticides to those areas that it has identified as epidemic prone and high risk areas. The Programme has distributed long-lasting insecticide-treated bed nets to people in other malaria risk areas.
These surveys are repeated once a month and local malaria vector control actions adapted accordingly.

"Initially, the malaria programme focused mainly on the people displaced through civil unrest in 2006. The priorities were diagnosis and treatment," says Dr Manel. "Very little attention was given to prevention."

**Huge strides in malaria prevention**

With increased political commitment, advances in diagnostic testing and treatment and financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, with support from WHO, Timor-Leste has made huge strides in the prevention and control of malaria in recent years. Today, all areas where there is a risk of malaria have control and prevention measures in place. All public health facilities are equipped to diagnose and treat the disease.

The ingenuity and perseverance of Dr Manel and her counterparts in the Ministry of Health have paid off: within only 6 years, the number of reported malaria cases in Timor-Leste dropped from 220 cases per 1000 people in 2006 to less than 1 case per 1000 in 2013.

Today the Government is making efforts to reach out to remote communities and train community health volunteers to diagnose malaria, treat uncomplicated cases and refer more complicated ones to the nearest health facility. The volunteers also check whether nets have been put in place and help families to mount the nets if needed.

Ingenuity and perseverance – these efforts from dedicated personnel in the malaria programme in Timor-Leste have not only made a dramatic improvement in malaria cases, but also leave many lessons learnt for other health programmes.

• Myanmar launches largest-ever public health intervention to immunize 17.4 million children – 9 months to 15 years of age – against measles and rubella
• Experiences from polio used for meticulous interdepartment planning, community participation, logistics mapping and training
• Government of Myanmar felicitates WHO, partners for successful campaign
Defeating Measles and Rubella in Myanmar

Expectations were high, and to accelerate progress towards this goal, Myanmar’s Ministry of Health, with support from WHO and other partners like UNICEF and GAVI, the Vaccine Alliance, launched a national Measles Rubella Vaccine campaign in January-February 2015 targeting all children in the age group of 9 months to 15 years irrespective of their previous immunization status.

The national MR campaign was conducted in two phases – the first phase in January 2015 targeted school children 5 years to 15 years of age in approximately 45,000 schools run by the government, private agencies and monasteries. The second phase targeted approximately 65,000 villages/urban wards in February 2015 vaccinating children from 9 months to 5 years of age plus children missed out in the school phase – children who do not attend school.

The figures reflect the scale of the operation. The national measles and rubella vaccination campaign launched in Nay Pyi Taw, Myanmar’s capital city, is the country’s largest-ever public health intervention.

Behind the numbers, there is also the inspiring story of the extraordinary determination with which WHO has teamed up with the local government and stakeholders at various levels to defeat measles and rubella.

Measles is one of the major causes of child mortality. Rubella is usually mild in children, but for some people, especially pregnant women and their babies, rubella can be serious. “Measles and rubella remain a threat to the survival and development of children and women in Myanmar,” says WHO Myanmar Representative, Jorge Mario Luna.

WHO estimates suggest that the highest congenital rubella syndrome (CRS) burden globally is in South-East Asia, with 46% of the 103,000 cases. Adolescent women need to be protected with the rubella vaccine before child bearing, because if a mother contracts the disease during pregnancy, the child could be born with several congenital problems, such as blindness, deafness and even congenital heart disease, all of which are a burden on the family and society. Also, the additional vaccine dose provides supplementary protection to all children. Investing in this combined vaccine

Myanmar has been witnessing unprecedented large-scale immunization campaigns this year. The country, with a population of over 62.3 million, has targeted 17.4 million children, the entire cohort of 9 months to 15 year-old children in the country, with the measles and rubella (MR) vaccine. The Government of Myanmar embarked on a grand mission to achieve the World Health Organization’s South-East Asia Regional goal of measles elimination and rubella control by 2020.
In supporting Myanmar to mount the national Measles Rubella Vaccine campaign, WHO drew on its regional experience in microplanning and advocacy in polio eradication. This will help accelerate national, regional and global progress in controlling this life-threatening disease.

“It was not easy. It took an enormous effort and advocacy to convince everyone including parents why even older children needed to be vaccinated. We had many meetings with the Education Ministry, teachers and school authorities. We also had to convince the parents on safety issues,” says Dr Vinod Bura, WHO Myanmar, Medical Officer for Immunization, who was closely involved with the Government of Myanmar from initial stages in planning these campaign.

All the hard work has not gone unnoticed. On 26 March 2015, the Myanmar Government felicitated representatives of WHO, UNICEF, other UN agencies, and international and local nongovernmental organizations, who were part of the campaign. The ceremony in Nay Pyi Taw was led by Vice President Dr Sai Mauk Kha and attended by all union ministers, deputy ministers and members of the National Health Committee.

Leveraging regional experience in polio eradication

In supporting Myanmar to mount the national Measles Rubella Vaccine campaign, WHO drew on its regional experience in microplanning and advocacy in polio eradication. As Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia, observes, “The direct benefit of polio eradication is clear in terms of lives saved and life-long disability prevented. It proves that such an achievement can also be reached for diseases such as measles and rubella.”

One of the most heartening aspects of the Measles Rubella Vaccination campaign has been the high quality of coverage. In the first phase, which targeted children in 45,000 schools across the country, 93% coverage was achieved, says Dr Bura. In the second phase, which targeted 65,000 villages for children who do not go to school or who missed out on the vaccination during school hours, the coverage at 93% was equally impressive. Therefore most of the 17.4 million children in Myanmar were covered in the campaign. The missing children will be covered in following immunization rounds.

Even parts of the country ravaged by conflict and intercommunal tensions, such as Rakhine and Kachin States, witnessed unprecedented mobilization of health staff, volunteers and community leaders, pushing the immunization coverage to levels comparable to the national average.

What did it take to achieve such high quality of coverage?

“It required meticulous advance planning. For example, 20 million invitation cards were sent to parents asking them to get their children vaccinated. This card was a key advocacy tool and it informed parents about the background of the initiative and the rationale for including all children in the age group,” says Dr Bura.

Simultaneously, extensive social mobilization was carried out in all communities using mass media. Country-wide, mobilization of nurses, teachers and efforts of countless community leaders were major factors for the successful immunization campaigns.

WHO coordinated strategic preparatory activities such as establishment of a Central Executive Committee; development of planning; and technical training guidelines for health workers, school teachers and volunteers. Village/ward-wise micro plans were established such as a master list of all eligible children, advocacy meeting with various stakeholders, for example, the department of education, local authorities, Myanmar Medical Association, Myanmar Maternal and Child Welfare Association (MMCWA), and national and international NGOs.

All health workers were retrained with special emphasis on injection safety practices, prevention and management of adverse events following immunization (AEFI). The cold chain and vaccine, and logistic supply chain were strengthened. WHO deployed additional international technical experts to support the preparedness and planning. Some children remained unimmunized because either they were sick or their parents were traveling or they lived in inaccessible remote areas. Four major AEFI cases were recorded during the campaign. However, detailed investigations did not show any association of these AEFI with the MR vaccine.
**What explains the success of the MR vaccination campaign?**

The prime reason for success is the high level of political commitment in Myanmar towards eliminating measles and rubella. Secondly, there was excellent preparedness, supported by technical assistance from WHO and UNICEF. The success of this campaign can be credited to the dedicated front-line health workers and teachers who made meticulous micro plans in health centres and schools and mobilized the community to ensure that all children received this life-saving vaccine.

Committed to eliminating the measles disease and controlling congenital rubella syndrome by the year 2020, Myanmar has included MR vaccines in routine immunization beginning May 2015.

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**HALTING AND REVERSING THE HIV EPIDEMIC IN THE SOUTH-EAST ASIA REGION – GETTING IT RIGHT**

- Many SEAR countries progress towards halting and reversing the HIV and AIDS epidemic. Despite the relatively low prevalence of the disease, key challenges remain in certain vulnerable populations such as female sex workers and their clients, men who have sex with men (MSM), transgender people and drug users.
- WHO-supported national plans and activities accelerate the process including access to antiretroviral therapy through national health programmes, maintaining the low incidence of disease.
- Active participation of civil society and special groups in the process for formulating WHO guidelines for treatment of HIV and AIDS improves quality, coverage and equity of services and interventions for key populations.
Making a Difference: WHO in South-East Asia Region

28 CASE STUDY

Home to an estimated 3.5 million people living with HIV, WHO’s South-East Asia Region accounts for 10% of the global burden of the disease. More than 95% of these people are in just five countries of the Region – India, Indonesia, Myanmar, Nepal and Thailand.

The Region has made impressive progress in halting and reversing the HIV and AIDS epidemic in a number of countries such as India, Myanmar, Nepal and Thailand. While the overall adult HIV prevalence in the Region is relatively low at 0.3%, some challenges remain in some countries within geographical pockets or among certain vulnerable populations groups such as female sex workers and their clients, men who have sex with men (MSM), transgender people and drug users.

Collective efforts by civil society, development partners and national governments have helped reduce the number of new infections by 34% – from a total of 350 000 in 2001 to 230 000 in 2013. One important cornerstone of this success is the provision of antiretroviral therapy drugs (ART) freely offered by national governments at the point of service delivery to all who need them.

Over the last decade, ART scale-up in low- and middle-income countries has saved an estimated 4.2 million lives and prevented an estimated 800 000 child infections. Price reductions have been spectacular for ART medicines – from US$ 10 000 to US$ 100 per person per year – this achievement is credited to civil society activism and close collaboration of national governments and development partners. WHO, through its AIDS Medicines and Diagnostic Services, monitors the use and cost of ARV drugs in countries. To ensure affordable access to medicines, WHO works closely with civil society and national governments to use Trade Related Aspects of Intellectual Property Rights (TRIPs) flexibilities for price negotiations.

There is frequent inflow of new scientific knowledge and break-throughs related to HIV treatment. An important contribution by WHO to the SEAR HIV success story has been to ensure that the latest information is made available to countries.

WHO has developed regional metrics for monitoring the cascade of HIV prevention, treatment and care information, and services. Ongoing programme monitoring is important to assess progress and identify areas for improvement.

One of the most heartening trends in the South-East Asia Region has been the active participation of civil society groups in the consultative process that has gone into the formulation of the World Health Organization’s recent guidelines for treatment of HIV and AIDS. “The consultations helped strengthen our relationship with WHO. We made a regional submission to WHO with examples of good practices from our partners. We are helping with the roll-out of the guidelines. This will eventually help in improving the quality, coverage and equity of services and interventions for key populations such as men who have sex with men (MSM),” says Midnight Poonkasetwattana, Executive Director of the Bangkok-based Asia-Pacific Coalition on Male Sexual Health (APCOM).

WHO’s consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations are a prime example of this collaboration. The recommendations focusing on earlier treatment saves lives and also prevents new infections – these guidelines were developed with inputs from affected communities living with HIV.

An important contribution by WHO to the SEAR HIV success story has been to ensure that the latest information is made available to countries.
critical to gauge the effectiveness of HIV tools and to plan for the future. WHO has also developed a set of simple five early warning indicators that can alert national programmes on emerging drug resistance and take corrective action before it is too late.

As Dr Razia N Pendse, WHO Regional Advisor, HIV/AIDS and STI, puts it, “Evidence-based guidelines are important for policy-making, benchmarking, resource allocation and designing systems for implementing programmes.”

Timely update of the national guidelines as per WHO global recommendation was a key factor behind the steady scale-up of access to antiretroviral treatment to those in need. While most countries have achieved success in the field of HIV/AIDS, Thailand’s example is notable. In the 1990s, its massive programme for 100% condom use achieved substantial reductions in new HIV infections and reduced prevalence of sexually transmitted diseases (STDs) dramatically, saving millions of lives and reducing new HIV infections.

Thailand was one of the early countries to use multi-drug regimen for prevention of mother- to-child transmission. Today with almost 99% coverage, Thailand could be the first country in Asia or even globally to eliminate mother- to-child transmission of HIV. Thailand has also contributed to the global knowledge on HIV prevention and treatment through its network of research institutions that have been doing cutting-edge research — most notable among them are the Thai Red Cross; HIVNAT based in Bangkok; and the Research Institute for Health Sciences, Chiang Mai.

Myanmar is another country that has recorded a steady decline in HIV and AIDS. From 2000, when the prevalence was 0.94% the figure came down to 0.6% in 2010 and to 0.47% in 2013. Timely update of the national guidelines as per WHO global recommendation was a key factor behind the steady scale-up of access to antiretroviral treatment to those in need.

WHO’s new consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations brings together all existing guidance relevant to five key populations – men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people – and updates of selected recommendations. To ensure that the technical content of WHO guidelines is effective at the ground level, it is important that these recommendations are understood clearly by the communities that they address. “Therefore, one of the things we have been doing is to pull out relevant bits and convert these into a more digestible form that ordinary people can absorb,” says Poonkasetsawattana.

The WHO South-East Asia Regional Office works closely with networks of people living with HIV and civil society organizations working on HIV to ensure equity and rights-based programming for people living with HIV, especially those belonging to key populations who are most at risk and yet stigmatized and marginalized. Examples of tools developed with community inputs include key publications such as the following: The Time Has Come: Enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific; Priority HIV and sexual health interventions in the health sector for men who have sex with men and transgender people in the Asia-Pacific Region.
STORY HIGHLIGHTS

• The appreciative inquiry (AI) approach was initiated by WHO in coordination with the Government of Nepal in 2012 to mobilize local communities and resources and build ownership among local communities towards the national immunization programme and ensure vaccination of every child in the country.

• The underlying principle of AI is to focus on existing strengths and achievements rather than analysis and criticism of unmet goals. This strength-based management tool is geared toward triggering an inner transformation within individuals who begin to see themselves as catalysts for change. Thus motivated, they take more responsibility and need less external support, supervision and monitoring to achieve their goals.

• Other countries, including Afghanistan and Bangladesh, are interested to learn from Nepal’s success in using AI to achieve improvement of maternal and child health goals, including immunization.

Civil society groups such as APCOM see themselves as active and engaged partners working hard to ensure that WHO guidelines do not remain a mere pieces of paper. “As APCOM and a community advocate for MSM and transgender in the Asia Pacific, we would like to understand how these guidelines will actually be implemented, and make them a reality,” Poonkasetwattana said

Advocates such as Poonkasetwattana exhort international agencies working in the field of HIV and AIDS to become part of the movement for the rights of vulnerable populations and advocate that the quality of services provided actually meet the needs of communities and that laws that punish or criminalize vulnerable populations such as the MSM group are removed, as recommended in the WHO guidelines.

WHO too has been hammering home this message; to achieve the UNAIDS fast-track targets with the aim of ending AIDS by 2030, Member States have to urgently reach out to key populations most vulnerable to HIV. This would become a reality only if these communities are treated as equal partners with governments in responding to the epidemic.

Roadblocks remain. Some countries in the Region continue to have punitive laws that criminalize and discriminate against populations such as sex workers, drug users and men who have sex with men.

WHO is playing a critical role in addressing many of these challenges. “Stigma, discrimination and restrictive laws continue to be barriers to accessing prevention, care and treatment services”, says Dr Poonam Khetrapal Singh, WHO Regional Director for the South-east Asia Region. “WHO ensures that the latest science with better and more effective interventions for the prevention and management of HIV is consolidated, updated and shared with Member countries. Our guidelines on the use of antiretroviral drugs for treating and preventing HIV infection, diagnosis, and treatment, are guided by human rights principles. WHO calls for governments to enforce protective laws to eliminate discrimination and violence faced by key populations,” adds Dr Singh.
Forty-one-year-old Nara Bahadur Karki was luckier than many in Kathmandu. The recent earthquake damaged his house. He slept out in the open for eight days. But no one died or was injured in his family. Now, he is back home, and has come to terms with the reality that he has lost many friends in the quake that devastated large parts of Nepal.

Now is the time for “healing and restoration,” says Mr Karki, a public health professional, who is a well-known appreciative inquiry practitioner and coach, and has conducted over 40 AI workshops in districts across Nepal. Perhaps it is the transformational nature of AI that lies behind his optimism.

“The underlying principle of appreciative inquiry is to focus on existing strengths and achievements rather than on analysis and criticism of unmet goals. After a three-day training session, this strength-based management tool helps to trigger a transformation within individuals who begin to see themselves as catalysts for change. Thus motivated, they take more responsibility and need less external support, supervision and monitoring to achieve their goals. This has been used very successfully in Nepal for social mobilization to ensure full immunization for every child,” adds Mr Karki.

Doing the same thing but in a different way

The national immunization programme is a top priority for Nepal. Currently the government provides 12 antigens – BCG, DPT-HepB-Hib, OPV, IPV, MR, PCV and JE (high-risk districts) – free of cost to children mainly through 16 000 outreach services. The vaccination coverage has increased over the years. The reported national coverage for the pentavalent (DPT-Hib-HepB) vaccine is more than 90% and that of the measles-rubella is about 88% but the overage is not uniform throughout the country. It varies due to many reasons – geography, sociocultural factors, ethnicity, mother’s education and family income.

Despite the government’s efforts to strengthen routine immunization over the years, 15% of children in this small, land-locked nation do not receive full immunization and 3% of children never receive any vaccines, according to the Multiple Indicator Cluster Surveys (MICS), 2014.

“The idea of using appreciative inquiry for full immunization was initiated by WHO in coordination with the Government of Nepal in November 2012. The AI facilitator, who works with WHO, facilitates AI-based workshops at the district level in addition to assisting in national reviews and monitoring,” says Dr Rajendra Bohara, National Coordinator, Programme for Immunization Preventable Diseases, WHO, Nepal.

How does AI help in ramping up immunization?

The process starts with a three-day AI workshop in the districts. The participants of the workshop include village development committee (VDC) secretaries, executives of municipalities, heads of health facilities, district-level officials, political leaders, media and local representatives of social organizations. During the workshop, participants make a commitment to ensure vaccination of every child. This is a transformative experience. After returning from the workshop, participants hold a series of meetings at the local level and take necessary action to ensure that every child eligible for vaccinations gets them. The AI session acts as an energizer.

In several places, there has been a palpable impact soon after the workshop. Vaccinators have been recruited. Additional incentives have been given to female community health workers to get every child vaccinated. Local leaders, media and teachers have pitched in for the initial verification process to certify that every child is vaccinated. Once the community is sure that all children below one year of age have been vaccinated, they invite the district coordination committee to verify the results, and request the VDC, municipality and district officials to go for a full immunization declaration.
The district coordination committee carries out a random survey to ascertain that no child is left unvaccinated. Then it gives permission for the declaration ceremony to take place to declare the district fully immunized for under-5-year-old children.

Goal achieved, there is a public ceremony that is attended by senior officials of the Ministry of Health including the minister, political leaders, partner agencies, the local community, schools, the media, mothers’ groups and female community health workers. In the ceremony, which takes the colour of a festival, the community workers and people who helped achieve the goal are felicitated for their hard work. In 2014, a village committee provided bicycles to the female community health workers for their contribution towards full immunization during the declaration ceremony in the Nawalparasi district.

“Being a part of the AI-based full immunization initiative has bought a sense of responsibility and commitment within us. The realization of potential within us has made us creators of new realities in our community through mobilization of local resources, ownership and participation,” says Lok Darshan Koirala Ward Secretary, Pokhara Sub-metropolitan City-9.

Mahendra Bista, Chairperson of the Federation of Nepalese Journalists, Morang, eastern Nepal, says that his involvement with the AI-based full immunization programme led him to recognize the constructive role that the media can play in bringing about social change by inspiring, empowering and motivating the community towards a shared dream.

Results

Since its inception in 2012, more than 900 VDCs, 35 municipalities and 8 districts have been declared fully immunized. The full immunization declaration process exemplifies successful coordination and cooperation between various line ministries (education, local development, women and child welfare, etc.). Nepal has set itself a goal – Declaration of a Fully Immunized Country by 2017.

Nepal’s experience in using AI to achieve public health goals such as improvement of maternal and child health and now full immunization has evoked interest by other countries. A delegation from the Ministries of Health from Afghanistan and Bangladesh visited Nepal to observe and participate in the AI training and declaration ceremonies.
Dr Rajendra Panda, an Indian doctor, now retired, vividly recalls the time when he led a government medical team deep into the forested areas of Dantewada in Central India in what is now Chhattisgarh state. “It was the summer of 1995. We were hearing reports of cases of yaws in Dantewada. But no doctor had actually seen anyone with yaws. Local health workers were unaware of its existence. So we set out to collect evidence. There were three of us – all medical doctors. We had to cross a river to get to the areas where yaws cases were suspected. There was no boatman; we rowed ourselves.

We walked 10 kms in the forest before we saw the first yaws case – a boy of about ten with heavy lesions on both his hands. He was roaming around, scantily clad, and seemed totally unaware that there was anything wrong.”

“We moved around the forest and found 12 more cases – mostly young children, some adults. We brought them to the nearest health sub-centre at Nelasar in Dantewada and took a blood test. They were diagnosed with yaws and each given a shot of penicillin,” says Dr Panda, a former Joint Director, National Centre for Disease Control at Bastar in Chhattisgarh.

“Very little of anecdotal patient perspective on yaws is available as it was such a neglected disease. The photographs of those yaws cases – some 30 slides – were used as teaching material for subsequent training sessions with doctors and paramedical staff,” points out Dr Panda. Soon after, India sought the help of the World Health Organization to deal with the disease.

Yaws, a chronic bacterial infection, is transmitted mainly through direct skin contact with an infected person. A single skin lesion develops at the point of entry of the bacterium, after 2-4 weeks of contact. If left untreated, multiple lesions appear all over the body. Although rarely fatal, yaws can lead to chronic disfigurement and disability. Overcrowding, poor personal hygiene and poor sanitation facilitate the spread of the disease. It is easily curable. Penicillin was the mainstay for the yaws eradication story in India. Subsequently, oral drugs have become available. Without treatment, every tenth person infected with yaws develops disfiguration and disabling complications. The bacteria causing yaws closely resembles the one that causes syphilis. However, unlike syphilis, yaws does not transmit through sexual route and is spread by intimate, skin-to-skin contact in humid tropical, remote, hilly and tribal regions of Africa, Asia and the Pacific Islands.

The global story of yaws eradication has had an uneven track record. Yaws was first targeted for global eradication in the postwar era. Between 1952 and 1964,
Making a Difference: WHO in South-East Asia Region

It spread in central and central-eastern parts of India. However, by late 1960s it declined dramatically worldwide including in India, where it remained confined to 51 districts across 11 states of the country.

While yaws-control activities were declining elsewhere globally, India sustained its efforts and launched the Yaws Eradication Programme in 1996–1997 and scaled up operations to its full geographical coverage by 1999, leading to its elimination in 2004. How did this turnaround come about?

Dr A. C. Dhariwal, presently Director of the National Vector-Borne Disease Control Programme, recalls his days as a young programme officer working on yaws: “Our focus was to interrupt yaws transmission and we did this by improving personal hygiene, sanitation, community awareness, and by early diagnosis and treatment of individual cases as well as targeted treatment of affected communities. Our interventions were a huge boon to the underserved population groups, as it provided them both health and social benefits,” says Dr Dhariwal.

The role of the community level functionaries in reaching inaccessible, at-risk populations and their success in controlling yaws paved the way for an important role for community-based health volunteers for future health interventions.

Dr S. K. Jain, National Programme Officer for Yaws Eradication Programme, says, “The strategy was kept simple yet effective by biannual pre-and-post-monsoon active house-to-house search, followed by treatment of cases and contacts. This was supplemented by strengthening capacity of health personnel in identification and management of the disease, strong surveillance, advocacy and community awareness, and intersectoral coordination with other concerned departments such as tribal welfare. To promote self-reporting and referrals, the programme also introduced cash incentives for patients as well as informers.”

“'Nil' case reporting has continued for more than 10 years now, and currently, yaws reporting has been integrated into weekly reports of the disease surveillance.
programme," says Dr Jain. ‘Nil’ case reporting is when the reporting unit reports zero cases even after completion of thorough surveillance activities.

The International Task Force for Disease Eradication at its meeting in October 2007 commended the example set by India in demonstrating the possibility of interrupting transmission of yaws nationwide, given sufficient political will and despite the biological constraints associated with the pathogen.

"India’s example hopefully will spur the global action to eradicate this highly curable and preventable neglected tropical disease,” says Dr Dhariwal.

In Bangladesh, since 2009, establishment of 14,000 community clinics (CCs) for every 6000 population across the country brings health care to the community doorstep. Now people can avail of health, family planning and nutrition services under one roof and within half-an-hour walking distance from their homes, even in remote areas.

CCs have contributed significantly to the improvement of the overall antenatal and postnatal care in Bangladesh. The clinics provide counseling on reproductive health and consequences of early marriage, and also supply contraceptives as well as care for pregnant women. Treatment is also provided for diarrhoea, pneumonia and other childhood infections.

People’s participation is an important element of CCs. Local community members actively participate in their management.
Dokhaiya Para, a ward (smallest local government administrative unit) in Bangladesh’s Rangamati district in the Chittagong Hill Tracts (CHT), is a picturesque place surrounded by hills and a lake. But Munni Chakma and Lima Sree Chakma, who commute every day by boat from the Rangamati town, have little time to enjoy the scenic beauty.

The boat journey takes more than an hour. It is not comfortable. The work they do, however, is quietly revolutionizing the health scenario across Bangladesh – from inaccessible, hilly terrain to storm and tidal bore-prone areas.

Both individuals work as community health care providers at the Dokhaiya Para Community Clinic. As soon as they arrive, there is a stream of patients that need immediate care. This community clinic is the only place for miles that offers basic health services and can also deal with a medical emergency.

Sumitra Chakma, an ethnic Pahari woman in her late 30s, is at the clinic to take her contraceptive injection; Jyoti Chakma is there with her sick three-year-old son. The clinic caters to pregnant women and sensitizes adolescent boys and girls about reproductive health. It also acts as the community’s hub for distributing vitamin and zinc tablets for malnourished children, and iron folic acid for pregnant and anemic women. The clinic has two family welfare assistants who make regular visits to 37 villages braving the tough hilly terrain, crossing raging creeks and defying hostile weather.
including women, teachers, representatives of landless and poorest of the poor, and adolescent girls and boys. The land, upon which most CCs are built, is donated by the local community, making it a great example of a public-private partnership. Before the opening of a clinic, CGs are given training by local health authorities on how to manage the clinics – on security, cleanliness and day-to-day maintenance. A community health care provider appointed by the government acts as the member secretary of the CG, manages the clinic and mobilizes people to avail of the health services.

“Twenty years ago, we couldn’t dream of having a fully-furnished medical centre literally in the courtyard of our community. For a far-flung community like ours, it was beyond anybody’s imagination. But the fact is that there is a community clinic here and everyone benefits from it,” says Biswajit Chakma, a member of the local union parishad and copresident of the community group managing the Dokhaiya Para Clinic.

WHO has not only played a pivotal role in the establishment of CCs, it also continues to provide technical support to the RCHCIB.

“CCs have positively contributed to the improvement of the health status of Bangladeshis, especially to the rural population,” says Dr N. Paranietharan, WHO Country Representative to Bangladesh. “We have been providing financial and technical support since the Revitalization Project started,” he further adds.

Bangladesh’s maternal mortality ratio has declined by an impressive 40% between 2000 and 2010. From 322 deaths per 100 000 live births in 2001, it fell to 194 deaths per 100 000 live births according to Bangladesh Maternal Mortality and Health Care Surveys. Effective services delivered by community clinics have been key to the decline in maternal deaths in the country.

An evaluation report by the Implementation Monitoring and Evaluation Division (IMED) of the Bangladesh Planning Ministry has noted that the number of people visiting the community clinics is increasingly due to the proximity of the clinics to their homes and the provision of free medicines for common ailments.
A 2014 report in Prothom Alo, a major Bangladeshi newspaper, points out that two other studies of the government also show 80% to 98% satisfaction among people who have used community clinic services. According to the IMED evaluation report, challenges remain, including repair and maintenance of the building infrastructure and tube wells in some of the community clinics.

But as Makhduina Nargis, RCHCIB Project Director, told Prothom Alo, “Despite shortcoming, it has been a great achievement that people across Bangladesh can now avail of health, family planning and nutrition services under one roof.”

**Mission Indradhanush: Leveraging Lessons from the Polio Success Story**

- Government of India partnering with WHO, UNICEF and other partners is leveraging the knowledge and infrastructure built during the polio campaign to step up routine immunization. This campaign, called Mission Indradhanush is targeting coverage for the seven vaccine preventable diseases.

- 2000 doctors and field monitors who were working with the WHO on the Polio eradication programme are now part of the nationwide initiative to vaccinate all unvaccinated and partially vaccinated children, under the Universal Immunization Programme by 2020.

- Strengthening routine immunization will ensure a decrease in the incidence of deaths due to these seven vaccine preventable diseases. Also the high population immunity against polio will help maintain the polio-free status of the South East Asia Region.
The work does not end there. There are house to house visits in high-risk settlements and traditionally under-served areas to check if any child has been missed out by the routine immunization sessions. Singh’s day usually ends with a meeting at the district headquarters with the Chief medical Officer reviewing the programme. Any lapses are immediately tackled. A phone call, a warning, usually work.

Singh, who was part of the WHO’s polio team and has worked in Barabanki for four years, is hugely excited about her work. “I am immensely proud of the fact that I was part of the collective effort to make India polio-free. Now we are using the same structures and skills to ramp up routine immunization through Mission Indradhanush.”

Singh is not the only one. These are exciting times for all the 2000-odd medical doctors and field monitors working with the WHO who are now part of the special nationwide initiative in India to vaccinate all unvaccinated and partially vaccinated children under the Universal Immunization Programme, by 2020.

“India’s victory against polio was a phenomenal feat. Now, we are leveraging the knowledge and infrastructure built during the polio campaign to step up routine immunization. This campaign, called Mission Indradhanush, is an inspiring reflection of the seven colours of the rainbow, and aims to protect all children in this country from the seven vaccine-preventable diseases: diphtheria, whooping cough, tetanus, polio, tuberculosis, measles and Hepatitis B,” says Mr. Jagat Prakash Nadda, India’s Minister for Health and Family Welfare.

“India’s victory against polio was a phenomenal feat. Now, we are leveraging the knowledge and infrastructure built during the polio campaign to step up routine immunization. This campaign, called Mission Indradhanush, is an inspiring reflection of the seven colours of the rainbow, and aims to protect all children in this country from the seven vaccine-preventable diseases: diphtheria, whooping cough, tetanus, polio, tuberculosis, measles and Hepatitis B,” says Mr. Jagat Prakash Nadda, India’s Minister for Health and Family Welfare.

“The Government of India, in partnership with the World Health Organization, UNICEF and other agencies, is leaving no stone unturned to ensure that there are no children who remain unvaccinated, or partially vaccinated against these seven vaccine preventable diseases. We hope to achieve this by 2020. The World Health Organization, one of our key partners in the polio eradication campaign, is assisting us with risk-analysis – identifying children in under-served areas who have not been fully immunized and the underlying reasons, to strengthen our efforts. The
WHO is also providing us valuable technical support in micro-planning, training and monitoring the work on the ground,” adds the Minister

The recently launched Mission focuses on interventions to expand full immunization coverage in India from 65% in 2013 to at least 90% children in the next five years.

India’s Health Ministry, with help from the WHO, has identified 201 high-focus districts across the country that have nearly 50% of all unvaccinated or partially vaccinated children in the country. Of these, 82 districts are in just four states -- Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan.

These districts are now the focus of intensive efforts to improve the routine immunization coverage in the country.

There are several reasons why India has so many unimmunised and partly immunised children -- vast pools of illiteracy, lack of awareness about the benefits of immunization and lack of access to healthcare facilities.

Reaching every child who missed out on immunization is not an easy task. The vulnerable are not just in the rural hinterland. Many live on the margins of urban India, like four-year-old Pooja. The girl lives with her family in a shanty made of corrugated iron at a construction site on the outskirts of Kolkata in eastern India, where Pooja’s father has been working for the past few months. The settlement is crowded with temporary workers and their families living in sheds and slum dwellings in and around the buildings that are under construction. They don’t have access to toilets or safe drinking water. The tenure of Pooja’s father’s work is uncertain. Once the construction at this site is completed, he and his family will pack up their few possessions and move on, setting up home wherever he can find work.

It is children of migrant workers like Pooja who often miss out on routine and supplementary immunization. Others at equal risk include those belonging to populations that are nomadic, living around brick kilns, urban slums, fishermens’ villages, living in riverine areas with shifting populations and other traditionally underserved and hard-to-reach groups like tribal communities and those living in forested areas. Those at risk also include populations which have a health facility exists but lack health workers.

**Why is routine immunization so critical for India and the South-East Asia Region?**

Strengthening routine immunization will ensure a decrease in the incidence of deaths due to the seven vaccine preventable diseases for which vaccines are being provided under the immunization programme.

Also, achieving high routine immunization coverage of children in the first year of life with the requisite three doses of oral polio vaccine is one of the pillars for polio eradication. The high population immunity against polio will help maintain polio-free status of the South East Asia Region. Without achieving this, pockets of non-immunized children could build up, reviving the threat of outbreaks of the polio virus.

“The virus does not understand the SEA Region has been certified polio-free and it can cross over at any time from polio hot-spots to any of the polio-free countries in the Region and the world. So we have to be alert and vigilant.

After polio-eradication, the National Polio Surveillance Project of WHO has transitioned into supporting routine immunization, elimination of measles and control of other vaccine-preventable diseases. The polio legacy that has been built up is being used for broader public health goals. The lessons and the resources that were used to fight polio are now being used to improve routine immunization,” says Dr Sunil Bahl, Medical Officer, Polio Eradication, Immunization and Vaccine Development at WHO’s Regional office.

WHO is assisting the Government of India in four key ways – risk-analysis which means mapping the high-risk pockets and settlements for inclusion in micro-plans, capacity-building and training key personnel, monitoring routine immunization activities and finally in building an accountability framework.

At the heart of the ongoing Mission Indradhanush is the meticulous risk-mapping, microplanning and monitoring that led to South-East Asia’s victory over polio.
Dr Bahl adds, “We not only know where the high-risk children are but also why they missed out on the routine immunization sessions. Polio monitors who went door to door checking if any children missed out on the polo drops are now doing same for routine immunization. On many occasions, we find that children are partially vaccinated because parents are not fully aware of the benefits of full immunization and also because sometimes they are scared about adverse effects following immunization. No one told them that slight pain or fever are routine symptoms after any vaccination. So training of health workers is also being ramped up. Frontline workers are being trained on how to build rapport with the community and to convince parents about the need to vaccinate their children and also to remove any irrational fears that families may have about the vaccines.

**STORY HIGHLIGHTS**

- Sri Lanka and Bhutan are providing inspiring stories of their battle to defeat malaria, with continuing support from WHO.
- With zero indigenous cases, Sri Lanka carefully monitors all possible imports from malaria-infested countries, at its borders – at all sea and air ports. Any person testing positive is immediately put on treatment.
- In Bhutan all entries from the vulnerable areas bordering India are screened for malaria and treated at the hospital located at the entry point, before entering the country. Malaria is now a notifiable disease and all high risk areas receive strict surveillance. Each index case is investigated, and active case detection undertaken.
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CASE STUDY

Battle against Malaria: Sri Lanka and Bhutan Show the Way

The other country on the verge of defeating malaria is the tiny Himalayan kingdom of Bhutan.

What lies behind their successes?

“...In both the countries, it was political commitment and sustained efforts of the health workers which produced the impressive results. WHO has helped the national effort by providing technical support, expertise, training as well as guidance for mobilizing resources. What produced results on the ground was very good surveillance, better targeting of interventions as well as community participation,” says Dr Leonard Ortega, Regional Adviser, Malaria – Department of Communicable Diseases, WHO SEAR.

Arguably more money for interventions like indoor residual spraying and insecticide treated bed nets, rapid diagnostic tests for accurate confirmation of malaria and artemisinin-combination drug therapy for treatment — have contributed to the anti-malaria campaign. But no one factor can be cited as the definitive one for paving the way towards victory.

According to Dr Risintha Premaratne, Director of Sri Lanka’s anti-malaria campaign, “Key components in the elimination efforts included enhanced malaria parasite screening in high transmission areas through active case detection using mobile malaria clinics; early diagnosis and prompt treatment effectively reducing the parasite reservoir and the potential for transmission; and strengthening the malaria mosquito surveillance leading to evidence-based vector control.” Dr Premaratne adds, “Lately, identification of specific high-risk groups and active foci and effective interventions targeting them has assisted in consolidating these achievements. Increased vigilance for imported malaria, prompt appropriate treatment with radical cure for imported cases, characterization and screening of high-risk groups, and high level of preparedness for rapid response are among the key activities employed now for the prevention of reintroduction.”

WHO has been a significant partner in progress throughout the malaria control and elimination efforts in Sri Lanka. The Roll-Back Malaria Initiative of WHO
How is Bhutan giving the last mile push to eliminating malaria?

"We have strengthened surveillance in every high risk area, and malaria is now a notifiable disease, which means every single case which is detected must be reported to a designated national agency. Each and every index case, or the case detected in a particular area, is investigated, and active case detection around the 1 Km radius covering all population is mandatory. As a main prevention and control strategy use of long lasting insecticidal nets (LLIN) in high risk areas is high. Besides this, two rounds of indoor residual spraying is being implemented in high risk areas annually.

WHO has been one of the main collaborating partners in malaria control in the country, providing technical support as well as logistics and malaria capacity development through trainings. WHO provided guidance during the national malaria strategic plan development in 2012 and also inputs during the Bhutan national strategic plan 2015–2020," adds Namgay.

Of particular significance in Bhutan’s battle against malaria is the situation in the 7 southern districts bordering India (the Indian states of West Bengal & Assam). These districts (Sarpang, Samtse, Chukha, Dagana, Zhengang, Pemagatshel and Samdrupjongkhar districts) are all “high-risk.”

"In Sarpang, Chhukha, Samdrupjongkhar and Samtse, the district hospital lies just at the entry point to the country. Everyone entering from the gate at the Border and intending to work or stay overnight in Bhutan is screened for malaria mandatorily and admitted to the hospital, if diagnosed positive to ensure adequate treatment before proceeding to interior of Bhutan, says Namgay.

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Bhutan too is pulling out all stops to eliminate malaria. In 2000, it reported more than 5000 malaria cases. Rinzin Namgay, Chief Programme Officer of Bhutan’s Vector-Borne Disease Control Programme proudly says that Bhutan had only 19 indigenous or locally acquired malaria cases in 2014 and the country is already in the malaria elimination phase.

A key issue is how to ensure that the profile of malaria stays up front in the minds of clinicians.

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screening every year during transmission season in summer and once in all mega-
hydroelectricity project areas. All positive cases are treated on site and followed up
till the 28th day,” Namgay adds.

Dr. Tashi Tobgay, Director, Human Resource and Planning in Bhutan’s Khesar Gyalpo
University of Medical Sciences, Bhutan, points out that throughout the land-locked
Himalayan nation, access to malaria diagnosis has been expanded. “Artemisinin-
based combination therapy was introduced and there is increased coverage of
high risk areas with Indoor Residual Spraying and long lasting insecticidal nets
and community involvement, and enhanced surveillance systems, all help malaria
elimination says Tobgay.

Tobgay appreciates WHO's catalytic role in the malaria control efforts. “WHO's
unwavering support has provided both technical and financial support in all the
endeavours that the program has initiated. WHO has also played a pivotal role in
helping Bhutan obtain grants from the Global Fund to Fight AIDS, Tuberculosis and
Malaria which have boosted the much needed funding for malaria elimination in
Bhutan,” adds Tobgay.

In both countries, the message is clear. In the battle against malaria, collaborations
are critical. The best results are when the health system teams up with other
government departments and external agencies.

Summarising the factors that led to the success against malaria in the two countries.
Dr Ortega says, “All the interventions were at the right place at the right time. WHO
provided technical support, and helped the countries obtain much-needed funds.
At the country level, there was lots of hard work. In Sri Lanka, for example, various
agencies of the government came together – the health ministry worked with other
sectors- agriculture, forestry, mining in carrying out the interventions.”